Soheil A. Hanjani, MD, FACOG, FACS

Obstetrics & Gynecology

830 Oak Street, Suite 201W
Brockton, MA 02301
(508) 583-4961
Fax (508) 583-4732
Soheil.Hanjani@Steward.org

Patient's Name: ______________________________ Date of Birth: ____/____/____

______________________________ ______________

The following questionnaire will help evaluate the health of your unborn baby. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible.

Question	Answer	Follow-up
1. Will you be age 35 or older on your due date?	❑ Yes ❑ No	Your due date is____/____/____
2. Are you OR the baby's father from any of these ethnic backgrounds?	❑ Southern Chinese, Asian Indian, Taiwanese, Filipino or Southeast Asian ❑ Italian, Greek, Middle Eastern, or Spanish	If yes, have you or the baby's father been tested to see if you are a carrier of thalassemia or other hemoglobin abnormality? ❑ Yes ❑ No ❑ Don't know If yes, who was tested and what were the results? ______________________________
3. Have you, the baby's father, or any relative had a neural tube defect (such as open spine, spina bifida, anencephaly)?	❑ Yes ❑ No ❑ Don't know	If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father? ______________________________
4. Have you, the baby's father, or anyone in your families been born with a heart defect?	❑ Yes ❑ No ❑ Don't know	If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father? ______________________________
5. Have you, the baby's father, or anyone in your families had a pregnancy or a child diagnosed with Down syndrome?	❑ Yes ❑ No ❑ Don't know	If yes, how is this person related to you or the baby's father? ______________________________
6. Are you or the baby's father Jewish or French Canadian?	❑ Yes ❑ No ❑ Don't know	If yes, have either you or the baby's father been tested to see if you are carriers of Tay-Sachs disease, cystic fibrosis, or Canavan disease? ❑ Yes ❑ No ❑ Don't know If yes, who was tested and what were the results? ______________________________
7. Are you or the baby's father African American or of African descent?	❑ Yes ❑ No	If yes, have either you or the baby's father been tested to see if you have sickle cell trait (are a carrier of sickle cell anemia)? ❑ Yes ❑ No ❑ Don't know If yes, who was tested and what were the results? ______________________________

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8. Do you, the baby's father, or anyone in your families have hemophilia or another bleeding disorder?	❑ Yes ❑ No ❑ Don't know	If yes, please write the diagnosis or describe the disorder. How is this person related to you or the baby's father? ______________________________
9. Do you, the baby's father, or anyone in your families have a neuromuscular disease or muscular dystrophy?	❑ Yes ❑ No ❑ Don't know	If yes, please write the diagnosis or describe the disease. How is this person related to you or the baby's father? ______________________________
10. Do you, the baby's father, or anyone in your families have cystic fibrosis?	❑ Yes ❑ No ❑ Don't know	If yes, how is this person related to you or the baby's father? ______________________________
11. Do you, the baby's father, or anyone in your families have Huntington's disease?	❑ Yes ❑ No ❑ Don't know	If yes, how is this person related to you or the baby's father? ______________________________
12. Do you, the baby's father, or anyone in your families have autism or mental retardation?	❑ Yes ❑ No ❑ Don't know	If yes, please write the diagnosis or describe the problem. How is this person related to you or the baby's father? ______________________________
13. Do you, the baby's father, or anyone in your families have an inherited disorder or chromosome abnormality not listed above?	❑ Yes ❑ No ❑ Don't know	If yes, please write the diagnosis or describe the problem. How is this person related to you or the baby's father? ______________________________
14. Do you have insulin dependent diabetes, PKU, lupus, or another chronic condition?	❑ Yes ❑ No	If yes, please write the diagnosis: ______________________________
15. Do you, the baby's father, or anyone in your families have a birth defect not listed above?	❑ Yes ❑ No ❑ Don't know	If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father? ______________________________
16. Have you or the baby's father had a stillborn child or two or more pregnancy losses in this or any other relationship?	❑ Yes ❑ No ❑ Don't know	If yes, please describe: ______________________________
17. Have you taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious diseases?	❑ Yes ❑ No ❑ Don't remember	If yes, please describe: ______________________________
18. Did you, the baby's father, or anyone in your families have any other serious medical condition in infancy or childhood?	❑ Yes ❑ No ❑ Don't know	If yes, please describe. How is this person related to you or the baby's father? ______________________________

I have answered these questions to the best of my knowledge ______________________________

Patient Signature

For office use only: Reviewed by ______________________________ Date: ____/____/____

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