

## Tay-Sachs Disease Prevention Program Questionnaire

Physician's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Physician's business address: \_\_\_\_\_  
(Medical Institution) (City) (State) (Zip Code)

### **Patient Background Information**

1. Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_
2. Marital status:  Single  Married  
If married, spouse's full name: \_\_\_\_\_
3. Religion (by birth):  Jewish  Protestant  Catholic  Other  None
4. Ancestors' (parents and/or grandparents) country of origin other than the United States:  
(check all that apply)  Poland  Russia  Germany  Austria  
 Other: \_\_\_\_\_
5. Do you have any chronic illness?  No  Yes
6. Are you diabetic?  No  Yes  
If yes, are you taking insulin?  No  Yes
7. Do you have any current illnesses?  No  Yes  
If yes, please specify \_\_\_\_\_
8. Have you taken any of the following medications in the past week?  
 Birth control pills  Vitamins  
 Other (please specify): \_\_\_\_\_
9. Has Tay-Sachs disease ever occurred in a blood relative?  
 No  Yes  Other (please specify): \_\_\_\_\_
10. Has any blood relative been identified as a Tay-Sachs carrier?  
 No  Yes If yes, what exact relationship? \_\_\_\_\_
11. Have your parents been tested for Tay-Sachs carrier status?  
 No  Yes If yes, list results and year tested: \_\_\_\_\_
12. Has your spouse been identified as a Tay-Sachs carrier?  
 No  Yes
13. Are you or your spouse currently pregnant?  
 No  Yes If yes, how many weeks? \_\_\_\_\_
14. Number of children: \_\_\_\_\_
15. Number of children who have died before 5 years old: \_\_\_\_\_

Please complete all information and attach this form to the test requisition.  
Send both with the specimen in the transport bag to the laboratory.