Questionnaire to Assess Your **Reproductive Genetic Risk**

InformedDNA®
Genetics, Decoded

If you are pregnant or planning pregnancy, this questionnaire will help determine if a genetic counseling appointment may be beneficial to you. Answer all questions as best as you can. As you answer the questions, think about yourself, your reproductive partner and all of your blood relatives, including children, parents, brothers, sisters, aunts, uncles, nieces, nephews, cousins and grandparents. If you don't have an answer, leave it blank.

Today's Date: _____

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Phone: _____ Cell: _____ E-mail: _____

PERSONAL AND FAMILY HISTORY

1. Patient, partner or family member with any of the following:

PATIENT/ PARTNER	FAMILY MEMBER	
☐	☐	2 or more miscarriages
☐	☐	pregnancy loss beyond 20 weeks gestation (stillbirth) not known to be caused by cervical insufficiency or a cord accident
☐	☐	chromosome abnormality (e.g., Down syndrome, 22q11.2 deletion syndrome, Turner syndrome, Klinefelter syndrome)
☐	☐	birth defect (e.g., neural tube defect, heart defect, clef lip and/or palate)
☐	☐	intellectual disability (e.g., developmental delay, autism)
☐	☐	premature ovarian failure
☐	☐	diagnosis of a known genetic disorder (e.g., fragile X syndrome, Tay-Sachs disease, cystic fibrosis, muscular dystrophy, sickle cell disease)
☐	☐	carrier of a known genetic disorder

2. Patient or partner with any of the following:

- ☐ maternal age >/=35 years
- ☐ paternal age >/=40 years
- ☐ azoospermia/oligospermia
- ☐ congenital absence of the vas deferens

3. Patient and partner are blood relatives (consanguinity)

- ☐ Yes
- ☐ No
- ☐ Unknown

CURRENT PREGNANCY (IF APPLICABLE)

Current pregnancy with any of the following:

- ☐ abnormal ultrasound (e.g., birth defect anomaly)
- ☐ prenatal diagnosis (via CVS, amniocentesis) of genetic condition
- ☐ abnormal prenatal genetic screening (e.g., non invasive prenatal screening, maternal serum screening, carrier screening)
- ☐ prenatal microarray testing planned, pending or complete

ADDITIONAL GENETIC COUNSELING TOPICS

I would like more information regarding:

- ☐ carrier screening options and/or results (e.g., spinal muscular atrophy, fragile x syndrome, cystic fibrosis).
- ☐ risks related to my ethnicity. Specific recommendations exist for Ashkenazi Jewish, Cajun, French Canadian, Asian, Mediterranean, Middle Eastern, and Hispanic ethnicities.
- ☐ non invasive prenatal screening (cfDNA) and my options and/or my results.

FOR OFFICE USE ONLY

- ☐ Referred to InformedDNA for genetic counseling. (Pick one)
  - ☐ meets criteria*
  - ☐ to discuss general population risks and testing options (aneuploidy, carrier screening)
  - ☐ to discuss genetic testing planned/performed
  - ☐ high risk ethnicity
- ☐ Meets criteria,* referral declined
- ☐ Meets criteria,* already had genetic counseling
- ☐ Does not meet criteria*

** If any boxes are checked under Personal and Family History or Current Pregnancy, patient meets criteria for genetic counseling referral. Genetic counseling should be considered if any boxes under Additional Genetic Counseling Topics are checked.*