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

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

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 _____			

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):

	# of cycles	Dates (mo/year)	Outcome
❑ Intrauterine insemination	_____	From___/___to___/___	❑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