HEALTHLAB

HealthLab
25 North Winfield Road
Winfield, Illinois 60190
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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.