SWEDISH
MEDICAL GROUP

OB, GYN & Midwifery Pregnancy and Genetic History Questionnaire

PATIENT LABEL

Preferred Name: _____

Date of Birth: _____

Today's Date: _____

Pregnancy Intent:

There are several options in pregnancy. Are you considering:

☐ continuing the pregnancy with intent to parent

☐ continuing the pregnancy with intent of adoption

☐ abortion

☐ other (surrogacy, etc.)

☐ uncertain – would like to discuss

Exposures Affecting Health:

1. Do you have any reason to believe you, or your sexual partner(s) may have been exposed to HIV/AIDS?
   ☐ Yes ☐ No

2. Have you been exposed to chemicals (e.g., pesticides, lead, hazardous materials/agents) or radiation (e.g., X-rays) since you became pregnant?
   ☐ Yes ☐ No
   If yes, please describe: _____

3. Have you, or your partner(s) recently traveled outside of the United States?
   ☐ Yes ☐ No
   If yes, where was the travel, and who traveled? _____

Gynecology History:

1. Have you ever had herpes? ☐ Yes ☐ No
   If yes: On what part of your body do you have outbreaks? _____
   How often do you have outbreaks? _____

2. Have you ever had syphilis? ☐ Yes ☐ No
   If yes: How and when were you treated? _____

3. Were you using an IUD for contraception when you became pregnant?
   ☐ Yes ☐ No

4. Have you been treated for infertility? ☐ Yes ☐ No
   If yes: Please describe when and treatment received:

   _____

Family/Inherited Genetic History:

We understand that there are many ways of building a family. The following questions ask about the people who contributed to the genetic makeup (genetics) of the current pregnancy. Please answer "yes" if the following applies to any person who is genetically related to the baby.

1. What ethnicity/race do you self-identify with? (List as many as appropriate)

   _____

2. What is the biological partner's ethnicity/race? (List as many as appropriate)

   _____

3. Please check if the baby has one of the following genetic backgrounds:
   a. Ashkenazi
      ☐ Yes ☐ No ☐ I don't know
   b. Black/African American
      ☐ Yes ☐ No ☐ I don't know
   c. Mediterranean or South Asian Ancestry
      ☐ Yes ☐ No ☐ I don't know
   d. French Canadian or Cajun Ancestry
      ☐ Yes ☐ No ☐ I don't know

4. Has there been testing for the following conditions in any of the baby's genetic relatives? This may have been in a previous pregnancy or due to a family history of these conditions/

a. Tay-Sachs	☐ Self	☐ Other genetic relative
b. Canavan	☐ Self	☐ Other genetic relative
c. Familial Dysautonomia	☐ Self	☐ Other genetic relative
d. Sickle Cell	☐ Self	☐ Other genetic relative
e. Thalassemia	☐ Self	☐ Other genetic relative
f. Cystic Fibrosis	☐ Self	☐ Other genetic relative
g. Spinal Muscular Atrophy	☐ Self	☐ Other genetic relative
h. Genetic carrier screening	☐ Self	☐ Other genetic relative

If yes for any of the above, please describe the testing done, who was tested, and the result:

_____

5. Does the baby have any genetic relative born with physical variations, or living with a disability since birth? This can include things like developmental variations, mental diversity, or other genetic conditions.

☐ Yes ☐ No

If yes, please describe:

_____

6. Is there a history of pregnancy loss (miscarriages or stillbirths)?

☐ Yes ☐ No

a. If yes, has there been genetic counseling and/or genetic testing related to the history of pregnancy loss?

☐ Yes ☐ No

If yes, please describe the testing and the results (if known):

_____

7. Is there a family or inherited history of Fragile X Syndrome, intellectual disabilities/cognitive delays, autism, or premature ovarian insufficiency?

☐ Yes ☐ No

8. Do you want screening test(s) to look for genetic or chromosomal problems like Down Syndrome during your pregnancy?

☐ Yes ☐ No ☐ I don't know