

MRN:

CURRENT PREGNANCY

During the pregnancy have you had:

- An illness or an infection? _____
- Fever? _____
- Vaginal bleeding or spotting? _____
- X-ray exposure? _____
- Alcohol? _____
- Cigarettes/Tobacco? _____
- Marijuana? _____
- Street Drugs? _____
- Medications (include doses if known)? _____
- Other Exposures? _____

During this pregnancy have you had an ultrasound? _____ If Yes, when? _____

Did it show any abnormalities? _____

During this pregnancy have you had any abnormal screening? _____ If Yes, which? _____

Did it show any abnormalities? _____

During this pregnancy have you or the father of the baby traveled out of the country and where? _____

Is there any chance that you and the father of the baby are related by blood (i.e.: cousins)? _____

Is the father of the baby involved in the pregnancy? _____

What questions or concerns about this pregnancy do you have for the genetic counselor?

For Office Use Only

Date: _____

Genetic Counselor: _____

Student/Observer: _____

Referring OB: _____

MFM: _____

Insurance: _____

Patient Accepted/Declined (circle accepted):

CVS Amnio FISH CMA NIPT FTS Quad Carrier Screen Other: _____

LabCorp Integrated Quest BCM Counsyl NTD Natara Other: _____

Database:

Pt. Name: _____
MR#: _____
DOB: _____
Pt. Accompanied By: _____

PRENATAL GENETIC COUNSELING
USF HEALTH
PEDIGREE FORM

Date Taken: _____
Counselor: _____
Student: _____
Indication: _____

(+/-)

- RSAB/SB
- ID/LD/DD
- Birth Defects
- Cancer <50
- Blind/Deaf
- Consanguinity
- Genetic Disease