

**Ventura County OB/GYN Medical Group, Inc**

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**PRENATAL DIAGNOSIS SCREENING QUESTIONNAIRE**

1. Will you be age 35 or older when the baby is due?  Yes  No  
 Age When Due
2. Have you or the baby's father, or anyone in either of your families, ever had:
  - a. Down syndrome or mongolism?  Yes  No
  - b. Spina bifida or meningomyelocele (open spine)?  Yes  No
  - c. Hemophilia (bleeding disorder)?  Yes  No
  - d. Muscular dystrophy?  Yes  No
  - e. Cystic fibrosis?  Yes  No
3. Have you or the baby's father had a child born dead or alive with a birth defect not listed in #2 above?  Yes  No  
If yes, describe: \_\_\_\_\_
4. Do you or the baby's father have any close relatives who are mentally retarded?  Yes  No
5. Do you or the baby's father, or a close relative in either of your families, have an inherited genetic or chromosomal disorder not listed above?  Yes  No  
If yes, describe: \_\_\_\_\_
6. Have you had two or more spontaneous pregnancy losses?  Yes  No
7. Do you or the baby's father have any close relatives descended from Jewish people who live in Eastern Europe (Ashkenazi Jews)?  Yes  No
8. Are you or the baby's father of African descent?  Yes  No  
Have you or the baby's father been screened for sickle cell trait and found to be positive?  Yes  No
9. Are you or the baby's father of Southeast Asian, Greek, Italian, or Mediterranean descent?  Yes  No  
Have you been screened for thalassemia?  Yes  No