

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? Other No Divorced _____

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? 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.				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No
6.				<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes-age: <input type="checkbox"/> No	
Father	<input type="checkbox"/> Yes -age: <input type="checkbox"/> No	
Brothers (number=___)	<input type="checkbox"/> Yes- ages: <input type="checkbox"/> No	
Sisters (number=___)	<input type="checkbox"/> Yes - ages: <input type="checkbox"/> No	
Maternal Grandmother	<input type="checkbox"/> Yes - age: <input type="checkbox"/> No	
Maternal Grandfather	<input type="checkbox"/> Yes - age: <input type="checkbox"/> No	
Paternal Grandmother	<input type="checkbox"/> Yes - age: <input type="checkbox"/> No	
Paternal Grandfather	<input type="checkbox"/> Yes - age: <input type="checkbox"/> 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 | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Ovarian Cancer | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Colon Cancer | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Other Cancer_____ | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Diabetes | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Thyroid Problems | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Heart Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Blood Clots | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |

- | | | |
|--------------------------|--|---|
| Psychiatric Problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Tuberculosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Endometriosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Menopause before age 40 | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Birth Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Cystic Fibrosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Tay-Sachs Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Canavan Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Bloom Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Gaucher Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Niemann-Pick Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Fanconi Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Familial Dysautonia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Muscular Dystrophy | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Neurologic (brain/spine) | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Neural Tube Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Bone/Skeletal Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Dwarfism | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Developmental Delays | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Learning Problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Polycystic Kidneys | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Heart defect from birth | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Down Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Other Chromosome defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Marfan Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Hemophilia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Sickle Cell Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Thalassemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Galactosemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Deafness/Blindness | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Color Blindness | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Hemochromatosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| | <input type="checkbox"/> 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:

- | | | |
|--------------------------------|--|-------------------------------------|
| Chickenpox (Varicella) | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| MMR-Measles, Mumps and Rubella | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| BCG (Tuberculosis) | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Hepatitis B | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Polio | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Hepatitis A | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Tetanus | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Influenza | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Human papilloma virus (HPV) | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |

Prior Infertility Testing and Treatment:

Have you had prior infertility testing or treatment ? No Yes

Prior Tests: (check all that apply):

- Basal 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):

<input type="checkbox"/> Intrauterine insemination	# of cycles	Dates (mo/year)	Outcome
	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Clomiphene citrate or Letrozole with timed intercourse: Maximum # tablets per day _____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Clomiphene citrate or Letrozole with insemination: Maximum # tablets per day _____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Fertility drug injections with insemination:	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Complete in vitro fertilization cycle(s):			
1. #eggs ____ #embryos transferred ____ #frozen ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
2. #eggs ____ #embryos transferred ____ #frozen ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
3. #eggs ____ #embryos transferred ____ #frozen ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
4. #eggs ____ #embryos transferred ____ #frozen ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Frozen embryo transfers:			
1. #embryos transferred ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
2. #embryos transferred ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
3. #embryos transferred ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
4. #embryos transferred ____	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Cancelled in vitro fertilization attempts:	_____	From ____/____ to ____/____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Any other prior treatment (describe): _____			

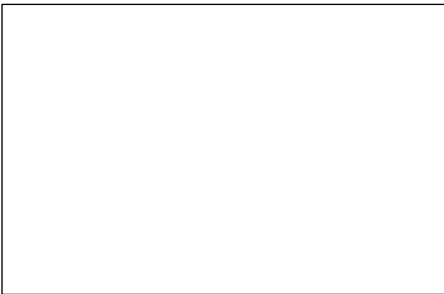
Additional information: _____

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** Cancer Yes No
 Multiple Sclerosis Yes No Other neurologic problems Yes No
 Prostate infection Yes No Urinary infections Yes No
 High Blood Pressure 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 | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Cystic Fibrosis | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Tay-Sachs Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Canavan Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Bloom Syndrome | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Gaucher Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Niemann-Pick Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Fanconi Anemia | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Familial Dysautonia | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Muscular Dystrophy | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Neurologic (brain/spine) | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Neural Tube Defects | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Bone/Skeletal Defects | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Dwarfism | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Developmental Delays | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Learning Problems | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Polycystic Kidneys | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Heart defect from birth | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Down Syndrome | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Other Chromosome defects | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Marfan Syndrome | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Hemophilia | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Sickle Cell Anemia | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Thalassemia | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Galactosemia | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Deafness/Blindness | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Color Blindness | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Hemochromatosis | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> 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) _____

