Palmetto Health USC
MEDICAL GROUP
Department of Obstetrics and Gynecology
USC Genetic Counseling

PRENATAL GENETIC COUNSELING INTAKE FORM

Patient's name _____ Date of Birth _____

Husband/Partner's name _____ Date of Birth _____

If you are pregnant: First Date of Last Menstrual Period (LMP) _____

Have you had an ultra sound during this pregnancy? ☐Yes ☐No

What is your due date? _____

What is the total number of times you've been pregnant (including current pregnancy)? _____

Full-term deliveries: _____ Preterm deliveries (before 32 weeks):_____ Miscarriages/Stillbirths: _____ Terminations:_____ Living: _____

If applicable, please list the names and ages of your children:

Name	Age	Health Problems

If applicable, please list the first names and ages of your husband/partner's children, if from another relationship(s):

Name	Age	Health Problems

Is there any the following in either your or the father of the baby's family?	Patient	Father of the baby
Birth defects (such as club foot, cleft lip or palate, spina bifida, heart defect, kidney problems, limb defects, etc.)	☐Yes ☐No	☐Yes ☐No
Chromosome abnormalities, such as Down syndrome?	☐Yes ☐No	☐Yes ☐No
Intellectual disabilities or learning disabilities?	☐Yes ☐No	☐Yes ☐No
More than 2 miscarriages or any still births?	☐Yes ☐No	☐Yes ☐No
Any other condition that seems to run in your or your partner's family?	☐Yes ☐No	☐Yes ☐No
Any diagnosed genetic condition in your or your partner's family?	☐Yes ☐No	☐Yes ☐No

If you answered yes to any of these questions, please explain: _____

_____

- Please list ***your*** *ancestry* (ex: English, Italian, Greek, Ashkenazi Jew, Hispanic, African American, Asian, Caucasian, etc)

Patient: _____

- Please list ***your partner's*** *ancestry* (ex: English, Italian, Greek, Ashkenazi Jew, Hispanic, African American, Asian, Caucasian, etc)

Partner: _____

Have you or your partner had testing for sickle cell trait?	☐Yes ☐No	Results: _____
Have you or your partner had testing for cystic fibrosis?	☐Yes ☐No	Results: _____
Have you or your partner had testing for β-Thalassemia?	☐Yes ☐No	Results: _____
Have you or your partner had any other genetic testing?	☐Yes ☐No	Results: _____

Do you have now or have you even been diagnosed with:

High Blood Pressure	☐Yes ☐No
Kidney Disease	☐Yes ☐No
Heart Disease	☐Yes ☐No
Diabetes mellitus (sugar)	☐Yes ☐No
Seizure disorder	☐Yes ☐No
Infertility	☐Yes ☐No
Depression	☐Yes ☐No

If you answered yes to any of the above, please explain: _____

_____

During THIS pregnancy (since your last period), have you:

Experienced any bleeding?	☐Yes ☐No
Had any infections or rashes?	☐Yes ☐No
Had a fever higher than 101?	☐Yes ☐No
Gone to the hospital for any medical problems?	☐Yes ☐No
Had any X-rays taken?	☐Yes ☐No
Used any medications?	☐Yes ☐No

If yes, please list: _____

Smoked cigarettes? ☐Yes ☐No

If yes, how many do you smoke a day? _____

Consumed alcohol (including beer, wine, and liquor)? ☐Yes ☐No

If yes, about how many drinks per day? _____

Used any illicit/street drug? ☐Yes ☐No

If yes, what type and how much per day? _____

Are your family and the father of the baby's family related before marriage? ☐Yes ☐No

If yes, how are you related (ex: first cousins, second cousins) _____

Please list any other questions or concerns that you would like to discuss during the counseling session.

_____

_____

_____

_____

_____

_____

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