Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

**GENETIC HISTORY PATIENT BABY’S FATHER**

Thalassemia Y N Y N UNKNOWN

Neural Tube Defects Y N Y N UNKNOWN

Down’s Syndrome Y N Y N UNKNOWN

Tay-Sachs Y N Y N UNKNOWN

Sickle Cell Disease / Trait Y N Y N UNKNOWN

Hemophilia Y N Y N UNKNOWN

Muscular Dystrophy Y N Y N UNKNOWN

Cystic Fibrosis Y N Y N UNKNOWN

Huntington Chorea Y N Y N UNKNOWN

Mental Retardation Y N Y N UNKNOWN

Fragile X Y N Y N UNKNOWN

Other Genetic / Chromosomal Y N Y N UNKNOWN

Child with other birth defect Y N Y N UNKNOWN

More than 3 miscarriages Y N Y N UNKNOWN

History of Stillbirth Y N Y N UNKNOWN

Twins Y N Y N UNKNOWN

Any NON-Prescription Drugs, Street Drugs or alcohol since last menstrual period? Y N