Date_____
Interviewer_____

Trisomy Mosaicism Questionnaire

Mother's Name_____ **Date of Birth** _____
(dd-mmm-yyyy)

Ethnicity _____

Pre-pregnancy weight _____ lbs/kg (circle)

# of pregnancies…….. ☐

# of terminations…….. ☐

# of spontaneous miscarriages…….. ☐

# of living children……. ☐
Please provide gestational age, birthdate, sex, type of delivery, and any complications for each:

#of twin or triplet pregnancies……. ☐

What was the first day of your last menstrual period (LMP) _____
(dd-mmm-yyyy)

Have you ever had an abnormal Maternal Serum Screen result in a previous pregnancy?

(please check)

Yes ☐ No ☐

If yes, did it indicate a risk for:

Down syndrome (trisomy 21)……. ☐

Trisomy 18 …… ☐

Open Spina Bifida…….. ☐

Do you suffer from:	**Yes**	**No**
Migraines?	☐	☐
Kidney disease?	☐	☐
High blood pressure?	☐	☐
Heart attack or stroke?	☐	☐
Diabetes?	☐	☐

Date_____
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Does your mother, father, or siblings (brothers or sisters) suffer from:

	Yes	No	If yes who?
Migraines?	☐	☐	_____
Kidney disease?	☐	☐	_____
High blood pressure?	☐	☐	_____
Heart attack or stroke?	☐	☐	_____
Diabetes?	☐	☐	_____

Has your mother and/or sisters had more than two spontaneous miscarriages?
Yes ☐ **No** ☐

Please list any medications you took during pregnancy:

	Yes	No	
Aspirin?	☐	☐	
Tylenol?	☐	☐	
Diclectin?	☐	☐	
Prescription medication?	☐	☐	Name/dose_____
other?	☐	☐	Name/dose_____

Please list any vitamins or herbal supplements you took during pregnancy:

	Yes	No	
Materna (or prenatal vitamin)?	☐	☐	Start date_____
Folic Acid?	☐	☐	Start date_____
Calcium?	☐	☐	
Iron?	☐	☐	
other?	☐	☐	Name/dose_____

Please circle any complications you experienced in this pregnancy:

Bleeding / fever / rash / infections / vomiting / headaches / abdominal pain