Associates in Women's Health, P.C.
2801 Youngfield St., Suite 200 □ Golden, CO 80401

Genetic/Family History Questionnaire

Will you be 35 years old or older at your due date?	Y N
Are you or your partner of:	
Jewish background?	Y N
Black/African background?	Y N
Mediterranean background (Italian/Greek)?	Y N
Asian background?	Y N
French/Canadian background?	Y N
Have you taken any medications (prescription or over the counter during your pregnancy?	Y N
Do you or your partner have epilepsy?	Y N
Have you used drugs (cocaine, marijuana, speed, etc) during your pregnancy?	Y N
During your pregnancy, have you taken Accutane, epilepsy medication, blood thinners, or lithium?	Y N
Are you diabetic?	Y N
Have you had radiation therapy or chemotherapy since your last menstrual period?	Y N
Are you and your partner related in any way (other than by marriage)?	Y N

Have you or your partner, or anyone in either family ever had:

	Me	My Partner	Family
A child with Down's syndrome or other chromosomal problem?	Y N	Y N	Y N
A child with mental retardation or significant learning disabilities?	Y N	Y N	Y N
Open spine (spina bifida), skull defect, or anencephaly?	Y N	Y N	Y N
Heart defect?	Y N	Y N	Y N
Muscle or neuromuscular disease (muscular dystrophy)?	Y N	Y N	Y N
Three or more miscarriages?	Y N	Y N	Y N
A stillborn baby?	Y N	Y N	Y N
A baby that died shortly after birth or in the first year?	Y N	Y N	Y N
Cystic fibrosis?	Y N	Y N	Y N
Hemophilia, sickle cell, thalssemia or other blood disorders?	Y N	Y N	Y N
Any birth defect or genetic disease not listed above?	Y N	Y N	Y N

Print Your Name _____

Date_____