

Tay-Sachs Disease Prevention Program Questionnaire

Physician 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.