DIANE LINK, RNC, NP

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

JACK W. TUBBS, JR., M.D.

GENETIC SCREENING/TERATOLOGY COUNSELING

Includes patient, baby's father, or anyone in either family

Name: _____ D.O.B.: ____/____/____

		YES	NO
1.	Patient's age is greater than 35 years	_____	_____
2.	Thalassemia (Italian, Greek Mediterranean or Asian background	_____	_____
3.	Neural Tube Defect (Meningomylocele, Spina Bifida or Anencephaly)	_____	_____
4.	Congenital Heart Defect	_____	_____
5.	Down Syndrome	_____	_____
6.	Tay-Sachs (e.g. Jewish, Cajun or French Canadian background)	_____	_____
7.	Sickle Cell Disease or Trait (African)	_____	_____
8.	Hemophilia	_____	_____
9.	Muscular Dystrophy	_____	_____
10.	Cystic Fibrosis	_____	_____
11.	Huntington Chorea	_____	_____
12.	Mental Retardation/Autism (If yes, was the person tested for Fragile X?)	_____	_____
13.	Other Inherited Genetic or Chromosomal Disorder	_____	_____
14.	Maternal Metabolic Disorder (e.g. Insulin Dependent Diabetes, PKU)	_____	_____
15.	Patient or baby's father had a child with Birth Defects not listed above	_____	_____
16.	Recurrent Pregnancy loss or a Stillbirth	_____	_____
17.	Medications, Street Drugs, Alcohol since last Menstrual Period	_____	_____

If yes, please list _____

18. Other Comments _____

_____

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