DVIF&G
Delaware Valley Institute of Fertility & Genetics
6000 Sagemore Drive, Suite 6102, Marlton, NJ 08053 • 856-988-0072 • Fax: 856-988-0056

# Genetic Risk Assessment Questionaire

**Patient Name** _____ **Partner Name** _____

**Date of birth** _____ **Date of birth** _____

*Please answer the following medical history questions about yourself. Please consider all family members related to you by blood, including parents, grandparents, siblings, half-siblings, nieces, nephews, aunts, uncles, cousins, and any children you have had together and/or with previous partners.*

| **Have any of the following conditions occurred in your family?** Check "yes" if the condition has occurred in you, your partner, and/or any of your relatives. Please specify how the person is related to you or your partner (example: grandmother, aunt, son, etc.) and details you know about the condition. Additional space id provided below. | **Patient and Family Members** | |
|---|---|---|
| | **Yes** | **Specify who in the family** |
| Open spine defect (e.g. spina bifida, anencephaly, hydrocephalus) | | |
| Heart defect at birth | | |
| Other birth defects (e.g. translocation carrier, Down Syndrome) | | |
| Bloood disorder (e.g. sickle cell anemia, thalassemia) | | |
| Bleeding disorder (e.g. hemophilia) | | |
| Blood clotting disorder (e.g. Factor V Leiden, Protein C deficiency) | | |
| Neuromuscular disease (e.g. muscular dystrophy) | | |
| Insulin dependent diabetes, PKU, lupus, or other chronic condition? | | |
| Cystic fibrosis | | |
| Adult onset neurological disorders (e.g. Huntington disease) | | |
| Fragile X syndrome | | |
| Mental retardation | | |
| Developmental delay or learning difficulties | | |
| Kidney disease at a young age (before 40 years old) | | |
| Ovarian cancer before age 50 | | |
| Any type of cancer diagnosed before age 21 | | |
| Two or more miscarriages | | |
| A stillborn baby or a baby that died within the first year | | |
| Premature menopause (before age 40) | | |
| Infertility | | |
| Any inherited disorder or chromasome abnormality not listed above? | | |
| Any other family history that is of concern? (please specify below) | | |

For any of the above answered "yes", please specify the condition. List who has the condition (you or the individual & how they are related to you, the approximate age that the condition was diagnosed, and any details about the condition that you know:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you and your partner related by blood? _____Yes _____No ____Unsure

If YES please explain how you are related

_____

_____

Have you taken any medication, or recreational drugs, now or in the past? _____Yes _____No ____Unsure

If YES please explain and list the name of the medication, dosage and duration of usage

_____

_____

Have you or anyone in your families had any serious medical conditions in infancy or childhood? _____Yes _____No ____Unsure

If YES please explain, and include if any family member has been diagnosed with ambiguous genetalia

_____

_____

*Some genetic conditions occur more commonly in certain racial and ethnic groups. please answer the following questions about your ethnic background and any genetic testing or carrier screening you may have had.*

## Ancestry:

| Are you or any of your blood relatives ... (Check all that apply) | Yes | Have you had carrier testing for ... | No | Yes | Unsure | If you had testing, when and what were the results? | |
|---|---|---|---|---|---|---|---|
| | | | | | | Date | Result |
| Caucasian? | | Cystic Fibrosis? | | | | | |
| From Italy, Greece, India, or the Middle East | | Thalassemia? | | | | | |
| From Southeast Asia, Taiwan, China, or the Phillipines? | | Thalassemia? | | | | | |
| African/African American or Hispanic? | | Sickle-cell trait? | | | | | |
| Jewish, French Canadian, or Cajan background? | | Cystic Fibrosis?<br>Tay-Sachs disease?<br>Canavan disease? | | | | | |
| Ashkenazi Jewish? | | Cystic Fibrosis?<br>Tay-Sachs disease?<br>Canavan disease? | | | | | |

Have you had chromosome analysis? _____Yes _____No ____Unsure

If YES what was the result?

_____

_____

Have you had any genetic testing not listed above? _____Yes _____No ____Unsure

If YES, please specify who had the testing, what the test was for and the result:

_____

_____

_____

_____

Name of the person completing form: _____ Date form completed: _____

Nurse/Medical Asst. who reviewed form: _____ Date:_____

Physician who reviewed form: _____ Date:_____