ANTEPARTUM RECORD: PG 1 NAME: ____________________

DATE: ____________________

<table>
<tr><td>BIRTH DATE AGE RACE
MO DAY YR</td><td>MARITAL STATUS

S M W D SEP</td><td rowspan="2">ADDRESS</td></tr>
<tr><td>EDUCATIONAL LEVEL</td><td>EMPLOYMENT</td></tr>
<tr><td rowspan="2">FATHER OF BABY

TELEPHONE NUMBERS</td><td rowspan="2">EMERGENCY CONTACT

TELEPHONE NUMBERS</td><td>TELEPHONE NUMBERS
H:
W:
C:</td></tr>
<tr><td>INS:</td></tr>
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GENETIC SCREENING QUESTIONNAIRE

Yes____ No____ Will you be 35 years or older when the baby is due?

Yes____ No____ Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

- Down syndrome (mongolism)
- Other chromosomal abnormality
- Neural tube defect such as spina bifida or anencephaly
- Hemophilia
- Muscular dystrophy
- Cystic fibrosis

If yes, please indicate your relationship to the affected person.____________________

Yes____ No____ Do you or your baby's father have a birth defect?____________________

Yes____ No____ In any previous relationships, have you or your baby's father had a child, born dead or alive, with a birth defect?____________________

Yes____ No____ Do you or your baby's father have any close relatives with mental retardation?____________________

Yes____ No____ In any previous relationships, have you or your baby's father had a stillborn child or three or more spontaneous pregnancy losses?____________________

Yes____ No____ Are you or your baby's father of Jewish ancestry? Have you been tested for Tay-Sach's disease?

Yes____ No____ If you or your baby's father is black, have either of you been tested for Sickle cell anemia?

Yes____ No____ If you or your baby's father are of Italian, Greek or Mediterranean background, have either of you been tested for B-Thalassemia?

Yes____ No____ If you or your baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for alpha-Thalassemia?

Yes____ No____ Have you taken any over-the-counter or prescription medications since pregnancy? If so, please list:

____

Yes____ No____ Have you used recreational or illegal drugs? If so, Please list:____________________

Yes____ No____ Have you consumed alcohol since pregnancy? If so, how much each day:____________________

Yes____ No____ Do you use tobacco products? If so, how much each day?____________________

____________________ Signature of Patient

____________________ Date