University of Washington Medical Center
University Reproductive Care

FEMALE MALE COUPLE FERTILITY NEW PATIENT HISTORY

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

CONTACT INFORMATION:

First name: _____ Middle initial: ____ Last name:_____

Preferred name: _____ Self-declared gender: _____

Preferred pronoun (he/him, she/her etc.) _____

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:(___)_____

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: _____

PLACE PATIENT LABEL HERE

□ 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 □ None
□ 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 having sex 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 _____

ZIKA and West Nile exposure
Have you or your partner traveled to a Zika Virus Zone? □ **No** □ Yes
Have you or your partner traveled to a West Nile Zone? □ **No** □ Yes
Do you or your partner plan to travel to a Zika virus or West Nile zone? □ **No** □ Yes

Have you or your partner experienced any of the following in the last 6 months?
Fever: □ **No** □ Yes Rash: □ **No** □ Yes Joint pain or body aches: □ **No** □ Yes
Conjunctivitis: □ **No** □ Yes Headache: □ **No** □ Yes

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
☐ CPAP machine
☐ Other_____
☐ **None**

Endocrine/Hormonal
☐ Thyroid gland problems
☐ Diabetes

Breasts
☐ Surgery (Type:_____)
☐ Discharge (Type:_____)

Neurological
☐ Dizziness
☐ Weakness or loss of balance

□ Frequently hot or cold
□ Rapid weight gain/loss
□ Hot flashes
□ Increased hunger/thirst
□ Adrenal disorder
□ Other_____
□ **None**

□ Lumps
□ Pain
□ Cancer
□ Other_____
□ **None**

□ 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
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

What is Your Race/Ethnicity?

□ African American
□ American Indian/Native American
□ Ashkenazi Jewish
□ Asian American
□ Cajun/French Canadian
□ Caucasian/ White
□ 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_____

PLACE PATIENT LABEL HERE

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 _____		

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?_____ Name of counselor:_____
Do you feel safe at home? ❑**Yes** ❑No

Vaccinations:

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 Fertility Testing and Treatment:

□ Have you had prior fertility 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):

❑ 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 ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
2. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
3. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
4. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Frozen embryo transfers:			
1. #embryos transferred ___	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
2. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
3. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
4. #embryos transferred ___		From___/___to___/___	❑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	PRINT NAME	DATE	TIME

I confirm that I have reviewed the information above.

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

PLACE PATIENT LABEL HERE

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? □ **Y**es □ **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	□ 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 _____

SPOUSE / MALE PARTNER NAME (PRINTED)		
PATIENT SIGNATURE	DATE	TIME

I confirm that I have reviewed the information above.

PROVIDER NAME AND TITLE (PRINTED)		
PROVIDER SIGNATURE	DATE	TIME

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian/White
☐ 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_____

Provider Notes (for office use only)_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLACE PATIENT LABEL HERE