Dynacare®
Genetics and Specialty Services

Prenatal Questionnaire

*These questions have been developed to allow us to prepare more accurately in advance of your appointment to make the session the most helpful it can be for you. We appreciate your time in completing this questionnaire.

Patient information

Patient Name: _____ DOB (MM/DD/YYYY): _____

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) _____

Health Card Number: _____ Your doctor(s): _____

Address: _____ Postal Code: _____

Phone: _____ Email: _____

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

Interpreter required: ☐ Yes ☐ No Language: _____

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1. What is your current weight? _____
2. What is the first date of your last menstrual period? (mm/dd/yyyy) _____
3. How many pregnancies have you had in total (including miscarriage, blighted ovum, termination, molar, carried to term)? _____
4. Have you had any pregnancy losses (miscarriage or termination)? _____
5. Are you currently pregnant? ☐ Yes ☐ No If you selected No, please go to question 16.
6. Do you have a date for/Have you had an ultrasound during this pregnancy? ☐ Yes ☐ No
   If you have selected yes, please indicate the date of your ultrasound: _____
7. If you have been referred due to an ultrasound finding, please indicate which finding(s) you are aware of:
   _____
8. Have you smoked cigarettes in this pregnancy? ☐ Yes ☐ No
9. Have you consumed any alcohol and/or used any substances in this pregnancy? ☐ Yes ☐ No
10. Have you had any spotting or bleeding in this pregnancy? ☐ Yes ☐ No
11. Do you have a diagnosis of diabetes (not including gestational diabetes)? ☐ Yes ☐ No
12. Have you been in a situation where your body temperature would have been very elevated for a prolonged period of time? ☐ Yes ☐ No
13. Do you have a history of hepatitis or HIV? ☐ Yes ☐ No
14. Have you taken any medication in this pregnancy? ☐ Yes ☐ No
    Name of medication: _____ Dose: _____
15. Do you have exposure to a cat at home? ☐ Yes ☐ No
16. Have you ever been diagnosed with a birth defect or genetic condition? _____
    If yes, relevant details: _____
17. Have you or your partner ever had a pregnancy affected with a birth defect or genetic condition?
    _____
    If yes, relevant details: _____

Prenatal Questionnaire

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: _____

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?

_____

_____