NYU Langone MEDICAL CENTER | FERTILITY CENTER

# Preconception Genetic Questionnaire

Patient Name: _____ Date of Birth: _____

Partner Name: _____ Date of Birth: _____

1. Do you, your partner, your children, or anyone in your families have a genetic or chromosomal disorder? If yes, please indicate the relationship of the affected person to you or your partner. _____

   *Examples of genetic disorders may include (but are not limited to):*

   - *Muscular dystrophy (e.g. Duchenne, myotonic dystrophy)*
   - *Bleeding disorder (e.g. hemophilia)*
   - *Neurofibromatosis*
   - *Dwarfism/skeletal dysplasia*
   - *Marfan syndrome*
   - *Polycystic kidney disease*
   - *Huntington's disease*
   - *Cystic fibrosis*
   - *Spinal muscular atrophy*
   - *Intellectual/developmental disability or autism (e.g. Fragile X syndrome, Down syndrome)*
   - *Birth defect (e.g. spina bifida, cleft palate, heart defect)*
   - *Blindness or deafness*
   - *Hereditary cancer syndrome or cancer diagnosed < age 50*
   - *Balanced translocation*

2. In this or any previous relationship, have you or your partner had a pregnancy diagnosed with a chromosome disorder (e.g. Down syndrome) or a birth defect? If yes, please specify the diagnosis. ☐ No ☐ Yes _____

3. In this or any previous relationship, have you or your partner had a stillbirth or more than two (2) miscarriages? If yes, please provide further information. ☐ No ☐ Yes

   _____

4. Please indicate your ancestry/ethnicity (list all countries of origin):

   Self: _____

   Partner: _____

5. Do you or your partner have any Eastern European (Ashkenazi) Jewish ancestry?
   ☐ Self ☐ Partner

6. Do you or your partner have any French-Canadian or Cajun ancestry?
   ☐ Self ☐ Partner

7. Do you or your partner have any African (including African-American), Caribbean, Hispanic, Asian, Middle Eastern, Mediterranean, or Sephardic/Mizrahi Jewish ancestry?
   ☐ Self ☐ Partner

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8. Did you or your partner have carrier testing for any of the following diseases? If yes, please indicate the results and include a copy of your report if possible.

| | | | |
|---|---|---|---|
| Cystic Fibrosis (CF) | ☐ Self | ☐ Partner | |
| Spinal Muscular Atrophy (SMA) | ☐ Self | ☐ Partner | |
| Fragile X | ☐ Self | ☐ Partner | |
| Sickle Cell Disease | ☐ Self | ☐ Partner | |
| Beta Thalassemia | ☐ Self | ☐ Partner | |
| Alpha Thalassemia | ☐ Self | ☐ Partner | |
| Bloom Syndrome | ☐ Self | ☐ Partner | |
| Canavan Disease | ☐ Self | ☐ Partner | |
| Dihydrolipoamide Dehydrogenase Deficiency | ☐ Self | ☐ Partner | |
| Familial Dysautonomia | ☐ Self | ☐ Partner | |
| Familial Hyperinsulinism | ☐ Self | ☐ Partner | |
| Fanconi Anemia Type C | ☐ Self | ☐ Partner | |
| Gaucher Disease | ☐ Self | ☐ Partner | |
| Glycogen Storage Disease Type 1A | ☐ Self | ☐ Partner | |
| Joubert Syndrome Type 2 | ☐ Self | ☐ Partner | |
| Maple Syrup Urine Disease | ☐ Self | ☐ Partner | |
| Mucolipidosis Type IV | ☐ Self | ☐ Partner | |
| Nemaline Myopathy | ☐ Self | ☐ Partner | |
| Niemann-Pick Disease Type A | ☐ Self | ☐ Partner | |
| Tay-Sachs Disease | ☐ Self | ☐ Partner | |
| Usher Syndrome Type IF | ☐ Self | ☐ Partner | |
| Usher Syndrome Type III | ☐ Self | ☐ Partner | |
| Walker-Warburg Syndrome | ☐ Self | ☐ Partner | |

I and my partner have answered the questions to the best of our knowledge. Based on our responses, my physician, Dr. _____ has recommended genetic counseling and the following testing:

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline

My physician listed above has also requested a genetic consult and the following testing be performed before an In Vitro Fertilization (IVF) cycle can be initiated:

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline