SINAI HOSPITAL
a LifeBridge Health center

FAMILY HISTORY FORM / GENETIC COUNSELING AND PRENATAL DIAGNOSIS PROGRAM

MOTHER OF BABY:
Name _____
Date of birth _____ Age _____
Occupation _____

FATHER OF BABY:
Name _____
Date of birth _____ Age _____
Occupation _____

Although most babies are born perfectly healthy, some are born with certain birth defects. Knowing this ahead of time can improve the pregnancy outcome and offer parents important options. The following questions will help us learn about your family history and any increased likelihood of birth defects. We would like to assure you that this information will be kept confidential. (Please CIRCLE your response to the following questions)

Will you be 35 or older when the baby is due? Y N

Have you been exposed to any of the following during your pregnancy:

medications?	Y	N
insulin?	Y	N
anti-seizure medication?	Y	N
street drugs?	Y	N
alcohol?	Y	N
cigarettes?	Y	N

Have you had any of the following during your pregnancy:

high fever?	Y	N
rashes?	Y	N
infections?	Y	N

Have you or the baby's father had serious medical problems, major surgeries, birth defects, or chronic illness? Y N

Are you and the baby's father blood relatives (for example, cousins)? Y N

Are you, or the baby's father:

Jewish (by ancestry) ?	Y	N
Italian/Greek/Middle Eastern?	Y	N
Black or African American?	Y	N
Asian?	Y	N

Does anyone in your family, or the baby's father's family, have one of the following condition(s):

Mental retardation or learning disability?	Y	N	Heart problems from birth?	Y	N
Cystic fibrosis or other lung disease?	Y	N	Cleft lip or palate?	Y	N
Spina bifida (open spine)?	Y	N	Bone problem?	Y	N
Hydrocephalus (water on the brain)?	Y	N	Tay-Sachs disease?	Y	N
Bleeding problems (like hemophilia)?	Y	N	Kidney disease or dialysis?	Y	N
Muscular dystrophy/muscle weakness?	Y	N	Neurologic (nerve) disease?	Y	N
Sickle cell disease or sickle cell trait?	Y	N	Down syndrome?	Y	N
Hearing loss or deafness?	Y	N	Blindness or Low vision ?	Y	N
Infertility or more than two miscarriages?	Y	N	Stillbirth or infant death?	Y	N

Is there anything else in your family, or the baby's father's family, that you are worried about? Y N

(If yes, please explain_____

_____

Please list any specific questions you would like addressed during your counseling session?

1._____
2._____
3._____
4._____