MORRIS HOSPITAL & HEALTHCARE CENTERS

People You Know. Extraordinary Care.

Morris Obstetrics and Gynecology Specialists

Prenatal Genetic Screen

Name: _____

Date of Birth: _____

These questions pertain to you, the father of the baby, and both you and the father of the baby's parents, grandparents, siblings, and children.

If you answer yes, please explain who or any other detail that would be helpful.

1. Are you going to be older than 35 years of age at estimated date of delivery? _____

Any history of the following:

2. Thalassemia (Italian, Greek, Mediterranean or Asian Heritage) _____
3. Neural Tube Defects _____
4. Congenital Heart Defects _____
5. Down Syndrome _____
6. Tay-Sachs _____
7. Sickle Cell Disease _____
8. Canavan Disease _____
9. Hemophilia or Other Blood Disorder _____
10. Muscular Dystrophy _____
11. Cystic Fibrosis _____
12. Cognitive Delays or Developmental Delays _____
13. Autism _____
14. Fragile X _____
15. Anyone with any Inherited, Genetic, or Chromosomal Disorder?
    _____
16. Any history of Maternal Metabolic Disorder? _____
17. Anyone with any Birth Defects? _____
18. Have you or the Father of the baby ever had Tuberculosis? _____
19. Have you or the Father of the baby ever had a Stillbirth or history of 3 or more Miscarriage?
    _____
20. Have you or the Father of the baby had any Sexually Transmitted Disease, HPV, or Genital Herpes? _____
21. Have you taken any medications (prescription or over the counter), drank alcohol, or done any recreational or illicit drugs since your last menstrual period? _____
22. Have you had any rash or viral illness since last menstrual period? _____
23. Have you ever had a Blood Transfusion or received any Blood Products? _____
24. Would you consent to having a Blood Transfusion if medically necessary? _____