KAMM MCKENZIE OBGYN
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GENETIC HISTORY QUESTIONNAIRE

PATIENT NAME____________________________________ **DOB**_____/_____/_______ **DATE**_______________

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Please list if patient, baby's father or anyone in either family has any of the following:

Will you be 35 or older at the time of delivery? Yes/No

Greek, Italian, Asian or Mediterranean ancestry ____

Neural Tube Defects (ie: Spina Bifida) ____

Congenital heart defects ____

Down Syndrome ____

Tay-Sachs (Jewish or French Canadian ancestry) ____

Canavan's Disease ____

Sickle cell disease or trait ____

Hemophilia or other blood disorders ____

Muscular dystrophy____

Cystic fibrosis____

Huntington's Chorea ____

Mental retardation/autism ____

Other inherited genetic or chromosomal disorder ____

Maternal metabolic disorder (DM, PKU, etc) ____

Pt or FOB with a child with a birth defect not listed above ____

Patient or FOB with a birth defect themselves ____

Recurrent pregnancy loss or stillbirth ____

Any medications since LMP other than prenatal vitamins ____

Any other genetic/environmental exposure to discuss? ____

____ ____________________________

Signature of Patient or parent if minor Date