Dynacare®
Genetics and Specialty Services

Preconception Questionnaire

This appointment is to discuss genetic testing options available to you prior to planning a pregnancy. Information on your personal and family history is collected to see if there are concerns, **other than the reason you were referred to us**, that should be addressed. If you have additional concerns, it may be necessary to arrange a separate appointment.

Today's date (mm/dd/yyyy): _____

Partner 1:

Name: _____ DOB (mm/dd/yyyy): _____

Your doctor : _____

Current gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Prefer not to say

Biological Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other (specify) _____
☐ Prefer not to say

What pronouns do you prefer? ☐ He/Him ☐ She/Her ☐ They/Them
☐ Other (specify) _____

Please indicate your preferred language of communication:
☐ English ☐ French ☐ English or French (bilingual) ☐ Mandarin ☐ Other: _____

Partner 2:

Name: _____ DOB (mm/dd/yyyy): _____

Your doctor : _____

Current gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Prefer not to say

Biological Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other (specify) _____
☐ Prefer not to say

What pronouns do you prefer? ☐ He/Him ☐ She/Her ☐ They/Them
☐ Other (specify) _____

Please indicate your preferred language of communication:
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Do you or your partner have a known medical condition or birth defect? ☐ Yes ☐ No

If yes, please describe. _____

_____

Have you or your partner (including any previous relationships) had a pregnancy or a child born with a birth defect or diagnosed with a genetic condition?
☐ Yes ☐ No

If yes, please specify (include relationship to affected individual): _____

_____

If yes, was any genetic testing done? (please provide results if available) ☐ Yes ☐ No

Have you or your partner (including any previous relationships) had a stillborn child or more than 2 miscarriages? ☐ Yes ☐ No

If yes, please provide details. _____

_____

Have you or your partner ever had carrier testing for a genetic condition (e.g. cystic fibrosis, thalassemia)? ☐ Yes ☐ No

If yes, please indicate who was tested, condition and results (Please include copy of report if possible): _____

_____

Are you and your partner related by blood?
☐ Yes ☐ No

If yes, how? (which side of family?)
☐ first cousins ☐ third cousins
☐ second cousins ☐ other/ I don't know

Family History

Are you or your partner adopted? ☐ Yes ☐ No

If yes, who? _____

Please indicate your ancestries (Please check all that apply):

African	☐ Partner 1	☐ Partner 2
Ashkenazi Jewish	☐ Partner 1	☐ Partner 2
Asian	☐ Partner 1	☐ Partner 2
Arab	☐ Partner 1	☐ Partner 2
Acadian	☐ Partner 1	☐ Partner 2
Caribbean	☐ Partner 1	☐ Partner 2
European	☐ Partner 1	☐ Partner 2
European (Eastern)	☐ Partner 1	☐ Partner 2
French Canadian	☐ Partner 1	☐ Partner 2
Hispanic	☐ Partner 1	☐ Partner 2
Indigenous Canadian	☐ Partner 1	☐ Partner 2
Pacific Islander	☐ Partner 1	☐ Partner 2
Other (Specify):	☐ Partner 1: _____	☐ Partner 2: _____

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Do you or your partner have a family history of any of the following?
If yes, please indicate condition and the relationship with the affected individual.

Muscular dystrophy	☐ Yes	☐ No	
Excessive bleeding or bruising	☐ Yes	☐ No	
Neural Tube defect (open spine)	☐ Yes	☐ No	
A child who was very ill or passed away in infancy or early childhood	☐ Yes	☐ No	
Childhood cancer or cancer that occurs at a younger age than usual	☐ Yes	☐ No	
Metabolic conditions (e.g., Gaucher disease, glycogen storage disease)	☐ Yes	☐ No	
Autism	☐ Yes	☐ No	
Learning disabilities or mental handicap	☐ Yes	☐ No	
Malformation at birth (e.g., hole in the heart, cleft lip and/or cleft palate)	☐ Yes	☐ No	
Hearing or vision loss from an early age	☐ Yes	☐ No	
Chromosome differences (e.g., Down syndrome)	☐ Yes	☐ No	

Do you have any other concerns about your family or your partner's family history?