

Part 1: Patient Contact and Insurance Information

Female / Patient		
Social Security No.	Date of Birth	Patient ID No.
Name (Last, First, Middle Initial)		Nickname
Address		
City/State/Zip		
Home Phone	Work Phone	Cell phone
Which number would you prefer that we leave messages: Circle all that apply: Home / Work / Cell Phone		
E-mail Address (required for patient care)		
Sex	Race	Age
Marital Status (Circle one): Married / Divorced / Single / Other		
Duration of current relationship: Years		
Have you been married previously? No / Yes: How many times?		
Emergency Contact		Day Phone

Spouse / Partner		
Social Security No.	Date of Birth	Patient ID No.
Name (Last, First, Middle Initial)		Nickname
Address		
City/State/Zip		
Home Phone	Work Phone	Cell phone
Which number would you prefer that we leave messages: Circle all that apply: Home / Work / Cell Phone		
E-mail Address (required for patient care)		
Sex	Race	Age
Marital Status (Circle one): Married / Divorced / Single / Other		
Duration of current relationship: Years		
Have you been married previously? No / Yes: How many times?		
Night Phone	Relationship	

Patient's Employment	
Company Name	Occupation
Address	
City / State / Zip	

Spouse / Partner Employment	
Company Name	Occupation
Address	
City / State / Zip	

Primary or Patient's Insurance	
Insurance Company Name	
P.O. Box / Address	
City / State / Zip	
Policy ID Number	Group Number
Policy Holder's Name	Day Phone

Secondary or Spouse/Partner Insurance	
Insurance Company Name	
P.O. Box / Address	
City / State / Zip	
Policy ID Number	Group Number
Policy Holder's Name	Day Phone

Who Referred You to RSC?		
Physician	Phone	
Address		
Former Patient	Family	Friend
Insurance Company	Radio Advertisement	Website

OB/GYN and Primary Care Physician Information	
OB/GYN Name	Phone
Address	
Primary Care Physician	Phone
Address	

Clinician Notes (for office use only)
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Part 2: Female Medical History and Information

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

General Information

- Reason for visit: Infertility testing/evaluation Insemination IVF
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 semen sample, etc.? No Yes

If yes, please explain: _____

Gynecologic History

Menstrual History

- 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
- Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____
- Menstrual cycle pattern (check all that apply): Regular periods Irregular periods Spotting before periods No periods
 Heavy periods Light periods Bleeding between periods
- If you do not have periods, at what age did you stop having them? _____ years old
- 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 any medication to bring on a period? No Yes – what type? _____
- Do you have **severe** cramping or pelvic pain with your periods?
 No Yes: ___ Always ___ Sometimes ___ Recently ___ in the past
- Did your mother take DES when she was pregnant with you? No Yes Don't know

Contraceptive History

Which of the following forms of birth control have you used? (check all that apply) None

Condoms – dates of use _____ Diaphragm – dates of use _____ IUD – dates of use _____

Foam or jelly – dates of use _____ Withdrawal – dates of use _____ Rhythm – dates of use _____

Birth control pills – dates of use _____ Complications? _____

Injectable contraception – dates of use _____ Complications? _____
(Depo-Provera, Lunelle, etc)

Skin patch – dates of use _____ Complications? _____

Tubal sterilization procedure (tubes tied) – date (month/year) ____/____ Tubes untied – date (month/year) ____/____

Clinician Notes (for office use only)

Part 2: Female Medical History and Information

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Sexual History

- How many times do you have intercourse per week? _____ times None Not applicable
- Have you ever used over-the-counter ovulation kits to time intercourse? No Yes
If yes, does it show ovulation? No Yes – what cycle day? _____ Unsure
- Do you have pain with intercourse? No Yes
- Do you use lubricants (K-Y Jelly, etc.) during intercourse? No Yes – what types? _____
- Have you ever had any of the following sexually transmitted diseases or pelvic infections? (check all that apply) None
 Chlamydia – date _____ Gonorrhea – date _____ Herpes – date _____ Genital warts/HPV – date _____
 Syphilis – date _____ HIV/AIDS – date _____ Hepatitis – date _____ Other – date _____
- When was your last pap smear (month/year)? ____/____ Normal Abnormal
- Have you ever had an abnormal pap smear? No Yes – date _____
 Have you undergone any procedures as a result of an abnormal pap smear? No Yes (check all that apply)
 Colposcopy Cryosurgery (freezing) Laser treatment Conization LEEP procedure

Obstetrical History

- Have you ever been pregnant? No Yes – if yes, please complete below:
- Total number ALL pregnancies _____ Number Miscarriages (less than 20 weeks) _____
- Number ectopic/tubal pregnancies _____ Number elective terminations (abortions) _____
- Number full term deliveries _____ of these, how many were live births? _____ How many were stillborn? _____
- Number premature (less than 37 weeks) deliveries? _____ of these, how many were live births? _____ How many were stillborn? _____
- Any pregnancies with birth defects? No Yes – explain _____

Date pregnancy ended or delivered	How Long to Conceive	Treatments 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

Clinician Notes (for office use only)

Part 2: Female Medical History and Information

Name: _____
(Please Print)
Date of Birth: _____
(MM/DD/YYYY)

Medical-Surgical History

Medical History

Height _____

Weight _____

- Are you allergic to any medications? No Yes (Please list and describe reactions)

- Are you allergic to any foods (peanuts, sesame, olive oil, shellfish, etc.)? No Yes (Please list and describe reactions)

- Are you allergic to latex? No Yes (Please list and describe reactions)

- List any medications you are currently taking, including over the counter medications: _____

- Do you take any herbal medicines/vitamins or health food store supplements? No Yes (Please list) _____

- Have you had Chickenpox? No Yes – age _____ Don't Know
- Do you know your blood type? No Yes _____
- Do you have any medical problems? No Yes (Please list types, dates, and treatments)
 - (1) _____
 - (2) _____
 - (3) _____
 - (4) _____
 - (5) _____

Surgical History

- Have you had any surgeries? No Yes (List all surgeries in chronological order.)

<u>Year</u>	<u>Reason and Type of surgery</u>
_____	(1) _____
_____	(2) _____
_____	(3) _____
_____	(4) _____
_____	(5) _____
_____	(6) _____
_____	(7) _____

- Did you have any anesthesia problems? No Yes (describe) _____

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ None
- Have you smoked cigarettes? Never Yes How many/day? _____ How many years? _____
- Do you still smoke? No – when did you quit (year)? _____ Yes
- Do you drink alcohol? No Yes
 - Beer - # per week _____ Wine - # per week _____ Liquor - # per week _____
- Do you use marijuana, cocaine, or any other recreational drugs? No Yes – describe _____
- Do you exercise? No Yes – describe _____
- Are you aware of any radiation exposures other than X-rays? No Yes – describe _____

Part 2: Female Medical History and Information

Review of Systems

General

- Recent weight gain or loss
- Anorexia/bulimia
- Lack of energy
- Fever/chills
- Other _____
- None

Endocrine/Hormonal

- Diabetes
- Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance – hot flashes or feeling cold
- Other _____
- None

Gastrointestinal

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

Musculoskeletal

- Increased muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myesthenia Gravis
- Other _____
- None

Mental Health Problems

- Depression
- Anxiety disorder
- Schizophrenia
- Bipolar disorder
- Other _____
- None

Head, Eyes, Ears, Nose, Throat

- Dizziness
- Loss of sense of smell
- Headaches
- Chronic nasal congestion
- Blurred vision
- Ringing in ears
- Hearing loss/deafness
- Other _____
- None

Breasts

- Discharge (clear? ___ bloody?___ milky?___)
- Lumps
- Pain
- Cancer
- Abnormal mammogram
- Reduction
- Augmentation/breast implants (saline? ___ silicone?___)
- Other _____
- None

Genito-Urinary

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Leaking urine
- Blood in urine
- Herpes
- Other _____
- None

Hematologic

- Blood clotting disorder/blood clot
- Sickle cell Anemia
- Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons _____)
- Other _____
- None

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Respiratory

- Shortness of breath
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Bloody cough
- Other _____
- None

Neurological Problems

- Weakness/loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other _____
- None

Skin/Extremities

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other _____
- None

Cardiovascular

- Palpitations/skipped beats
- Chest pain
- Heart attack
- Stroke
- Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse
(Need antibiotics before dental procedures?)
 Yes No
- Other _____
- None

Clinician Notes (for office use only)

Part 2: Female Medical History and Information

Family History

	<u>Living</u>	<u>Cause of Death/Age of Death</u>
• Mother No _____	<input type="checkbox"/> Yes – age _____	<input type="checkbox"/> _____
• Father	<input type="checkbox"/> Yes – age _____	<input type="checkbox"/> No _____
• Brother(s)	<input type="checkbox"/> Yes – age _____	<input type="checkbox"/> No _____
	<input type="checkbox"/> Yes – age _____	<input type="checkbox"/> No _____
• Sister(s)	<input type="checkbox"/> Yes – age _____	<input type="checkbox"/> No _____
	<input type="checkbox"/> Yes – age _____	<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 _____

Disorders in Your Family

	<u>Relationship to You</u>		
• 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
• Obesity	<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
• Infertility	<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
• Gauchier 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
• Mental Retardation	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Developmental Delay	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Polycystic kidney disease	<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
• Downs Syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Other chromosomal 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"/> None of the above	<input type="checkbox"/> Other (specify) _____	

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

What is your Ancestry?

- African-American
- American Indian/Native American
- Ashkenazi Jewish
- Asian American
- Cajun/French Canadian
- Eastern European
- Hispanic/Caribbean
- Middle Eastern
- Northern European
- Southern European
- Other (specify _____)

Have you been screened for:

- Cystic Fibrosis ___yes ___no
 Sickle Cell Anemia ___yes ___no
 Tay Sachs Disease ___yes ___no
 Thalassemia ___yes ___no

Are you and your partner
related by blood? ___yes ___no

Part 2: Female Medical History and Information

Infertility History

- Have you had any prior infertility testing or treatment elsewhere? No Yes
- How long have you been having unprotected intercourse? ___ months ___ years
From: ___/___/___ to ___/___/___

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Prior Tests (check all that apply)

- Day 3 blood test for FSH level (date _____/result _____)
- Thyroid blood test (date _____/result _____)
- Prolactin blood test (date _____/result _____)
- Progesterone blood test (date _____/result _____)
- Basal Body Temperature chart (date _____/result _____)
- Ovulation test kits (date _____/result _____)
- Uterine evaluation (HSG/HSC/SHG) (date _____/result _____)
- Hysteroscopy surgery (date _____/result _____)
- Laparoscopic surgery (date _____/result _____)

	# of cycles	Dates (mo/yr) (mo/yr) From ___/___ to ___/___	Outcome
<input type="checkbox"/> Intrauterine insemination:	_____	From ___/___ to ___/___	_Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant
<input type="checkbox"/> Clomiphene citrate with timed intercourse: maximum # tablets per day? ____	_____	From ___/___ to ___/___	_Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant
<input type="checkbox"/> Clomiphene citrate with insemination: maximum # tablets per day? ____	_____	From ___/___ to ___/___	_Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant
<input type="checkbox"/> Daily fertility drug injections with insemination: maximum # vials per day? ____	_____	From ___/___ to ___/___	_Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant
<input type="checkbox"/> 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 ___	_____	_____/_____ _____/_____ _____/_____ _____/_____	_Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant
<input type="checkbox"/> Frozen embryo transfers: 1. # embryos transferred ___ 2. # embryos transferred ___ 3. # embryos transferred ___ 4. # embryos transferred ___	_____	_____/_____ _____/_____ _____/_____ _____/_____	_Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant
<input type="checkbox"/> Cancelled in vitro fertilization attempt(s):	_____		
<input type="checkbox"/> Any other prior treatment (describe): _____			

Prior Treatment (check all that apply):

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? No Yes – For how long? _____ How often? _____
- List any antidepressant/antianxiety medications you are currently taking. _____
Describe any emotional, marital or sexual problems caused by your infertility. _____

Patient Signature _____ Date _____

I confirm that I have reviewed this form and all the information entered on this form is true to the best of my knowledge.

Clinician Signature _____ Date _____

Part 3: Male Medical History and Information

Medical-Surgical History

Name: _____
(Please Print)
Date of Birth: _____
(MM/DD/YYYY) Yes
 No Yes

- Have you been evaluated by an urologist?
- Have you previously fathered a pregnancy?
If yes, with current partner? _____
with previous partner? _____
- Have you had a semen analysis?
Were the results of the semen analysis abnormal? No Yes → count motility morphology
- Do you have difficulty with erections? No Yes
- Have you ever been told that you have retrograde ejaculation (ejaculation of sperm into the bladder)? No Yes
- Have you ever had any of the following sexually transmitted diseases or pelvic infections? (check all that apply) None
 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? No Yes → one both
- Do you have scrotal or testicular pain? No Yes
- Did you have the mumps after puberty? No Yes
- Have you had a prior injury to your testicles requiring hospitalization?
If yes, please describe _____
- Have you been diagnosed with any of the following diseases? (check all that apply)
 Diabetes Mellitus Cancer - What type? _____
 Prostatic infections Other neurologic problems _____
 Multiple Sclerosis Urinary infections
 High blood pressure
If yes, any medications? No Yes – specify _____
- Have you had a fever in the last 3 months? No Yes
- Have you had a vasectomy? No Yes
If yes, date _____
- Have you had a vasectomy reversal? No Yes
If yes, date _____
- Have you had surgery for a varicocele repair? No Yes
- Have you had hernia surgery? No Yes
- Did you undergo any bladder or penis surgery as a child? No Yes
- Are you exposed to prolonged heat in the workplace? No Yes
- Are you exposed to any radiation or harmful chemicals in the workplace? No Yes
- Have you had chemotherapy for cancer? No Yes
- Are you allergic to any medications? No Yes
If yes, please specify _____
- List your current medications: _____
- List any current medical problems: _____

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ None
- Have you smoked cigarettes? Never Yes- How many/day? _____ How many years? _____
Do you still smoke? No – when did you quit (year)? _____ Yes
- Do you drink alcohol? No Yes
 Beer - # per week _____ Wine - # per week _____ Liquor - # per week _____
- Do you use marijuana, cocaine or any other recreational drugs? No Yes – describe _____
- Do you exercise? No Yes – describe _____
- Are you aware of any radiation exposures other than X-rays? No Yes – describe _____
- Do you use hot tubs regularly? No Yes

Part 3: Male Medical History and Information

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Family History

Living Cause of Death/Age of Death

- Mother Yes – age _____ No _____
- Father Yes – age _____ No _____
- Brother(s) Yes – age _____ No _____
- Sister(s) Yes – age _____ 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
- Have any of your immediate family members had difficulty conceiving a child?
 Yes No
If yes, please describe _____

What is your Ancestry?

African-American
 American Indian/Native American
 Ashkenazi Jewish
 Asian American
 Cajun/French Canadian
 Southern European
 Other (specify _____)

Have you been screened for:

Cystic Fibrosis ___yes ___no
Sickle Cell Anemia ___yes ___no
Tay Sachs Disease ___yes ___no
Thalassemia ___yes ___no

Are you and your partner related by blood? ___yes ___no

Disorders in Your Family

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
- Gauchier 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
- Mental Retardation Yes _____ No Don't Know
- Developmental delay Yes _____ No Don't Know
- Polycystic kidney disease Yes _____ No Don't Know
- Heart defect from birth Yes _____ No Don't Know
- Downs Syndrome Yes _____ No Don't Know
- Other chromosomal 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) _____

Spouse/Male partner's Signature _____ Date _____

I confirm that I have reviewed this form and all the information entered on this form is true to the best of my knowledge.

Clinician Signature _____ Date _____