AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

FOR OFFICE USE ONLY

IMPORTANT:
Please complete this form and return it to our office at least one week prior to your appt.
This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

Part I: Contact information
Part II: Your medical history
Part III: Your spouse/male partner's medical history (if applicable)

PART I: CONTACT INFORMATION

First Name ________________________ **Middle Initial** _______ **Last Name** ____________________________ **Age** _______

Date of Birth (MM/DD/YY) _______/_______/_________ Occupation ____

Home Street Address ____

City __________________________ State __________ Zip/Postal Code _______________ Country ______________________

Indicate which number to call or leave messages.
☐ Home Telephone (   ) ______________ ☐ Cell Phone (   ) _____________ ☐ Email ______________________

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ ____

Spouse/Male Partner
First Name ________________________ **Middle Initial** ________ **Last Name** ___________________________ **Age** _______
☐ Not Applicable

Date of Birth (MM/DD/YY) ______/_______/_________ Occupation ____

Home Street Address ____

City __________________________ State _________ Zip/Postal Code ________________ Country ______________________

Indicate which number to call or leave messages.
☐ Home Telephone (   ) ______________ ☐ Cell Phone(   ) ______________ ☐ Email: ______________________

Who referred you?
☐ Physician
Name ________________________________ Phone (   ) _________________
Address ____
☐ Former Patient/Friend ____
☐ Web Site ____
☐ Insurance (Name of Insurance) ____

Who is your Ob/Gyn?
Name __________________________________ Phone (   ) _______________
Address ____

Who is your Primary Care Physician?
Name __________________________________ Phone (   ) _______________
Address ____

Physician Notes
(for office use only)
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PART II: FEMALE HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other ____

What are your expectations for this visit? ____

What questions do you want answered at this visit? ____

____

Do you have any **personal, ethical or religious objections** to any of our tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? ☐ No ☐ Yes ___________________

How many months have you been having intercourse without using any form of birth control? ____________

Pregnancy Summary

* Total Number of ALL Pregnancies: _________ * Number of miscarriages (less than 20 weeks): __________
* Number of Ectopic/Tubal Pregnancies: ________ * Number of Elective Terminations (Abortions): __________
* Number of Full Term Deliveries: ________ Of these, how many were live births? ______ How many were stillborn? _______
* Any Pregnancies with Birth Defects? ☐ No ☐ Yes – explain ____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1. ______________	____________	__________________________	_________________________	Y N
2. ______________	____________	__________________________	_________________________	Y N
3. ______________	____________	__________________________	_________________________	Y N
4. ______________	____________	__________________________	_________________________	Y N
5. ______________	____________	__________________________	_________________________	Y N
6. ______________	____________	__________________________	_________________________	Y N

Menstrual History

* Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods
☐ Heavy periods ☐ Light periods ☐ Bleeding between periods
* Number of days between the start of one period to the start of the next period: _________ days
* How many days of bleeding do you have? _________ days
* Dates of the 1st day of your last 2 menstrual periods: ______/______/______; ______/______/______
* Age when you had your first period: ____ years old
* Age when you first noticed: Breast development: ____ years old; Pubic hair: ____ years old; Underarm hair: ____ years old
* How many periods do you have per year? ______
* Do you need medication to bring on a period? ☐ Yes – what type? ________________________ ☐ No
* If you do not have periods, at what age did you stop having them? ______ years old
* Do you have severe cramping or pelvic pain with your periods? ☐ Yes: __Always __Sometimes __Recently __In the Past ☐ No

Contraceptive History

☐ None ☐ Condoms – dates of use__________ ☐ Diaphragm – dates of use__________ ☐ IUD – dates of use_________
☐ Birth control pills – dates of use_________-complications? ___________________________ ☐ Never used birth control pills
☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) – dates of use______________-complications? _________________
☐ Skin patch – dates of use___________-complications? _________________________ ☐ Foam or jelly
☐ Tubal sterilization procedure (tubes tied) – date (month/year) ______/______ ☐ Tubes untied – date (month/year) ____/____

* Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

Sexual History

* How many times do you have intercourse per week? _____times per week ☐ None ☐ Not applicable
* Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No
* Do you have pain with intercourse? ☐ Yes ☐ No
* Do you use lubricants (K-Y Jelly®, etc) during intercourse? ☐ Yes-what types? _________________ ☐ No

Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ Yes (check all that apply) ☐ No
☐ Chlamydia – date______ ☐ Gonorrhea – date______ ☐ Herpes – date______ ☐ Genital warts/HPV – date______
☐ Syphilis – date______ ☐ HIV/AIDS – date______ ☐ Hepatitis – date______ ☐ Other – date________________

Pap Smear History
* When was your last pap smear (month and year)? ______/______ ☐ Normal ☐ Abnormal
* When was your last abnormal pap smear? ______ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?
☐ Yes (check all that apply) ☐ No
☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History
Have you ever had a mammogram? ☐ No ☐ Yes – date______ Result: ☐ normal ☐ abnormal – explain________________
Do you perform breast self exams? ☐ Yes ☐ No

Medical History
* Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions) ________________________________
____
____

* Are you allergic to any foods (peanuts, eggs, etc.)? ☐ No ☐ Yes (Please list and describe reactions) ___________________
____

* List any medications you are currently taking, including over-the-counter medicines:______________________________________
____

* Do you take any herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (Please list) _________________
____

* Do you have any medical problem(s)? ☐ No ☐ Yes (Please list type, dates and treatments.)
(1)____
(2)____
(3)____
(4)____
(5)____

* Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know
Other childhood diseases:____

Vaccinations

* Chickenpox (Varicella):	☐ No	☐ Yes (dates____________)	☐ Don't know
* MMR – Measles, Mumps and Rubella (German Measles):	☐ No	☐ Yes (dates____________)	☐ Don't know
* BCG (Tuberculosis):	☐ No	☐ Yes (dates____________)	☐ Don't know
* Hepatitis B:	☐ No	☐ Yes (dates____________)	☐ Don't know
* Polio:	☐ No	☐ Yes (dates____________)	☐ Don't know
* Hepatitis A:	☐ No	☐ Yes (dates____________)	☐ Don't know
* Tetanus:	☐ No	☐ Yes (dates____________)	☐ Don't know
* Influenza:	☐ No	☐ Yes (dates____________)	☐ Don't know

Social History
* How many caffeinated beverages (coffee, tea, soda) do you drink every day?_____ ☐ None
* Do you smoke cigarettes: ☐ No ☐ Yes How many/day?_____ How many years?______ ☐ Quit – when?______________
* Do you drink alcohol? ☐ No ☐ Yes
☐ Beer - # per week______ ☐ Wine - # per week ☐ Liquor - # per week
* Do you use marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes (describe____________________________________)
* Do you exercise? ☐ No ☐ Yes (describe____)
* Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes (describe_________________________________)

Physician Notes (for office use only)____
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Surgical History

* Have you had any surgeries? ☐ No ☐ Yes (List all surgeries in chronologic order.)

Year	Reason and Type of Surgery
___________	(1)____
___________	(2)____
___________	(3)____
___________	(4)____
___________	(5)____
___________	(6)____
___________	(7)____

*Did you have any anesthesia problems? ☐ No ☐ Yes (describe____)

Physical Symptoms

General:
☐ Recent weight gain or loss
☐ Anorexia/Bulimia
☐ Lack of energy
☐ Fever/Chills
☐ Other__________________
☐ None

Head, Eyes, Ears, Nose and Throat:
☐ Dizziness ☐ Loss of sense of smell
☐ Headaches ☐ Chronic nasal congestion
☐ Blurred vision ☐ Ringing ears
☐ Hearing loss/deafness
☐ Other__________________
☐ None

Respiratory:
☐ Shortness of breath
☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Tuberculosis
☐ Bloody cough
☐ Other__________________
☐ None

Endocrine/Hormonal:
☐ Diabetes ☐ Hair Loss
☐ Thyroid gland problems
☐ Rapid weight gain or loss
☐ Excessive hunger/thirst
☐ Temperature intolerance- hot flashes or feeling cold
☐ Other__________________
☐ None

Breasts:
☐ Discharge (clear?__ bloody?__ milky?)
☐ Lumps ☐ Pain ☐ Cancer
☐ Abnormal mammogram
☐ Reduction
☐ Augmentation/Breast implants (saline?___ silicone?___)
☐ Other__________________
☐ None

Neurological Problems:
☐ Weakness/Loss of balance
☐ Seizures/Epilepsy
☐ Headaches
☐ Migraine headaches
☐ Numbness
☐ Memory loss
☐ Other__________________
☐ None

Gastrointestinal:
☐ Nausea/Vomiting ☐ Ulcers
☐ Hepatitis ☐ Diarrhea
☐ Blood in your stools ☐ Constipation
☐ Irritable Bowel Syndrome
☐ Change in bowel habits
☐ Colitis (ulcerative or Crohn's)
☐ Other__________________
☐ None

Genito-Urinary:
☐ Bladder infections
☐ Kidney infections
☐ Vaginal infections
☐ Frequent urination ☐ Leaking urine
☐ Blood in the urine
☐ Herpes
☐ Other__________________
☐ None

Skin/Extremities:
☐ Unexplained rash/inflammation
☐ Acne
☐ Skin cancer
☐ Burn injury
☐ Moles changing in appearance
☐ Excessive hair growth
☐ Other__________________
☐ None

Musculoskeletal:
☐ Unusual muscle weakness
☐ Decreased energy/stamina
☐ Rheumatoid arthritis
☐ Lupus Erythematosus
☐ Myasthenia gravis
☐ Other_________________________
☐ None

Hematologic:
☐ Blood clotting disorder/Blood clot
☐ Sickle Cell Anemia ☐ Thrombophlebitis
☐ Easy bruising
☐ Swollen glands/lymph nodes
☐ Blood transfusions (dates/reasons_______________)
☐ Other_________________________
☐ None

Cardiovascular:
☐ Palpitations/Skipped beats
☐ Chest pain ☐ Heart attack
☐ Stroke ☐ Murmurs
☐ High blood pressure
☐ Rheumatic fever
☐ Mitral valve prolapse (Need antibiotics before dental procedures?) Y N
☐ Other_____________________
☐ None

Mental Health Problems:
☐ Depression ☐ Anxiety disorder
☐ Schizophrenia
☐ Other_________________________
☐ None

Physician Notes (for office use only) ___________________________________
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____
____
____

Family History

	Living		Cause of Death/Age at Death
* Mother	☐ Yes – age___	☐ No	______________________
* Father	☐ Yes – age___	☐ No	______________________
* Brother (s)	☐ Yes – age___	☐ No	______________________
	☐ Yes – age___	☐ No	______________________
* Sister(s)	☐ Yes – age___	☐ No	______________________
	☐ Yes – age___	☐ No	______________________
* Maternal Grandmother	☐ Yes – age___	☐ No	______________________
* Maternal Grandfather	☐ Yes – age___	☐ No	______________________
* Paternal Grandmother	☐ Yes – age___	☐ No	______________________
* Paternal Grandfather	☐ Yes – age___	☐ No	______________________

What is your ancestry?

____ African-American

____ American Indian/Native American

____ Ashkenazi Jewish

____ Asian-American

____ Cajun/French Canadian

____ Caucasian

____ Eastern European

____ Hispanic/Caribbean

____ Northern European

____ Southern European

____ Other (specify________________)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No

____ Sickle Cell Anemia: __Yes __No

____ Tay-Sachs Disease: __Yes __No

____ Thalassemia: __Yes __No

Disorders in Your Family

		Relationship to You		
* Breast cancer	☐ Yes	____________________	☐ No	☐ Don't Know
* Ovarian cancer	☐ Yes	____________________	☐ No	☐ Don't Know
* Colon cancer	☐ Yes	____________________	☐ No	☐ Don't Know
* Other cancer	☐ Yes	____________________	☐ No	☐ Don't Know
* Diabetes	☐ Yes	____________________	☐ No	☐ Don't Know
* Thyroid problems	☐ Yes	____________________	☐ No	☐ Don't Know
* Heart disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Blood clots	☐ Yes	____________________	☐ No	☐ Don't Know
* Obesity	☐ Yes	____________________	☐ No	☐ Don't Know
* Psychiatric problems	☐ Yes	____________________	☐ No	☐ Don't Know
* Tuberculosis	☐ Yes	____________________	☐ No	☐ Don't Know
* Endometriosis	☐ Yes	____________________	☐ No	☐ Don't Know
* Infertility	☐ Yes	____________________	☐ No	☐ Don't Know
* Menopause before age 40	☐ Yes	____________________	☐ No	☐ Don't Know
* Birth defects	☐ Yes	____________________	☐ No	☐ Don't Know
* Cystic Fibrosis	☐ Yes	____________________	☐ No	☐ Don't Know
* Tay-Sachs disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Canavan disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Bloom syndrome	☐ Yes	____________________	☐ No	☐ Don't Know
* Gaucher disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Niemann-Pick disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Familial Dysautonia	☐ Yes	____________________	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes	____________________	☐ No	☐ Don't Know
* Neurologic (brain/spine)	☐ Yes	____________________	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes	____________________	☐ No	☐ Don't Know
* Bone/Skeletal Defects	☐ Yes	____________________	☐ No	☐ Don't Know
* Dwarfism	☐ Yes	____________________	☐ No	☐ Don't Know
* Developmental delay	☐ Yes	____________________	☐ No	☐ Don't Know
* Learning problems	☐ Yes	____________________	☐ No	☐ Don't Know
* Polycystic kidney disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Heart defect from birth	☐ Yes	____________________	☐ No	☐ Don't Know
* Down syndrome	☐ Yes	____________________	☐ No	☐ Don't Know
* Other chromosome defects	☐ Yes	____________________	☐ No	☐ Don't Know
* Marfan syndrome	☐ Yes	____________________	☐ No	☐ Don't Know
* Hemophilia	☐ Yes	____________________	☐ No	☐ Don't Know
* Sickle Cell Anemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Thalassemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Galactosemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Deafness/Blindness	☐ Yes	____________________	☐ No	☐ Don't Know
* Color Blindness	☐ Yes	____________________	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	____________________	☐ No	☐ Don't Know

☐ None of the above ☐ Other (Specify____

PRIOR INFERTILITY TESTING AND TREATMENT

* Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

Prior Tests (check all that apply): ☐ Basal body temperature chart (date_____/results_______________________________________)

☐ Thyroid test (date_____/results____________________________) ☐ Ovulation test kit (date_____/results__________________)

☐ Day 3 blood test for FSH level (date_____/results______________) ☐ Hysterosalpingogram (HSG) (date_____/results_________)

☐ Laparoscopy surgery (date_____/results_____________________) ☐ Hysteroscopy surgery (date_____/results______________)

☐ Progesterone blood test (date_____/results___________________) ☐ Prolactin blood test (date_____/results________________)

Prior Treatment (check all that apply):

	# of cycles	**Dates** (mo/yr) (mo/yr)	**Outcome**
☐ Intrauterine insemination:	________	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with timed intercourse: Maximum # tablets per day?_____	________	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with insemination: Maximum # tablets per day?_____	________	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Daily fertility drug injections with insemination?: Maximum # vials per day?_____	________	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Completed in vitro fertilization cycle(s): 1. # eggs___ # embryos transferred__ # frozen___ 2. # eggs___ # embryos transferred__ # frozen___ 3. # eggs___ # embryos transferred__ # frozen___ 4. # eggs___ # embryos transferred__ # frozen___	________	______/______ ______/______ ______/______ ______/______	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Frozen embryo transfers: 1. # embryos transferred _____ 2. # embryos transferred _____ 3. # embryos transferred _____ 4. # embryos transferred _____	________	______/______ ______/______ ______/______ ______/______	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
Canceled in vitro fertilization attempt(s):	________		
☐ Any other prior treatment (describe): ____			

* Additional Information/Complications:____

____

____

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. __________

Do you see a counselor? ☐ No ☐ Yes – For how long? ________________ How often? _____________________

List any antidepressant/antianxiety medications you are currently taking. ____

Describe any emotional, marital or sexual problems caused by your infertility.______________________________________

____

PATIENT'S SIGNATURE____ **DATE** _______________________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE ____ **DATE** ______________________

Complete with your male partner, if applicable.

* Have you been evaluated by a urologist? ☐ Yes ☐ No
* Have you previously conceived with another woman? ☐ Yes: How many times? ____ ☐No: Birth control used? Yes___ No___
* Have you had a semen analysis? ☐ Yes ☐ No
* Do you have difficulty with erections? ☐ Yes ☐ No
* Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No
* Have you had any of the following sexually transmitted diseases or pelvic infections?
☐ Yes (check all that apply) ☐ No
☐ Chlamydia-date_____ ☐ Gonorrhea-date_____ ☐ Herpes-date_____ ☐ Genital warts/HPV-date_____
☐ Syphilis-date_____ ☐ HIV/AIDS-date_____ ☐ Hepatitis-date_____ ☐ Other____________________
* Have you had a history of undescended testicles? ☐ Yes – One side____ Both____ ☐ No
* Do you have scrotal or testicular pain? ☐ Yes ☐ No
* Did you have mumps after puberty? ☐ Yes ☐ No
* Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

*Have you been diagnosed with any of the following diseases?
☐ Diabetes Mellitus – Yes___ No___ ☐ Cancer – Yes___ No___
☐ Multiple Sclerosis – Yes___ No___ ☐ Other neurologic problems – Yes___ No___
☐ Prostatic infections – Yes___ No___ ☐ Urinary infections – Yes___ No___
☐ High Blood Pressure – Yes___ No___ If yes, any medications?__________________________

* Have you had any fever in the last 3 months? ☐ Yes ☐ No
* Have you had a vasectomy? ☐ Yes (date______) ☐ No
If yes, have you had a vasectomy reversal? ☐ Yes (date______) ☐ No
* Have you had surgery for varicocele repair? ☐ Yes ☐ No
* Have you had hernia surgery? ☐ Yes ☐ No
* Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No
* Are you exposed to prolonged heat in the workplace? ☐ Yes ☐ No
* Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
* Have you had chemotherapy for cancer? ☐ Yes ☐ No
* Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions)______________________________
____
____

List your current medications: ____

List any current medical problem(s)____

* How many caffeinated beverages do you drink per day?______ ☐ None
* Do you smoke cigarettes? ☐ No ☐ Yes How many/day? How many years?____ ☐ Quit – when?______________________
* Do you drink alcohol? ☐ No ☐ Yes
☐ Beer - # per week___ ☐ Wine - # per week___ ☐ Liquor - # per week___
* Do you use marijuana, cocaine or any other similar drug? ☐ No ☐ Yes (describe___________________________________)
* Do you use herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (describe_________________________)
* Are you aware of any radiation/toxic materials exposure? ☐ Yes ☐ No

* Do you use hot tubs regularly? ☐ Yes ☐ No
* Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't Know
* Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No
If yes, please describe____

Physician Notes (for office use only)
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____

Disorders in Your Family

Disorder		Relationship to You		
* Cystic Fibrosis	☐ Yes	______________________	☐ No	☐ Don't Know
* Tay-Sachs disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Canavan disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Bloom syndrome	☐ Yes	______________________	☐ No	☐ Don't Know
* Gaucher disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Niemann-Pick disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Familial Dysautonia	☐ Yes	______________________	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes	______________________	☐ No	☐ Don't Know
* Neurologic (brain/spine)	☐ Yes	______________________	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes	______________________	☐ No	☐ Don't Know
* Bone/Skeletal Defects	☐ Yes	______________________	☐ No	☐ Don't Know
* Dwarfism	☐ Yes	______________________	☐ No	☐ Don't Know
* Developmental delay	☐ Yes	______________________	☐ No	☐ Don't Know
* Learning problems	☐ Yes	______________________	☐ No	☐ Don't Know
* Polycystic kidney disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Heart defect from birth	☐ Yes	______________________	☐ No	☐ Don't Know
* Down syndrome	☐ Yes	______________________	☐ No	☐ Don't Know
* Other chromosome defects	☐ Yes	______________________	☐ No	☐ Don't Know
* Marfan syndrome	☐ Yes	______________________	☐ No	☐ Don't Know
* Hemophilia	☐ Yes	______________________	☐ No	☐ Don't Know
* Sickle Cell Anemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Thalassemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Galactosemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Deafness/Blindness	☐ Yes	______________________	☐ No	☐ Don't Know
* Color Blindness	☐ Yes	______________________	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	______________________	☐ No	☐ Don't Know

☐ None of the above

☐ Other (Specify____

What is your ancestry?

____ African-American

____ American Indian/Native American

____ Ashkenazi Jewish

____ Asian-American

____ Cajun/French Canadian

____ Caucasian

____ Eastern European

____ Hispanic/Caribbean

____ Northern European

____ Southern European

____ Other
(specify_________________)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No

____ Sickle Cell Anemia: __Yes __No

____ Tay-Sachs Disease: __Yes __No

____ Thalassemia: __Yes __No

SPOUSE/MALE PARTNER'S SIGNATURE____ DATE________________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE____DATE________________

Physician Notes (for office use only) ____

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