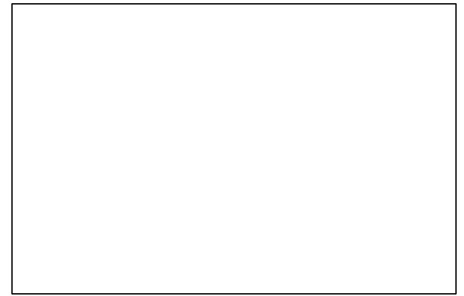


University of Washington Medical Center
University Reproductive Care

FERTILITY HISTORY FORM

Please complete this form and bring it with you to your scheduled appointment.

CONTACT INFORMATION:

First name: ____________________ Middle Initial: ____ Last Name:____________________________

Date of Birth: ____/____/____ Age: _________ Occupation:_________________________________

Home Street Address:____

City: ____________________ State: ________________ Zip/Postal Code: ______________________

Indicate which number to call or leave messages

☐Home Phone: (___) ___________ ☐Cell Phone: (___)___________ ☐Work Phone:(___)__________

Do you feel safe at home? ☐ Yes ☐No

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

Spouse/Partner:☐ Not Applicable

First name: ____________________ Middle Initial: ____ Last Name:____________________________

Date of Birth: ____/____/____ Age: _________ Occupation:_________________________________

Home Street Address:____

City: ____________________ State: ________________ Zip/Postal Code: ______________________

Indicate which number to call or leave messages

☐Home Phone: (___) ___________ ☐Cell Phone: (___)___________ ☐Work Phone:(___)__________

Who Referred you?

☐ Physician Name: ________________________Clinic: __________________

Phone: (___)___________Address: ____

☐ Former Patient/Friend: ____

☐ Website/Advertisement: ____

☐ Insurance Carrier: ____

Who is your Ob/Gyn?

Name: _____________________________Clinic: _________________ Phone: (___) _____________

Address: ____

FEMALE MEDICAL HISTORY AND INFORMATION:

Reason for visit? ☐Fertility evaluation ☐Sperm insemination
☐Other____
What is your primary goal for 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 ____

Menstrual History:
Age when you had your first period: _______
Age when you first noticed breast development: _______ pubic hair: _______underarm hair: _____

Current menstrual cycle pattern: ☐ Regular ☐ Irregular (if irregular check all that apply)
☐ <25 days ☐ >35 days ☐ No periods ☐ Heavy ☐ Light ☐ Bleed between periods ☐ Bleed after sex

Number of days between the start of one period to the start of the next period: _________________
How many periods do you have a year? ______ How many days of bleeding do you have?________
Dates of the 1st day of your last 2 periods (month/day/year): ____/____/____ , ____/____/____
If you do not have periods, at what age did you stop having them? _____
Do you have severe menstrual cramps/pain? ☐ **No** ☐ Yes: Always __Sometimes __ In the Past___

Contraceptive History: (please check all that apply and provide dates of use) ☐ N/A ☐
☐ Condoms: ___________ ☐ Diaphragm____ ☐ IUD________
☐ Implanon/Nexplanon___________ ☐ Birth control pills___________________
☐ Patch _________________ ☐ Nuva-ring _________________
☐ Injectable (Depo-Provera, Lunelle etc.) _______________________
☐ Tubal sterilization (tubes tied, cut, burned, Essure, etc.) date ____/____/____ Type:____________
☐ Tubes untied – date ____/____/____

Sexual History:
☐How many months have you been intercourse without using any form of birth control? _________
☐How many times do you have intercourse per week? ______ ☐ None ☐
☐Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐No
☐Do you have pain with intercourse? ☐ No ☐ Yes
☐Do you use lubricants (K-Y Jelly, etc.) during intercourse? ☐ Yes- What type? ___________ ☐ No

Have you been treated for or diagnosed with one of the following sexually transmitted infections?
☐ **No** ☐ Yes (Please check all that apply and provide the date of diagnosis)
☐ Chlamydia ________ ☐ Gonorrhea ___________ ☐ Herpes __________ ☐ Hepatitis B ________
☐ Genital warts (HPV) ________ ☐ Syphilis __________ ☐ HIV/AIDS _________

Have you been treated for or diagnosed with one of the following problems?
☐ **No** ☐ Yes (Please check all that apply and provide the date of diagnosis)
☐ Ovarian failure________ ☐ Ovarian cysts (specify type)____________☐ Fibroids________
☐ Endometriosis________☐ Tubal disease________☐ Uterine polyps ________ ☐Adrenal disease
☐ Pelvic inflammatory disease (PID)________ ☐PCOS________ ☐Thyroid disease________

Pap Smear History:
When was your last pap smear (month and year)? ____/____
Have you ever had an abnormal pap smear ☐ **No** ☐ Yes
If yes, when was your last abnormal pap smear?____/____
Have you had any of the following treatments for abnormal pap smear? (please check all that apply)
☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser treatment
☐ Conization ☐ LEEP procedure

Breast Screening History:
Do you perform breast self-exams? ☐ No ☐ Yes
Have you ever had a mammogram? ☐ No ☐ Yes – date ___/___/___ Result: ☐ Normal
☐ Abnormal – explain ______________________

Pregnancy Summary:
☐Total Number of ALL pregnancies: __________ ☐Number of living children ________
☐Miscarriages (less than 20 weeks): __________ ☐Ectopic/Tubal Pregnancies: ______
☐Elective Terminations (Abortions): __________
☐Full Term Deliveries:________ ☐Premature Deliveries (less than 37 weeks): _______
☐Any Pregnancies with birth defects? ☐No ☐ Yes ______________________________

Date Pregnancy Ended or Delivered	Months to Conception	Treatment to Conceive	Delivery Type D&C/Complications	Current Partner?
1.				☐ Yes ☐No
2.				☐ Yes ☐No
3.				☐ Yes ☐No
4.				☐ Yes ☐No
5.				☐ Yes ☐No
6.				☐ Yes ☐No

Medical History:
Are you allergic to any medications or foods? ☐ **No** ☐ Yes (list allergies and describe reactions)

Drug or food	Reaction

List all medications, including over-the-counter medicines, herbal remedies, and vitamins

Medication	Dose	Why are you taking this medication

Do you have any medical problem(s)? ☐ **No** ☐ Yes (please list type, dates and treatments)

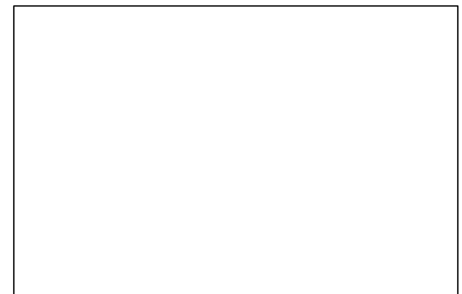
Medical problem	Diagnosis date	Treatments

Surgical History: Have you had any surgeries? ☐ **No** ☐ Yes

Any anesthesia problems? ☐ **No** ☐ Yes (describe)_______________________________________

Year	Reason and Type of Surgery
1.	
2.	
3.	
4.	

Social History:
Number of caffeinated beverages (coffee, tea, soda) per day? _____
Do you smoke cigarettes? ☐ **No** ☐ Quit/when_____ ☐ Yes
Number of years______ Number of cigarettes per day ______
Do you drink alcohol? ☐ **No** ☐ Yes
Number of drinks per week: Beer ____ Wine ____ Liquor _____
Do you use recreational drugs (i.e. marijuana)? ☐ **No**
☐ Yes (describe) ____________________________________
Do you Exercise? ☐ No ☐ **Yes**-- Number of hours per week _________
Type____



Review of Physical Symptoms:

General
☐ Fever/chills
☐ Recent weight gain or loss
☐ Anorexia/bulimia
☐ Lack of energy
☐ Other:________________
☐ **None**

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

Respiratory
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Pneumonia ☐Tuberculosis
☐ Other_________________
☐ **None**

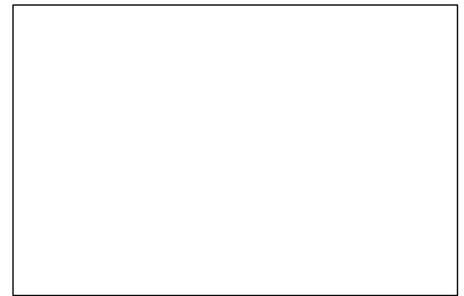
Endocrine/Hormonal
☐ Thyroid gland problems
☐ Diabetes
☐ Frequently hot or cold
☐ Rapid weight gain/loss
☐ Hot flashes
☐ Increased hunger/thirst
☐ Adrenal disorder
☐ Other___________
☐ **None**

Breasts
☐ Surgery (Type:______________)
☐ Discharge (Type:____________)
☐ Lumps
☐ Pain
☐ Cancer
☐ Other____________________
☐ **None**

Neurological
☐ Dizziness
☐ Weakness or loss of balance
☐ Seizures/Epilepsy
☐ Stress headaches
☐ Migraine headaches
☐ Numbness
☐ Memory Loss
☐Other_________________
☐ **None**

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar depression disorder
- ☐ Personality disorder
- ☐ Eating disorder
- ☐ Suicidal
- ☐ Other___________________
- ☐ **None**

Kidney/Urinary
- ☐ Kidney cysts
- ☐ Frequent bladder infections
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Other_______________
- ☐ **None**



Cardiovascular
- ☐ Murmurs
- ☐ Chest pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Mitral valve prolapse (antibiotics are required with dental procedures ☐ No ☐ Yes)
- ☐ Other:_________________
- ☐ None

Hematologic
- ☐ Blood clots
- ☐ Sickle cell anemia
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Stroke
- ☐ Blood Transfusion date and reason:______________
- ☐ Other________________________
- ☐ None

Skin/Extremities
- ☐ Hair loss
- ☐ Rash
- ☐ Acne
- ☐ Skin cancer
- ☐ Excessive facial or body hair
- ☐ Eczema
- ☐ Other_________________
- ☐ **None**

Gastrointestinal
- ☐ Ulcers
- ☐ Nausea/Vomiting
- ☐ Diarrhea ☐ Constipation
- ☐ Blood in stool
- ☐ Irritable bowel disease
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ Other:_________________
- ☐ **None**

Musculoskeletal/Immune
- ☐ Osteoporosis
- ☐ Decreased energy/fatigue
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematosus
- ☐ Myasthenia gravis
- ☐ Other_______________
- ☐ **None**

Family History	**Living**		**Age and Cause of Death**
Mother	☐ Yes-age:	☐ No	
Father	☐ Yes –age:	☐ No	
Brothers (number=___)	☐ Yes- ages:	☐ No	
Sisters (number=____)	☐ Yes – ages:	☐ No	
Maternal Grandmother	☐ Yes – age:	☐ No	
Maternal Grandfather	☐ Yes – age:	☐ No	
Paternal Grandmother	☐ Yes – age:	☐ No	
Paternal Grandfather	☐ Yes – age:	☐ No	

☐ Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't know

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

Condition	Yes		No	Don't Know
Psychiatric Problems	☐ Yes	________________	☐ No	☐ Don't Know
Tuberculosis	☐ Yes	________________	☐ No	☐ Don't Know
Endometriosis	☐ 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 Delays	☐ Yes	________________	☐ No	☐ Don't Know
Learning Problems	☐ Yes	________________	☐ No	☐ Don't Know
Polycystic Kidneys	☐ 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

☐ Other-Specify ______________________________

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian
☐ Eastern European
☐ Hispanic/Caribbean
☐ Northern European
☐ Southern European
☐ Other ________________

Would you like to be screened for?

Cystic Fibrosis	☐ Yes	☐No
Sickle Cell Anemia	☐ Yes	☐No
Tay - Sachs disease	☐ Yes	☐No
Thalassemia	☐ Yes	☐No

☐ Other________________

Emotional Status: Please rate on a scale of 1-10 (1 is best and 10 is worst)

How do you estimate your average level of stress to be? 1 2 3 4 5 6 7 8 9 10

Over the last two weeks have you felt little pleasure in doing things?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day

Over the last two weeks have you felt down, depressed or hopeless?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day

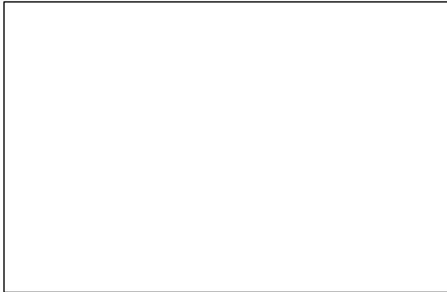
Do you see a counselor?
☐ **No** ☐Yes- for how long? ______________ How often?________________

Do you feel safe at home? ❑**Yes** ❑No

Vaccinations:

Vaccine	No	Yes	Don't know
Chickenpox (Varicella)	☐ No	☐ **Yes** (dates ____________)	☐ Don't know
MMR-Measles, Mumps and Rubella	☐ 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
Human papilloma virus (HPV)	☐ No	☐ **Yes** (dates ____________)	☐ Don't know

Prior Infertility Testing and Treatment:



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

Prior Tests: (check all that apply):

☐ Basil body temperature chart (date_____/results_____________)
☐ Thyroid blood test (date_____/results_____________
☐ Ovulation test kit (date_____/results_____________)
☐Day 3 blood test FSH level (date_____/results_____________)
☐AMH blood test (date_____/results_____________)
☐ Prolactin blood test (date_____/results_____________
☐ Hysterosalpingogram (date_____/results____)
☐ Laparoscopy surgery (date_____/results____)
☐ Hysteroscopy surgery (date_____/results____)

Prior Treatments: (check all that apply):

❑ Intrauterine insemination	# **of cycles** ______	**Dates** (mo/year) From___/___to___/___	**Outcome** ❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Clomiphene citrate or Letrozole with timed intercourse: Maximum # tablets per day___	______	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Clomiphene citrate or Letrozole with insemination: Maximum # tablets per day___	______	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Fertility drug injections with insemination:	______	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Complete 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 ___	______	From___/___to___/___ From___/___to___/___ From___/___to___/___ From___/___to___/___	❑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 ___	______	From___/___to___/___ From___/___to___/___ From___/___to___/___ From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant ❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant ❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant ❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Cancelled in vitro fertilization attempts:	______	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Any other prior treatment (describe): ______________________________			

Additional information:____
____
____

PATIENT SIGNATURE ________________________________ DATE___/___/_____
I confirm that I have reviewed the information above.

PROVIDER SIGNATURE ________________________________DATE ___/___/____

MALE MEDICAL HISTORY AND INFORMATION:

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
If yes, your result:____
☐Do you have difficulty with erections? ☐ Yes ☐ No
☐Do you have retrograde ejaculation of sperm into bladder? ☐ Yes ☐ No

Have you been treated for or diagnosed with one of the following sexually transmitted infections?
☐ **No** ☐ Yes (Please check all that apply and provide the date of diagnosis)
☐ Chlamydia ________ ☐ Gonorrhea ___________ ☐ Herpes ___________ ☐ Hepatitis B ________
☐ Genital warts (HPV) ________ ☐ Syphilis ___________ ☐ HIV/AIDS __________

☐Do you have a history of undescended testicles? ☐ Yes ☐ No
☐Do you have scrotal or testicular pain? ☐ Yes ☐ No
☐Did you have the 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**
Multiple Sclerosis ☐Yes ☐ No
Prostate infection ☐Yes ☐ No
High Blood Pressure ☐Yes ☐ No
Cancer ☐Yes ☐ No
Other neurologic problems ☐Yes ☐ No
Urinary infections ☐Yes ☐ No

☐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 or foods? ☐ **No** ☐ Yes (list allergies and describe reactions)

Drug or food	Reaction

List all medications, including over-the-counter medicines, herbal remedies, and vitamins

Medication	Dose	Why are you taking this medication

Do you have any medical problem(s)? ☐ **No** ☐ Yes (please list type, dates and treatments)

Medical problem	Diagnosis date	Treatments

Social History:

Number of caffeinated beverages (coffee, tea, soda) per day? _____

Do you smoke cigarettes? ☐ **No** ☐ Quit/when_____ ☐ Yes

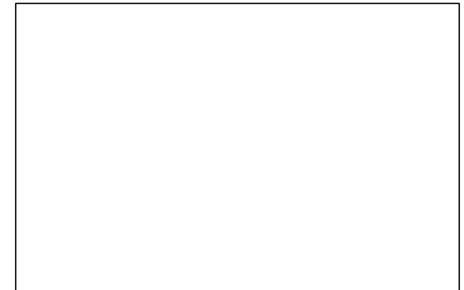
Number of years______ Number of cigarettes per day ______

Do you drink alcohol? ☐ **No** ☐ Yes

Number of drinks per week: Beer ____ Wine ____ Liquor _____

Do you use recreational drugs (i.e. marijuana)? ☐ **No**

☐ Yes (describe) ____



☐Are you aware of any radiation/toxic material exposure? ☐ Yes ☐ No

☐Do you use hot tubs regularly? ☐ Yes ☐ No

☐Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No

If yes, please describe____

Disorders in Your Family		**Relationship to you**		
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 Delays	☐ Yes	____________________	☐ No	☐ Don't Know
Learning Problems	☐ Yes	____________________	☐ No	☐ Don't Know
Polycystic Kidneys	☐ 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

☐ Other-Specify ______________________________

What is Your Race/Ethnicity?

☐ African American

☐ American Indian/Native American

☐ Ashkenazi Jewish

☐ Asian American

☐ Cajun/French Canadian

☐ Caucasian

☐ Eastern European

☐ Hispanic/Caribbean

☐ Northern European

☐ Southern European

☐ Other: __________________

Would you like to be screened for?

Cystic Fibrosis	☐ Yes ☐No
Sickle Cell Anemia	☐ Yes ☐No
Tay - Sachs disease	☐ Yes ☐No
Thalassemia	☐ Yes ☐No

☐ Other____________________

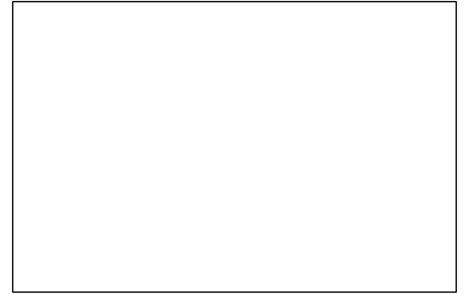
SPOUSE/ MALE PARTNER SIGNATURE

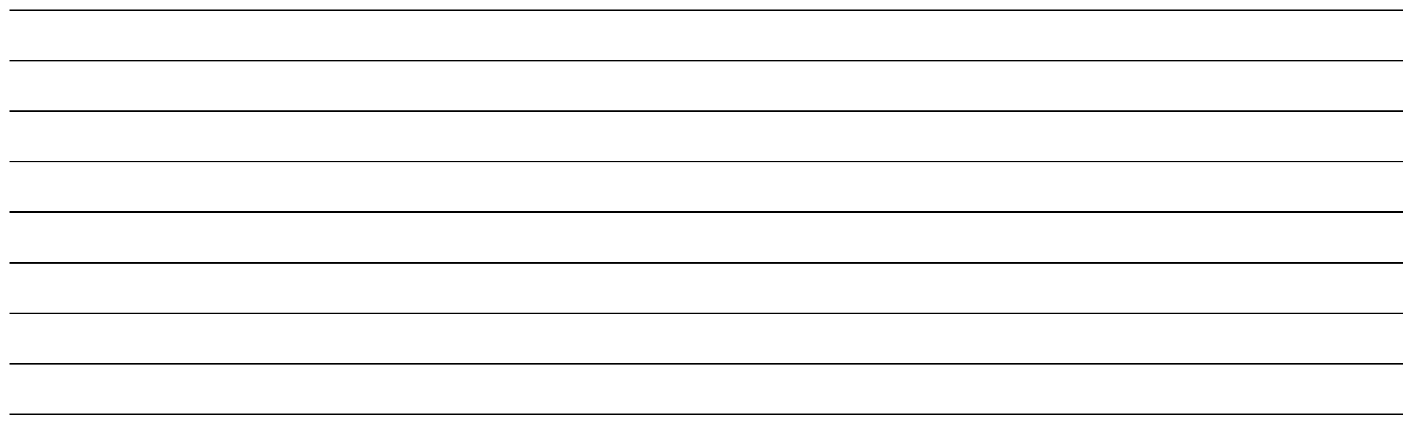
______________________________________ DATE ___/___/____

I confirm that I have reviewed the information above.

PROVIDER SIGNATURE

______________________________________DATE ___/___/___





Provider Notes (for office use only)____