

Prenatal Diagnosis Clinic - Questionnaire (2023)

The questions below are for us to understand you better, and to help us to provide you with the best care. Please fill in the information to the best of your ability, and as accurately as possible. If you have questions or concerns regarding these questions, please feel free to ask your Genetic Counsellor during the private portion of your consultation.

1. Please tell us more about **yourself**:

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**First name:**

**Last name:**

**Preferred name:**

**Preferred pronouns:**      she/her      he/him      they/them      other:

**Date of birth:**

**Your health card number, including the version code (the two letters at the end)**

**Are you the biological parent of the current pregnancy, or a gestational carrier?**      Biological parent      Gestational carrier

**Age at the expected due date:**

**Occupation:**

**Ancestry:** (ethnic background, family countries of origin)

**First language:**

**Do you require an interpreter?**      No      Yes, language:

**Were you born with any birth defects that may have required surgery?** No Yes:

**Do you have any major health concerns or diagnoses that may require treatment?** No Yes:

**Do you have any allergies? If yes, please list what you are allergic to, and the reaction you get.** No Yes:

**Have you ever had general anaesthetic/sedation for a surgery or procedure before? If yes, have you ever had a bad reaction to the medication?** No Yes:

**Height:** cm ft **Most recent weight:** kg lbs

**Have you ever been to our clinic before? If yes, for what reason?** No Yes:

2. Please tell us more about the father of the pregnancy or sperm donor:

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*If you used a sperm donor, please only fill out the information that you know.*

**First name:** **Last name:**

**Preferred name:**

**Preferred pronouns:** she/her he/him they/them other:

**Date of birth:** **Age:**

**Occupation:**

**Ancestry** (ethnic background, family countries of origin):

**Were they born with any birth defects that may have required surgery?** No Yes:

**Do they have any major health concerns or diagnoses that may require treatment?** No Yes:

**Are you related to the father of the pregnancy, or from the same family?** No Yes:  
If yes, how are you related to each other?  
(e.g. first cousins)

3. Please tell us about your partner if they are NOT the biological father of the baby:

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**First name:**

**Last name:**

**Preferred name:**

**Preferred pronouns: :** she/her he/him they/them other:

**Occupation:**

4. Please tell us about your **current** pregnancy:

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**Due date:**

**Did you take any fertility medications or have fertility procedures to become pregnant (e.g. IUI, IVF)** No Yes:

**Please list any vitamins or medications you have had in the pregnancy**

**Did you take folic acid or prenatal vitamins BEFORE becoming pregnant?** No Yes

**Any infections, high fever, bleeding, spotting, or rashes in the pregnancy?** No Yes:

**Any environmental exposures (eg X-rays) or exposures to recreational drugs (eg. Heroin, cocaine)** No Yes:

**Are you smoking cigarettes? If yes, how many per day?** No Yes:

5. Contact and other information about you:

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<b>Preferred contact number:</b>	
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Cell    Home    Work	Can we leave a detailed message here?    Yes    No
<b>Secondary contact number:</b> Cell    Home    Work	Can we leave a detailed message here?    Yes    No
<b>Family doctor</b>	Name:  City:  May we send a copy of your summary letter to this doctor? Yes    No
<b>Obstetrician</b>  <b>Midwife</b>	Name:  City:  May we send a copy of your summary letter to them? Yes    No

6. Please tell us more about your previous pregnancies. If you have confidentiality concerns regarding a previous pregnancy, you may also choose to discuss that privately with your Genetic Counsellor.

Year	Outcome of pregnancy (abortion, ectopic, miscarriage, livebirth, etc.)	Gestation at delivery (Full term, 40 weeks etc.)	Birth weight	Singleton/ Multiple	Fetal sex / gender	Delivery type (Vaginal, C-section?)	Complications of delivery or pregnancy? (preeclampsia, gestational diabetes, growth restriction (IUGR) etc.)	Same or different partner?	Health concerns for the baby?

7. Family history information: For both you and the biological father of the pregnancy or sperm donor, please tell us about any family members with any major health concerns, and how they are related to you. It is most helpful to hear about children, brothers and sisters, parents, aunts and uncle, grandparents and cousins. Major health concerns may include the following:

- Birth defects requiring surgery
- Stillbirth
- Multiple miscarriages or pregnancy losses (3 or more for any one person)
- Significant developmental delay or cognitive impairments
- Genetic or inherited syndromes (such as Cystic Fibrosis or Muscular Dystrophy)
- Early onset (under 50 years of age) of cancer

<b>Related to the:</b>	<b>Type of relative</b>	<b>Details of the health concern</b>
<i>E.g. Mother</i>	<i>E.g. Paternal uncle (aka her father's brother)</i>	<i>E.g. Passed away after birth because of water on the brain</i>