March of Dimes
Serving babies, together

Prenatal/Preconception Family History Questionnaire

Name of Patient_____ Name of Partner_____
DOB_____ DOB_____

Ethnic background/ countries of origin of ancestors
Mother of the pregnancy_____
Father of the pregnancy_____

Do you have the following ancestry?		
Southeast Asia, Taiwan, China, Philippines	Yes___	No___
Italy, Greece, or the Middle East	Yes___	No___
Eastern European (Ashkenazi) Jewish	Yes___	No___
French Canadian	Yes___	No___
Cajun	Yes___	No___
African American	Yes___	No___
Caucasian (White)	Yes___	No___
Hispanic	Yes___	No___

Does your partner have the following ancestry?		
Southeast Asia, Taiwan, China, Philippines	Yes___	No___
Italy, Greece, or the Middle East	Yes___	No___
Eastern European (Ashkenazi) Jewish	Yes___	No___
French Canadian	Yes___	No___
Cajun	Yes___	No___
African American	Yes___	No___
Caucasian (White)	Yes___	No___
Hispanic	Yes___	No___

Has Anyone in either of your families had:	Your Family		Partner's Family	
Down Syndrome	Yes___	No___	Yes___	No___
Other chromosome abnormalities	Yes___	No___	Yes___	No___
Neural tube defects (e.g. open spine, spina bifida, anencephaly	Yes___	No___	Yes___	No___
Hemophilia or other bleeding disorder	Yes___	No___	Yes___	No___
Cystic Fibrosis	Yes___	No___	Yes___	No___
Sickle Cell Anemia	Yes___	No___	Yes___	No___
Thalassemia (Mediterranean anemia)	Yes___	No___	Yes___	No___
Tay-Sachs disease	Yes___	No___	Yes___	No___
Mental Retardation	Yes___	No___	Yes___	No___
Fragile X syndrome	Yes___	No___	Yes___	No___
Muscular Dystrophy	Yes___	No___	Yes___	No___
Neurofibromatosis	Yes___	No___	Yes___	No___
Huntington disease	Yes___	No___	Yes___	No___
Other nerve, muscle, or seizure disorder (e.g. epilepsy)	Yes___	No___	Yes___	No___
Phenylketonuria (PKU) or any other metabolic condition requiring special foods or other treatment	Yes___	No___	Yes___	No___
Kidney disease	Yes___	No___	Yes___	No___
Heart defect (from birth)	Yes___	No___	Yes___	No___
Cleft lip and/or cleft palate	Yes___	No___	Yes___	No___
Limb birth defects (extra/missing digits, malformed arms, legs, hands, feet)	Yes___	No___	Yes___	No___
Any other birth defects (missing kidney, water on the brain)	Yes___	No___	Yes___	No___
Deafness or hearing loss beginning in childhood	Yes___	No___	Yes___	No___

(over)

Name of Patient _____ **Date**_____

Prenatal/Preconception Family History Questionnaire (continued)

Has Anyone in either of your families had:	**Your Family**	**Partner's Family**
Blindness/early onset vision loss	Yes___ No___	Yes___ No___
Diabetes	Yes___ No___	Yes___ No___
Other medical conditions that run in the family	Yes___ No___	Yes___ No___
A child who died, a stillborn child, or three or more first trimester miscarriages?	Yes___ No___	Yes___ No___

For any " yes" answers, please list who was affected and any other information you know about that person's condition:

Are you and the baby's father blood-related (i.e. cousins, uncle-niece)?
Yes_____ No_____

Is there any other family history that you have concerns about?

During this pregnancy, have you had or been exposed to any of the following?		
Infections, rashes, or other illness, or a fever over 101 degrees?	Yes___	No___
X-rays, hospitalizations, or surgery?	Yes___	No___
Cigarettes?	Yes___	No___
Alcoholic beverages (beer, wine or hard liquor)?	Yes___	No___
"Street" drugs (cocaine, speed, marijuana, heroin)?	Yes___	No___
Occupational, chemical, or other exposures?	Yes___	No___
Accutane, epilepsy medication, blood thinners or Lithium?	Yes___	No___
Any other prescription or non-prescription medications?	Yes___	No___
Insulin for the treatment of diabetes?	Yes___	No___

If yes to any of the above, please describe:

Patient Signature_____

(over)