

**Please complete this form and bring it with you to your appointment.*

OHIO STATE UNIVERSITY DIVISION OF MATERNAL FETAL MEDICINE

SCREENING QUESTIONNAIRE

Patient's name: _____ Referring physician: _____

First day of your last menstrual period (LMP): _____ Due date: _____

Your answers to the following questions will help us take a more complete family history and help us know whether to offer any additional testing. For each question, please check "yes" or "no" for yourself and for the father of the baby. The term "family" includes children, sisters, brothers, parents, nieces, nephews, aunts, uncles, and cousins. Your responses will be kept confidential.

	PATIENT		FATHER OF THE BABY	
	Yes	No	Yes	No
Will you be 35 years old or more by the time your baby is due?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your parents or grandparents from Southeast Asia, China, Taiwan, the Philippines, India, Greece, Italy, or the Middle East?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any Jewish or French Canadian ancestry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you Hispanic or African American?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have muscular dystrophy or any other neuromuscular disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have cystic fibrosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have a bleeding disorder such as hemophilia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had a neural tube defect (open spine, spina bifida, or anencephaly)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have mental retardation, learning disabilities, or autism?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have Down syndrome or any other chromosomal abnormality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is anyone in your family blind or deaf?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a stillborn child or more than two miscarriages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was anyone in your family born with a birth defect or condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe the problem: _____

*List any medications or drugs (including alcohol) you have used since your pregnancy began: _____

*Please list any allergies you have (including latex or medications): _____