

MILFORD OB-GYN PHYSICIANS, P.C.
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Please answer the following questionnaire:

GENETICS SCREENING

The following questions pertain to you, the father of the baby, or anyone in either family:

	<u>YES</u>	<u>NO</u>
1. Is your age greater than or equal to 35 years?	_____	_____
2. Hemophilia or bleeding disorder?	_____	_____
3. Neural Tube Defect (Meningomyelocele, Open Spine or Anencephaly)?	_____	_____
4. Down Syndrome (Mongolism)?	_____	_____
5. Are either you or the baby's father of Jewish or French-Canadian ancestry?	_____	_____
Have either of you been screened for Tay Sach's Disease?	_____	_____
6. Are either you or the baby's father Afro-American?	_____	_____
Have either of you been screened for Sickle Cell Trait?	_____	_____
7. Are either you or the baby's father Italian, Greek or Mediterranean background?	_____	_____
Have either of you been tested for B-thalassemia?	_____	_____
8. Are either you or the baby's father Philippine or Southeast Asian ancestry?	_____	_____
Have either of you been tested for A-thalassemia?	_____	_____
9. Congenital heart defects?	_____	_____
10. Muscular Dystrophy?	_____	_____
11. Cystic Fibrosis?	_____	_____
12. Huntington Chorea?	_____	_____
13. Polycystic Kidney Disease?	_____	_____
14. Phenylketonuria?	_____	_____

GENETICS SCREENING

Cont'd.

	<u>YES</u>	<u>NO</u>
15. Mental Retardation?	_____	_____
16. Other inherited genetic or chromosomal disorder?	_____	_____
If yes, was person treated for Fragile X?	_____	_____
17. Patient or baby's father had a child with birth defect not listed above?	_____	_____
(a) More than 2 First Trimester Spontaneous Abortions, or a Stillbirth?	_____	_____
(b) Have either of you had a chromosomal study?	_____	_____
If yes, indicate who and the results:		
18. Medications or street drugs since last menstrual period?	_____	_____
If yes, agents(s):		
19. Have you had any X-Ray studies done just before you became pregnant or just after you missed a period?	_____	_____
20. Do you own or take care of a cat?	_____	_____
21. Do you eat raw meat or raw fish?	_____	_____

DATE

PATIENT'S SIGNATURE