Genetic Screening Questionnaire

Fertility and Reproductive Medicine Center
Washington University Physicians and Barnes-Jewish Hospital

Patient's Name _____ Date of Birth _____

Partner's Name _____ Partner's Date of Birth _____

This questionnaire is designed to identify risk factors in your personal or family history that may impact your reproductive risks. The questions will enable us to determine whether you may benefit from additional testing or genetic counseling. All answers will be kept confidential.

Please note that no questionnaire can be comprehensive so if you have specific concerns about your/your partner's personal medical history or family history, please make your physician aware.

1. Please indicate your ancestry/ethnic origin (e.g. German, African, etc.).

   Self: _____

   Partner: _____

2. Do you or your partner have any Eastern European (Ashkenazi) Jewish ancestry?

   ☐ Self ☐ Partner ☐ Neither

3. Do you or your partner have any French-Canadian or Cajun ancestry?

   ☐ Self ☐ Partner ☐ Neither

4. Do you or your partner have any African/African-American, Asian, Caribbean, Hispanic, Mediterranean, Mennonite, Middle Eastern, or Sephardic/Mizrahi Jewish ancestry?

   ☐ Self ☐ Partner ☐ Neither

5. Have you or your partner ever had genetic testing such as carrier screening or a karyotype (chromosomes)?

   ☐ Self ☐ Partner ☐ Neither

   If yes, explain and please provide a copy of the test report(s) to our office: _____

   _____

6. Do you or your partner have a genetic condition or chromosome abnormality such as a translocation?

   ☐ Self ☐ Partner ☐ Neither

7. Have your or your partner ever had a stillbirth or more than two miscarriages together or with a different partner?

   ☐ Self ☐ Partner ☐ Neither

Fertility and Reproductive Medicine Center
4444 Forest Park Ave. Ste 3100, St. Louis, MO 63108
Phone: (314) 286-2497 • Fax: (314) 286-2455

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8. Are you and your partner biologically related to one another?

☐ Yes, relationship: _____ ☐ No

9. Do you, your partner, or any family member (children, parents, brothers, sisters, nieces, nephews, aunts, uncles, or grandparents) have any of the following? *If yes, please provide details and, if available, genetic test results.*

Condition	**Yes**	**No**	**Details** (affected individual, age diagnosed, etc)
Intellectual disability/developmental delay	☐	☐	
Autism	☐	☐	
Heart defect present at birth	☐	☐	
Cleft lip or palate	☐	☐	
Neural tube defect (e.g. spina bifida, anencephaly)	☐	☐	
Limb anomaly (e.g. extra/missing fingers, abnormality of arms, legs, hands, feet)	☐	☐	
Other birth defect	☐	☐	
Hearing loss or deafness diagnosed less than age 60	☐	☐	
Serious eye conditions or blindness	☐	☐	
Hemophilia or other bleeding/clotting disorder	☐	☐	
Alpha or beta thalassemia	☐	☐	
Sickle cell anemia or sickle cell trait	☐	☐	
Cystic fibrosis (CF) or CF carrier	☐	☐	
Spinal muscular atrophy (SMA)	☐	☐	
Tay-Sachs disease	☐	☐	
Polycystic kidney disease	☐	☐	
Neurofibromatosis	☐	☐	
Seizures/epilepsy	☐	☐	
Muscular dystrophy (e.g. Duchenne, myotonic) or other neuromuscular disease	☐	☐	
Dwarfism or skeletal dysplasia	☐	☐	
Huntington's disease	☐	☐	
Hereditary cancer syndrome (e.g. BRCA)	☐	☐	
Cancer diagnosed less than age 50	☐	☐	
Chromosome translocation or other chromosome condition (e.g. Down syndrome)	☐	☐	
Known carrier of a genetic condition	☐	☐	

10. Do you or your partner have concerns about any other conditions in either of your families not listed above?

☐ Yes, explain: _____ ☐ No

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