Advanced Reproductive Medicine and Surgery, P.C.
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INFERTILITY HISTORY FORM

PART I.: CONTACT INFORMATION

First Name ______________________ Middle Initial ______ Last Name ____________________ Age ______
Date of Birth (MM/DD/YY)______________________ Height: _________________ Weight: ______________
Occupation _______ ____
Home Street Address ____
City ______________________________ State _______ Zip/Postal Code ___________ Country ___________
Indicate which number to call or leave messages:
☐ Home Phone __________________ ☐ Work Phone _________________ ☐ Cell Phone _______________
Are you married? ☐ YES ☐ NO ☐ DIVORCED ☐ OTHER ______________________________________

Spouse/Male Partner's

First Name ________________________ M.I. _____ Last Name _________________________ Age ________
☐ Not Applicable
Date of Birth (MM/DD/YY) ___________________________ Occupation _____________________________
Home Street Address ____
City ______________________________ State _______ Zip/Postal Code ___________ Country ___________
Indicate which number to call or leave messages:
☐ Home Phone __________________ ☐ Work Phone _________________ ☐ Cell Phone _______________

Who referred you?

☐ Physician Name _________________________________ Phone _________________________________
Address ____
☐ Former Patient/Friend ____
☐ Website ____
☐ Insurance (Name of Insurance) ____

Who is your OB/GYN?

Name ____ Phone ________________________________
Address ____

Who is your Primary Care Physician?

Name ____ Phone ________________________________
Address ____

PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)
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PART II. FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other ___________________________________

What are your expectations for this visit? ____

What questions do you want answered at 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 sperm sample, etc.? ☐YES ☐NO

How many months have you been having intercourse without using any form of birth control? ______________________

Pregnancy Summary

- Total Number of ALL Pregnancies: ________
- Number of Miscarriages (less than 20 weeks): _________
- Number of Ectopic/Tubal Pregnancies: ______
- Number of Elective Terminations (Abortions): _________
- Number of Full Term Deliveries: _______ Of these, how many were live births? ________ Stillborn? ______________
- Number of Premature(less than 37 weeks) Deliveries: _____Of these, how many were live births? _____Stillborn?____
- Any pregnancies with Birth Defects? ☐ YES ☐ NO Explain ____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments Conceive	Delivery Type/D&C Complications	Current Partner?
1.______________	_____________	_________________	____________________	☐Y ☐N
2.______________	_____________	_________________	____________________	☐Y ☐N
3.______________	_____________	_________________	____________________	☐Y ☐N
4.______________	_____________	_________________	____________________	☐Y ☐N
5.______________	_____________	_________________	____________________	☐Y ☐N
6.______________	_____________	_________________	____________________	☐Y ☐N

Menstrual History

- Menstrual cycle pattern (check all that apply): ☐ Regular Periods ☐ Irregular Periods ☐ No Periods
  ☐ Heavy Periods ☐ Light Periods ☐ Bleeding Between Periods ☐ Spotting Before Periods
- Number of days between the start of one period to the start of the next period: _____________days
- How many days of bleeding do you have? ______________days
- Age when you had your first period: ______________years old
- Age when you first noticed: Breast development:_____years old Pubic hair:____years old Underarm hair:___years old
- How many periods do you have per year? ___________
- Do you need medication to bring on a period? ☐ YES – what type? _______________________ ☐ NO
- If you do not have periods, at what age did you stop having them? ____________years old
- Do you have severe cramping or pelvic pain with your periods? ☐YES: __Always __Sometimes __Recently
  ☐ NO __In the past

Contraceptive History

☐ None ☐ Condoms – date of use __________ ☐Diaphragm – dates of use____________ ☐ IUD – dates of use _____________ ☐Birth control pills – dates of use __________ -complications? _______________________

☐ Never used birth control pills ☐ Skin patch – dates of use ___________-complications? _______________

☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) – date of use ___________ ☐ Foam or Jelly

☐ Tubal sterilization procedure (tubes tied) –date (month/year) __________ ☐ Tubes untied –date ________

• Did your mother take DES when she was pregnant with you? ☐ YES ☐ NO ☐ Don't Know

Sexual History

- How many times do you have intercourse per week? _______times per week ☐ None ☐ Not applicable
- Have you used over-the-counter ovulation kits to time intercourse? ☐ YES ☐ NO
- Do you have pain with intercourse? ☐ YES ☐ NO
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ YES-what types? _______________ ☐ NO

Have you had any of the following sexually transmitted disease or pelvic infections? ☐YES ☐NO (check all that apply)

☐ Chlamydia-date _______ ☐ Gonorrhea-date _______ ☐ Herpes-date _______ ☐ Genital warts/HPV-date _____

☐ Syphilis-date ________ ☐ HIV/AIDS-date ______ ☐ Hepatitis-date _____ ☐ Other-date _____________

Pap smear History

- When was your last Pap smear (MM/YY) ________________________ ☐ NORMAL ☐ ABNORMAL
- When was your last abnormal Pap smear? ________________________ ☐ Not Applicable

Have you undergone any procedures as a result of an abnormal Pap smear?

☐ Yes (check all that apply) ☐ No

☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser Treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram? ☐ Yes-date __________ ☐ No

Result: ☐ Normal ☐ Abnormal-explain______________________________

Do you perform breast self-exams? ☐YES ☐NO

Medical History

- Are you allergic to any medications? ☐YES ☐NO (Please list and describe reactions) __________________________
- Are you allergic to any foods (peanuts, eggs, etc.)? ☐YES ☐NO (Please list and describe reactions) ______________
- List any medications you are currently taking, including over-the-counter medicines: ____________________________
- Do you take any herbal medicines/vitamins or health food supplements? ☐YES ☐NO (Please list) _______________
- Do you have any medical problem(s)? ☐YES ☐NO (Please list type, dates, and treatments)

(1) ______________________________

(2) ______________________________

(3) ______________________________

(4) ______________________________

(5) ______________________________

•Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German measles (Rubella) ☐ Not Sure

Other childhood diseases: ______________________________

Vaccinations

Vaccine			
• Chickenpox (Varicella)	☐ Yes-date _____________	☐ No	☐ Don't Know
• MMR-Measles, Mumps, and Rubella (German measles)	☐ Yes-date _____________	☐ No	☐ Don't Know
• BCG (Tuberculosis)	☐ Yes-date _____________	☐ No	☐ Don't Know
• Hepatitis B	☐ Yes-date _____________	☐ No	☐ Don't Know
• Polio	☐ Yes-date _____________	☐ No	☐ Don't Know
• Hepatitis A	☐ Yes-date _____________	☐ No	☐ Don't Know
• Tetanus	☐ Yes-date _____________	☐ No	☐ Don't Know
• Influenza	☐ Yes-date _____________	☐ No	☐ Don't Know

Social History

- Have you ever been sexually abused, molested, or raped? ☐YES ☐NO If yes, would you like to discuss it? ☐YES ☐NO
- How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____________________ ☐ None
- Do you smoke cigarettes? ☐YES ☐NO How many/day? ______ How many years? ______ ☐ Quit-when________
- Do you drink alcohol? ☐YES ☐NO ☐ Beer # per week _____ ☐ Wine # per week ____ ☐ Liquor # per week_____
- Do you use marijuana, cocaine, or any other similar drug? ☐YES ☐NO Describe: ____________________________
- Do you exercise? ☐YES ☐NO Describe: ______________________________
- Are you aware of any radiation exposures other than x-rays? ☐YES ☐NO Describe: _________________________

PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)

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• Have you had any surgeries? ☐YES ☐NO (List all surgeries in chronologic order.)

YEAR	REASON AND TYPE OF SURGERY

•Did you have any anesthesia problems? ☐YES ☐NO Describe ____________________

Physical Symptoms

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia / Bulimia
- ☐ Lack of energy
- ☐ Fever / Chills
- ☐ Other ____________
- ☐ None

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

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other ____________
- ☐ None

Endocrine / Hormonal:
- ☐ Diabetes ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger / thirst
- ☐ Temperature intolerance hot flashes / or cold feeling
- ☐ Other ____________
- ☐ None

Breasts:
- ☐ Discharge (clear? __ bloody? __ milky? __)
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation / Breast implants (saline? _____ silicone? ______)
- ☐ Other ____________
- ☐ None

Neurological Problems:
- ☐ Weakness / Loss of balance
- ☐ Seizures / Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other ____________
- ☐ None

Gastrointestinal:
- ☐ Nausea / Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Other ____________
- ☐ None

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Blood in urine
- ☐ Herpes
- ☐ Other ____________
- ☐ None

Skin / Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other ____________
- ☐ None

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other ____________
- ☐ None

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle Cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons ____________)
- ☐ Other ____________
- ☐ None

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Other ____________
- ☐ None

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other ____________
- ☐ None

PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)

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Family History:

	Living		Cause of Death / Age at Death
• Mother	☐ Yes – age ____	☐ No	______________________
• Father	☐ Yes – age ____	☐ No	______________________
• Brother(s)	☐ Yes – age ____	☐ No	______________________
	☐ Yes – age ____	☐ No	______________________
• Sister(s)	☐ Yes – age ____	☐ No	______________________
	☐ Yes – age ____	☐ No	______________________
• Maternal Grandmother	☐ Yes – age ____	☐ No	______________________
• Maternal Grandfather	☐ Yes – age ____	☐ No	______________________
• Paternal Grandmother	☐ Yes – age ____	☐ No	______________________
• Paternal Grandfather	☐ Yes – age ____	☐ No	______________________

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
• Obesity	☐YES	______________	☐NO	☐DON'T KNOW
• Psychiatric problems	☐YES	______________	☐NO	☐DON'T KNOW
• Tuberculosis	☐YES	______________	☐NO	☐DON'T KNOW
• Endometriosis	☐YES	______________	☐NO	☐DON'T KNOW
• Infertility	☐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 delay	☐YES	______________	☐NO	☐DON'T KNOW
• Learning problems	☐YES	______________	☐NO	☐DON'T KNOW
• Polycystic kidney disease	☐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

☐ None of the above ☐Other (specify____)

What is your Ancestry?

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

(specify_______________)

Would you like to be screened for:

☐ Cystic Fibrosis	☐Y	☐N
☐ Sickle Cell Anemia	☐Y	☐N
☐ Tay - Sachs disease	☐Y	☐N
☐ Thalasemia	☐Y	☐N

• Have you had prior infertility testing or treatment elsewhere? ☐ YES ☐ NO

Prior Tests (check all that apply): ☐ Basal body temperature chart (date _________ results________________________)
☐ Thyroid test (date _________ results ______________) ☐ Ovulation test kit (date _________ results ______________)
☐ Day 3 blood test for FSH level (date ______ results___) ☐ Hysterosalpingogram (HSG) (date ______ results _______)
☐ Laparoscopy surgery (date ________ results ________) ☐ Hysteroscopy surgery (date __________ results ________)
☐ Progesterone blood test (date _______ results _______) ☐ Prolactin blood test (date __________ results __________)

Prior Treatment (check all that apply):

☐ Intrauterine insemination:	# of cycles ___________	Dates(mm/yy)(mm/yy) From ______To_____	Outcome __Pregnant: _Delivered _Ectopic _Miscarriage _Not Pregnant
☐ Clomiphene citrate with timed intercourse: maximum # tablets per day? ___________	___________	From ______To_____	__Pregnant: _Delivered _Ectopic _Miscarriage _Not Pregnant
☐ Clomiphene citrate with insemination: maximum # tablets per day? __________	___________	From ______To_____	__Pregnant: _Delivered _Ectopic _Miscarriage _Not Pregnant
☐ Daily fertility drug injections with insemination maximum # vials per day? ___________	___________	From ______To_____	__Pregnant: _Delivered _Ectopic _Miscarriage _Not Pregnant
☐ Completed 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
Canceled in vitro fertilization attempt(s):	___________		
☐ Any other prior treatment (describe): ____			

•Additional Information/Complications: ____
____
____

Emotional Status
• On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. _____
• Do you see a counselor? ☐ YES ☐ NO For how long? _______________________ How often? ________________
• List any antidepressant/anti-anxiety medications you are currently taking. ______________________________
• Describe any emotional, marital, or sexual problems caused by your infertility. ___________________________
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PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)____________________________________
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PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by an 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
- Do you have difficulty with erections? ☐ YES ☐ NO
- Do you have retrograde ejaculation of sperm into the bladder? ☐ YES ☐ NO
- Have you had any of the following sexually transmitted diseases or pelvic infections?

☐ YES (check all that apply) ☐ NO

☐ Chlamydia - date _______ ☐ Gonorrhea – date _______ ☐ Herpes – date __________ ☐ Genital warts/HPV – date ________

☐ Syphilis – date _________ ☐ HIV/AIDS – date _______ ☐ Hepatitis – date ________ ☐ Other ___________ date _________

- Have you had a history of undescended testicles? ☐ YES one side ____ both sides ______ ☐ 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
  - ☐ Prostatic infections ☐ YES ☐ NO
  - ☐ High blood pressure ☐ YES ☐ NO If yes, any medications? ____
  - ☐ 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? ☐ YES ☐ NO (Please list and describe reactions) ________________________

____

____

List your current medications: ____

List any current medical problem(s): ____

- How many caffeinated beverages do you drink per day? ________ ☐None
- Do you smoke cigarettes? ☐ YES ☐ NO How many per day? ____ How many years? ____ ☐Quit – when? ________
- Do you drink alcohol? ☐ YES ☐ NO ☐Beer -# per week? ____ ☐Wine -# per week? ___ ☐ Liquor -# per week? __
- Do you use marijuana, cocaine, or any other similar drug? ☐ YES ☐ NO (describe) __________________________
- Do you use herbal medicines/vitamins or health food store supplements? ☐ YES ☐ NO (describe) _______________
- Are you aware of any radiation/toxic materials exposure? ☐ YES ☐ NO
- Do you use hot tubs regularly? ☐ YES ☐ NO
- Did your mother take DES during pregnancy to prevent miscarriage? ☐ YES ☐ NO ☐DON'T KNOW
- Have any of your immediate family members had difficulty conceiving a child? ☐ YES ☐ NO
  If yes, please describe ____

PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)

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Disorders In Your Family: **Relationship To You**

Disorder		Relationship To You		
• 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 delay	☐YES	______________	☐NO	☐DON'T KNOW
• Learning problems	☐YES	______________	☐NO	☐DON'T KNOW
• Polycystic kidney disease	☐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

☐ None of the above ☐Other (specify____)

What is your Ancestry?

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

Would you like to be screened for:

☐ Cystic Fibrosis ☐Y ☐N
☐ Sickle Cell Anemia ☐Y ☐N
☐ Tay - Sachs disease ☐Y ☐N
☐ Thalasemia ☐Y ☐N

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