

# Rusk Women's Center

OBSTETRICS, GYNECOLOGY & INFERTILITY

**RUSK WOMEN'S CENTER**  
**115 S. BARRON ST.**  
**RUSK, TX 75785**

## OB/GYN GENETIC SCREENING FORM

### 1. Patient's Name:

\_\_\_\_\_

Last First Maiden

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of the Father of the Child:

\_\_\_\_\_

Last First Maiden

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

### 2. Pregnancy History:

Number of Pregnancies: \_\_\_\_\_ Number of Livebirths: \_\_\_\_\_ Number of Stillbirths: \_\_\_\_\_

Number of Miscarriages/Abortions: \_\_\_\_\_

Delivery Dates (living and deceased):

\_\_\_\_\_

Sex: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Health Status: \_\_\_\_\_

Was father different from above? \_\_\_\_\_

3. Are you and the father of this pregnancy blood relatives? \_\_\_\_\_

4. Are there inherited disorders, or any birth defects, in the families of you or of the father of this pregnancy? If yes, list:

\_\_\_\_\_

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**5.** Do you have any belief that would change the type of medical care you prefer to receive? For example, are you a Jehovah's Witness? \_\_\_\_\_

**6.** If you or the child's father identify within one or more of the following demographics, please circle which may apply and answer the corresponding questions.

Black      Indian      Eastern Mediterranean

Have you and/or the child's father or any family members had the diagnosis of Sickle Cell Anemia or Sickle Cell Trait or had Sickle Cell Anemia Carrier test? \_\_\_\_\_

Jewish

Have you and/or the child's father or any family members had Tay-Sachs carrier testing, or have any family members had Tay-Sachs disease? \_\_\_\_\_

Italian      Greek      Asian      African

Have you and/or the child's father or any family members had any form of Thalassemia or had Thalassemia carrier testing? \_\_\_\_\_

**7.** Please list any medicines (prescription or over the counter) taken since becoming pregnant:

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Do you use any drugs (street, illegal, recreational) not listed above? If yes, please list:

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Have you been exposed to any x-rays, chemicals, or environmental hazards since this pregnancy? If yes, please list:

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**8.** Have any of the following disorders, or other disorders, occurred in you or the father of this child or in the families of either of you (parents, children, sisters, brothers, and descendants)? Please provide at the bottom of this sheet IN DETAIL all information on ANY disorder you check. If possible, please bring any medical records documenting the occurrence of this disorder. If there is no family history of birth defects or disorders, please list "NONE" and your initials. \_\_\_\_\_

\_\_\_\_ Infant or Childhood Deaths

\_\_\_\_ Mental Retardation

\_\_\_\_ Stillbirths

\_\_\_\_ Downs Syndrome (mongolism)

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- |  |  |
|--|--|
| <input type="checkbox"/> Spina Bifida (open spine)                 | <input type="checkbox"/> Acute Intermittent Porphyria                              |
| <input type="checkbox"/> Anencephaly                               | <input type="checkbox"/> Cleft Lip or Palate                                       |
| <input type="checkbox"/> Hydrocephaly (water on the brain)         | <input type="checkbox"/> Congenital Heart Disease/Defect                           |
| <input type="checkbox"/> Sickle Cell Anemia or Trait               | <input type="checkbox"/> Blindness   |
| <input type="checkbox"/> Tay-Sachs Disease or Carrier              | <input type="checkbox"/> Deafness  |
| <input type="checkbox"/> Thalassemia                               | <input type="checkbox"/> Polycystic Kidney Disease                                 |
| <input type="checkbox"/> Cystic Fibrosis                           | <input type="checkbox"/> Any Skeletal (bone) Disorder                              |
| <input type="checkbox"/> Galactosemia                              | <input type="checkbox"/> Dwarfism (short stature)                                  |
| <input type="checkbox"/> Phenylketonuria (PKU)                     | <input type="checkbox"/> Multiple Miscarriages                                     |
| <input type="checkbox"/> Hemophilia or Bleeding Disorder           | <input type="checkbox"/> Enzyme or Metabolic Disease                               |
| <input type="checkbox"/> Muscular Dystrophy or any Muscle Disorder | <input type="checkbox"/> Other known or suspected inherited or genetic conditions: |
| <input type="checkbox"/> Birth Defects (list below)                | _____  |
| <input type="checkbox"/> Huntington's Chorea                       | _____  |

9. Do you have reason to believe that you have been exposed to AIDS?  YES  NO  
Have you ever had any blood transfusions?  YES  NO

10. Do you currently or have you ever had a viral infection known as herpes?  YES  NO

11. Do you have any other concerns or history not covered above?  YES  NO

IF ANY OF YOUR RESPONSES IN THIS FORM WERE "YES", EXPLAIN WHO IN THE FAMILY IS AFFECTED AND PROVIDE THE MEDICAL DETAILS BELOW IN DETAIL:

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Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_