CHICAGO WOMEN'S HEALTH GROUP

Genetic Screening Questionnaire 2014

Name: _____ **Date:** _____

Instructions: Please answer the following questions to the best of your ability. Your healthcare provider will review the information given at your visit. Thank You.

1.	Will you be 35 years or older when the baby is due?	Yes	No
2.	Age of father of the child? _____		
3.	If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for Beta-Thalassemia?	Yes	No
4.	If you or the baby's father are of African descent, have either of you been screened for sickle cell trait?	Yes	No
5.	If you or the baby's father are of Philippine or Southeast Asian Ancestry, have either of you been tested for Alpha-Thalassemia?	Yes	No
6.	If you or the baby's father of Jewish background?	Yes	No
7.	Do you have any religious reasons that you cannot receive blood products/ transfusions?	Yes	No
8.	Have you, the baby's father, or anyone in either of your families ever had any of the following disorder:		
	• Neural Tube defect, i.e., Spina Bifida (myelomeningocele or Open spine), anencephaly	Yes	No
	• Congenital Heart Defect	Yes	No
	• Down Syndrome	Yes	No
	• Tay-Sachs	Yes	No
	• Canavan disease	Yes	No
	• Sickle cell disease	Yes	No
	• Hemophilia	Yes	No
	• Muscular dystrophy	Yes	No
	• Cystic Fibrosis	Yes	No
9.	Do you or the baby's father have any close relatives with mental retardation/ Autism?	Yes	No
10.	Do you or the baby's father have any close relatives with Fragile X?	Yes	No
11.	Do you or the baby's father have Diabetes, Metabolic Syndrome, Celiac Disease, PKU or any other disorder that prevents you from metabolizing food without assistance?	Yes	No
12.	Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal disorder not listed above?	Yes	No
13.	In this or any previous relationships, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses?	Yes	No

OVER →

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14. Have you taken any prescribed medications, over-the-counter medications, recreational drugs, or alcohol since your last menstrual period? Yes No

if yes, list medication and dose. _____

15. Have you ever had Chicken Pox? Yes No

16. Have you had any previous surgeries? Yes No
If yes, please list procedure and date.
_____

17. Have you or the baby's father ever had or been treated for a sexually transmitted disease, such as Chlamydia, herpes, gonorrhea, syphilis? Yes No

18. Have you or the baby's father ever had a positive test for HIV or been exposed to AIDS? Yes No

19. Have you ever had or tested positive for Tuberculosis? Yes No

20. Are you and the baby's father related (besides marriage)? Yes No

21. Have you or the baby's father ever had Hepatitis? Yes No

22. Do you work in the Healthcare field? Yes No

23. Do you have cats? **Y or N**

Do you Garden? **Y or N**

Traveling outside the country during pregnancy? **Y or N**

24. Have you had any previous pregnancies with a different practice? Yes No
If yes,

Date of delivery: _____

How many weeks when delivered: _____

Vaginal or C-Section: _____

Weight of baby: _____

25. Have you had gestational diabetes in a previous pregnancy Yes No

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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