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Women's Lifecycles
Obstetrics & Gynecology
Healthcare for Women by Women

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GENETIC RISK ASSESSMENT

Name:_____

Age:_____ Your partner's age:_____

Please circle both you and your partner's ethnic background(s):

Chinese, Asian, Indian, Taiwanese, Filipino, Korean, Southeast Asian, Italian, Greek, Middle Eastern, Spanish, French Canadian, Cajun, African American, African descent, Puerto Rican, Central American, Black, Caucasian, Jewish, Mennonite/Amish.

Please indicate if either you or your partner have a personal or a family history of any of the following conditions: Circle "YES" or "NO". If yes, indicate your relationship to the person:

Down Syndrome	NO	YES
Other chromosomal problem	NO	YES
Diabetes	NO	YES
PKU (Phenylketonuria)	NO	YES
Lupus	NO	YES
Mental retardation or autism	NO	YES
Spina Bifida (open spine)	NO	YES
Anencephaly (opening in the head/brain)	NO	YES
Bleeding/clotting disorder (like hemophilia)	NO	YES
Muscular dystrophy or neuromuscular disease	NO	YES
Cystic fibrosis	NO	YES
Neurofibromatosis ("elephant man syndrome")	NO	YES
Skeletal disorder (like dwarfism)	NO	YES
Polycystic kidney disease	NO	YES
Huntington disease	NO	YES
Heart defect at birth	NO	YES
Cleft lip/cleft palate	NO	YES
Baby who died after birth, or before the first birthday	NO	YES
Baby who was stillborn	NO	YES
Two (2) or more pregnancy losses (miscarriages/ectopics)	NO	YES

Please list:

Any birth defects not noted above, which apply to you or your family: _____

Other inherited or genetic conditions: _____

Any other serious medical condition, illness or surgery: _____