Advanced Reproductive Medicine and Surgery, P.C.
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REPRODUCTIVE GENETIC HISTORY QUESTIONNAIRE

Patient Name____ Date of Birth _______________

MEDICAL HISTORY

YES	NO	DO YOU…	COMMENTS
☐	☐	1. Have diabetes?	____________
☐	☐	2. Have seizures or epilepsy?	____________
☐	☐	3. Have kidney disease?	____________
☐	☐	4. Or your husband/partner have a history of cancer treatment?	____________
☐	☐	5. Have any skin disorders including moles, acne, light or dark patches of skin?	____________
☐	☐	6. Have rheumatoid arthritis or systematic lupus erythematosus (SLE)?	____________
☐	☐	7. Have a history of being on a special diet as a baby or small child? (You may need to ask your parents)	____________
☐	☐	8. Know the results of routine prenatal blood test for Rubella (German measles) susceptibility and if yes, check: ☐ Immune ☐ Susceptible (not immune)	____________
☐	☐	9. Have any other medical condition not mentioned?	____________

FAMILY HISTORY

YES	NO	DO YOU…	
☐	☐	10. Are you 34 years old or older?	____________
☐	☐	11. Is your husband/partner 55 years old or older?	____________
☐	☐	12. Are you and your husband/partner blood relatives (e.g. cousins)?	____________
☐	☐	13. Are you and your husband/partner of ☐ Jewish, ☐ Black, ☐ Mediterranean descent?	____________
☐	☐	14. Have you had a stillbirth or miscarriage?	____________

DO YOU OR YOUR HUSBAND / PARTNER…

☐	☐	15. Have any birth defects, handicapping condition, or disorder that may be hereditary?	____________
☐	☐	16. Have any previous children with birth defects, handicaps, or genetic diseases?	____________
☐	☐	17. Have any children who died (other than an accident)?	____________
☐	☐	18. Have any relatives who have had a stillborn infant or multiple miscarriages?	____________
☐	☐	19. Have a brother, sister or parent with a handicap, birth defects, or genetic diseases?	____________
☐	☐	20. Have uncles, cousins, nieces, nephews, grandparents, or grandchildren with birth defects or genetic diseases?	____________
☐	☐	21. Know any family member with mental retardation (even mild) or learning disabilities?	____________

SOME EXAMPLES OF BIRTH DEFECTS AND GENTIC DISEASES THAT MIGHT BE IN YOUR FAMILY
(Please check any of the following that might be in your family)

- ☐ **Anencephaly (open skull)**
- ☐ **Blindness or eye problem**
- ☐ **Bone disorder**
- ☐ **Cerebral palsy**
- ☐ **Chromosome abnormality**
- ☐ **Cleft lip/palate**
- ☐ **Cystic fibrosis**
- ☐ **Deafness**
- ☐ **Down syndrome (mongolism)**
- ☐ **Epilepsy or seizures**
- ☐ **Heart defect**
- ☐ **Hemophilia (bleeding tendency)**
- ☐ **Hydrocephalus (water on the brain)**
- ☐ **Limb defects**
- ☐ **Other ____**
- ☐ **Malformations or birth defects**
- ☐ **Mental illness**
- ☐ **Mental retardation**
- ☐ **Muscular dystrophy**
- ☐ **Neurologic or degenerative disorder**
- ☐ **Neurofibromatosis**
- ☐ **Short stature (under 5 ft.)**
- ☐ **Sickle Cell Anemia**
- ☐ **Skeletal problems (like easily broken bones or curvature of the spine)**
- ☐ **Skin disease (including dark or light patches of skin)**
- ☐ **Spina bifida (open spine)**
- ☐ **Tay-Sachs disease**
- ☐ **Urinary tract abnormality**

MEDICATION / DRUG EXPOSURES

YES	NO	
☐	☐	**22. Do you take any prescription drugs or over-the-counter medications? If you are pregnant, have you taken any medications since your last period?**

Examples: Please check those you have taken during this pregnancy.

- ☐ **Accutane or other dermatologic or acne medications**
- ☐ **Antibiotics**
- ☐ **Anticoagulants (blood thinners to prevent blood clots)**
- ☐ **Antithyroid drugs**
- ☐ **Birth control pills**
- ☐ **Chemotherapeutic drugs (anti-cancer drugs)**
- ☐ **Diet pills**
- ☐ **Female hormones**
- ☐ **Male hormones**
- ☐ **Medications for epilepsy (seizures)**
- ☐ **Multi-vitamins**
- ☐ **Steroids**
- ☐ **Tranquilizers**
- ☐ **Vitamin A supplements**
- ☐ **Other high dose vitamins**
- ☐ **Other ________________________________**

YES	NO	
☐	☐	**23. Have you had any illness or infection recently or do you have any chronic disease not covered on the other side?**
☐	☐	**24. Have you had frequent or high fevers or do you take saunas or hot whirlpool baths?**
☐	☐	**25. Have you recently had x-rays or surgery or are you planning to do so soon?**
☐	☐	**26. Are you exposed to pesticides or potentially toxic chemicals at home or elsewhere?**
☐	☐	**27. Have you been exposed to pesticides or potentially toxic chemicals at home or elsewhere?**
☐	☐	**28. Do you drink more than one glass of alcohol per week (including beer)?**
☐	☐	**29. Do you have a household cat or clean a cat litter box?**
☐	☐	**30. Do you eat raw or very rare meat?**
☐	☐	**31. Do you smoke? How many packs of cigarettes per day?**
☐	☐	**32. Do you use any other drugs or medications not previously listed?**