

Prenatal Genetics Screen



Name: _____ Date of Birth: ____/____/____

This form is intended to simply learn more about you and your family's history to better understand how it may influence your pregnancy. Your provider will be with you through your entire pregnancy and will answer any questions that arise along the way.

1. Will you be 35 years or older when the baby is due? Yes No

2. Have you, the baby's father or anyone in either of your families had any of the following? List relation (e.g. me, baby's father, relative)

- | | |
|---|---|
| <input type="checkbox"/> Birth Defect _____ | <input type="checkbox"/> Heart Defect _____ |
| <input type="checkbox"/> Canavan Dysautonomia _____ | <input type="checkbox"/> Hemophilia or Other Blood Disorders _____ |
| <input type="checkbox"/> Chromosomal Abnormality _____ | <input type="checkbox"/> Huntington's Disease _____ |
| <input type="checkbox"/> Cystic Fibrosis _____ | <input type="checkbox"/> Muscular Dystrophy _____ |
| <input type="checkbox"/> Developmental Disabilities _____ | <input type="checkbox"/> Neural Tube Defect (Spina Bifida, Anencephaly) _____ |
| <input type="checkbox"/> Downs Syndrome _____ | <input type="checkbox"/> Phenylketonuria (PKU) _____ |
| <input type="checkbox"/> Familial Dysautonomia _____ | <input type="checkbox"/> Spinal Muscular Atrophy (SMA) _____ |
| <input type="checkbox"/> Fragile X Syndrome _____ | <input type="checkbox"/> Other: _____ |

3. Indicate if the following questions apply to either you or the baby's father:

- Jewish Ancestry? Yes No
 Tested for Tay-Sachs Disease? Yes No
- African-American? Yes No
 Tested for Sickle Cell Trait? Yes No
- Philippine or Southwest Asian background? Yes No
 Tested for A-Thalassemia? Yes No
- Italian, Greek or Mediterranean background? Yes No
 Tested for B-Thalassemia? Yes No

4. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? Yes No

5. Do you have a litter box in your home? Yes No

6. Have you had chicken pox? Yes No

7. Have you had the rubella vaccine? Yes No

8. Have you had any x-rays during the pregnancy? Yes No

9. Have you been exposed to infectious diseases during the pregnancy? Yes No

10. Have you traveled outside of the country in the last three months? Yes No

Patient Signature: _____ Patient Name (Printed): _____

Provider Signature: _____ Date: _____

Safe Medications & Vaccines in Pregnancy



Allergies

Adhesive Nasal Strips
Allegra
Benadryl
Claritin
Flonase Allergy Relief
Nasonex
Saline Nasal Spray
Singulair
ZYRTEC

Cold, Flu & Cough

Chloroacetic Spray
Cough Drops / Lozenges
Delsym
Dextromethorphan
Mucinex
Robitussin
Sudafed (2nd and 3rd Trimester)
Tylenol Cold and Flu
Vicks

Constipation

Benefiber
Citrucel
Colace
FiberCon
Metamucil
Milk of Magnesia
MiraLAX
Senokot

Diarrhea

Imodium A-D
Kaopectate
Simethicone (Milicon or Gas-X)

Headaches, Aches & Pains

Magnesium Oxide
Tylenol / Acetaminophen
No Advil, Aspirin, Ibuprofen or Motrin

Heartburn, Reflux & Gas

Axid
Maalox
Mylanta
NEXIUM
PEPCID
Prevacid
Prilosec OTC
Rolaids
Simethicone (Mylicon or Gas-X)
TUMS Antacid Chewable Tablets

Hemorrhoids

Anusol-HC
Preparation H
Tucks Medicated Cooling Pads

Insomnia

Benadryl
TYLENOL PM
Unisom

Nausea & Vomiting

Dramamine
Emetrol for Nausea & Upset Stomach
Tigan
Vitamin B6

Vaginal Yeast Infection

Clotrimazole / Gyne Lotrimin
Femstat Vaginal
Monistat (7-Day Insert)
Mycelex

Vaccines

Hepatitis A
Hepatitis B
Influenza
TB Skin Test
Tetanus (Tdap)

Prescription Medications

Albuterol Inhaler
Amoxicillin / Ampicillin
Augmentin
Azithromycin / Zithromax
Bonjesta
Compazine
Diclegis
Erythromycin
Fioricet
Keflex
Macrobid
Mycolog II Cream
Phenergan
Lidocaine (Local Anesthetics)
Nystatin
Penicillin
Prednisone
Reglan
Tamiflu
Terazol
Theo-Dur / Theophylline
Valtex
Ventolin

Other

Hydrocortisone / Cortisone Cream
Nix Lice

NOTE: If you have questions about any medications not included on this list, please talk to your provider.