



# Seattle Reproductive Medicine<sup>®</sup>

A N I N T E G R A M E D<sup>®</sup> A F F I L I A T E

## MEDICAL AND REPRODUCTIVE HISTORY—INFERTILITY

Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of appointment \_\_\_\_/\_\_\_\_/\_\_\_\_

**FEMALE PATIENT:**

**(Legal)** Last name: \_\_\_\_\_ **(Legal)** First name: \_\_\_\_\_ Middle initial \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Marital Status: \_\_\_\_single \_\_\_\_married \_\_\_\_domestic partner Length of Relationship: \_\_\_\_years

**PARTNER:**

**(Legal)** Last name: \_\_\_\_\_ **(Legal)** First name: \_\_\_\_\_ Middle initial \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**MAILING ADDRESS:**

Street: \_\_\_\_\_ City: \_\_\_\_\_

State/Providence: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ OK to leave message? Best # to reach you:  
 Yes  No

Female Work Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Yes  No

Partner Work Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Yes  No

Female Cell Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Yes  No

Partner Cell Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Yes  No

Female Email Address: \_\_\_\_\_ Partner Email Address: \_\_\_\_\_

How did you hear about SRM?

- Family/Friend
- Internet
- Radio
- Medical office/physician referral
- Other \_\_\_\_\_

Would you like medical notes sent to your other healthcare providers

- Yes
- No

If yes, please indicate which provider(s) you would like us to send medical notes to:

Provider Name	Address	Please indicate provider type:		
		Primary care	OB/Gyn	Other

Reason for visit: \_\_\_\_\_

## FERTILITY HISTORY

Do you have any theories as to why you have been unable to conceive? \_\_\_\_\_

**PREGNANCY HISTORY:** List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER ( check one )	
				Present partner	Previous partner

Time since contraception last used? \_\_\_\_\_

How long have you been trying to conceive? \_\_\_\_\_

If you previously have been pregnant, how long has it been since the most recent pregnancy? \_\_\_\_\_

Have you experienced any difficulty conceiving for a year or more with any man other than your current partner?  Yes  No

**PREVIOUS FERTILITY EVALUATION:**

**Have you had any of the following tests performed?**

Fertility Test:	Yes No		Date	Result normal?		If no, describe:
	Yes	No		Yes	No	
Day 3 FSH level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 Estradiol level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antimullerian hormone	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antral Follicle Count (AFC)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Progesterone level(s)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometrial Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterosalpingogram (HSG)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sonohysterogram (SHG or SIS)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prolactin blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fasting blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Testosterone level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post Coital Test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____

**PRIOR TREATMENTS: (check all that apply)**

Treatment	#of cycles	Dates: (mo./year) to (mo./year)	Outcome (baby, miscarriage, etc.)
Intrauterine inseminations (no medication):	_____	from: ___/___ to: ___/___	
Clomid-maximum # of tablets per day _____ with timed intercourse with intrauterine inseminations with Metformin	_____ _____ _____	from: ___/___ to: ___/___ from: ___/___ to: ___/___ from: ___/___ to: ___/___	
Letrozole/Femara-maximum # per day _____ with timed intercourse with intrauterine inseminations	_____ _____	from: ___/___ to: ___/___ from: ___/___ to: ___/___	
Gonadotropins (Follistim, Gonal F, Menopur, Repronex, Bravelle) with intrauterine inseminations	_____	from: ___/___ to: ___/___	
Acupuncture	_____	from: ___/___ to: ___/___	
Chinese Herbs	_____	from: ___/___ to: ___/___	
Complete in vitro fertilization (IVF) cycle(s): 1. # eggs _____ # fertilized _____ # transferred _____ # frozen _____  2. # eggs _____ # fertilized _____ # transferred _____ # frozen _____  3. # eggs _____ # fertilized _____ # transferred _____ # frozen _____	_____ _____ _____	from: ___/___ to: ___/___  from: ___/___ to: ___/___  from: ___/___ to: ___/___	
Frozen embryo transfers:  1. #embryos transferred _____  2. #embryos transferred _____  3. #embryos transferred _____	_____ _____ _____	_____/_____  _____/_____  _____/_____	
Canceled in vitro fertilization attempt(s)	_____	from: ___/___ to: ___/___	

**REPRODUCTIVE HEALTH HISTORY-FEMALE PARTNER**

**MENSTRUAL HISTORY:**

Age when you had your first menstrual period: \_\_\_\_\_ years old

The first day of your most recent menstrual period: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Menstrual cycle pattern without hormones or oral contraceptive pills (OCP's)-- (check all that apply):

- Regular periods
- Irregular periods
- No periods
- Spotting between periods
- Heavy periods
- Light periods

How many days from the first day of one period to the first day of the next? \_\_\_\_\_ days

How many days of bleeding do you usually have? \_\_\_\_\_ days

Do you need medication to bring on a period?  Yes  No If yes, what type? \_\_\_\_\_

Do you have cramping or pelvic pain with your periods? (check one)

- Always
- Sometimes
- Recently
- In the past
- No

Degree of pain (1 to 10, with 10 being most severe): \_\_\_\_\_

Over the past few years, is the pain:  getting better  getting worse  staying the same

If you do not have periods, at what age did you stop having them? \_\_\_\_\_ years old

When was your last Pap smear? \_\_\_\_ / \_\_\_\_ Was it normal?  Yes  No

Have you ever had an abnormal Pap smear?  Yes  No If "Yes," date and treatment: \_\_\_\_\_

Did your mother take DES while pregnant with you?  Yes  No  Don't know

Have you ever had a mammogram?  Yes  No If yes, when was the last one? \_\_\_\_ / \_\_\_\_

Was your mammogram normal?  Yes  No

**CONTRACEPTIVE METHOD HISTORY:**

Type	Years Used
<input type="checkbox"/> Birth Control Pill / Patch	
<input type="checkbox"/> Depo-Provera, Lunelle	
<input type="checkbox"/> Nuva Ring	
<input type="checkbox"/> Norplant/Implanon	
<input type="checkbox"/> Diaphragm	
<input type="checkbox"/> IUD	
<input type="checkbox"/> Condoms	
<input type="checkbox"/> Tubal Sterilization	
<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Rhythm (natural method)	
<input type="checkbox"/> Other	

**SEXUAL HISTORY:**

How many times per week do you have intercourse? \_\_\_\_\_

How many times do you have intercourse mid-cycle? \_\_\_\_\_

Any pain with intercourse? Yes No

Do you regularly use lubricant with intercourse? Yes No If yes, what type? \_\_\_\_\_

Have you ever had any sexually transmitted infections? (please check all that apply)

- |                                    |                                        |                                      |                                |
|------------------------------------|----------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea     | <input type="checkbox"/> Herpes      | <input type="checkbox"/> Other |
| <input type="checkbox"/> Syphilis  | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Trichomonas | _____                          |
| <input type="checkbox"/> HIV       | <input type="checkbox"/> HPV           | <input type="checkbox"/> Hepatitis   |                                |

Have you ever had pelvic inflammatory disease? Yes No

If yes, when? \_\_\_\_\_ Were you hospitalized? \_\_\_\_\_

**GENERAL MEDICAL HISTORY-FEMALE PARTNER**

What is your current weight? \_\_\_\_\_ Height? \_\_\_\_\_ Usual weight? \_\_\_\_\_

Recent weight loss or gain in the past 6 months? \_\_\_\_\_

Approximately how much did you weigh at age 18? \_\_\_\_\_

Are you currently being treated or being seen for any medical condition(s)? Yes No

If yes, please describe: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Check any of the following that you are presently having or have had in the past:

- |                                                      |                                                         |                                                    |
|------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|
| Eye problems <input type="checkbox"/>                | Gall bladder problems <input type="checkbox"/>          | Excessive thirst <input type="checkbox"/>          |
| Stuffy nose, hay fever <input type="checkbox"/>      | Liver disease <input type="checkbox"/>                  | Temperature intolerance <input type="checkbox"/>   |
| Frequent nose bleeds <input type="checkbox"/>        | Frequent urination at night <input type="checkbox"/>    | Headaches <input type="checkbox"/>                 |
| Fast or irregular heartbeat <input type="checkbox"/> | Vaginal discharge,itching,pain <input type="checkbox"/> | Shaking, tremor <input type="checkbox"/>           |
| Heart murmur <input type="checkbox"/>                | Pelvic pain <input type="checkbox"/>                    | Anxiety <input type="checkbox"/>                   |
| Mitral valve prolapse <input type="checkbox"/>       | Sexual problems <input type="checkbox"/>                | Depression <input type="checkbox"/>                |
| Dizziness, fainting <input type="checkbox"/>         | Endometriosis <input type="checkbox"/>                  | Bulimia or anorexia <input type="checkbox"/>       |
| Shortness of breath <input type="checkbox"/>         | Ovarian tumor <input type="checkbox"/>                  | Anemia <input type="checkbox"/>                    |
| Lung disease <input type="checkbox"/>                | Dark skin on neck, armpits <input type="checkbox"/>     | Easy bleeding or bruising <input type="checkbox"/> |
| Asthma <input type="checkbox"/>                      | Acne or pimples <input type="checkbox"/>                | Poor circulation <input type="checkbox"/>          |

Tuberculosis <input type="checkbox"/>	Enlarged or painful breasts <input type="checkbox"/>	Blood transfusion <input type="checkbox"/>
Heartburn, indigestion <input type="checkbox"/>	Discharge from nipples <input type="checkbox"/>	Fatigue <input type="checkbox"/>
Gas, cramps, pain <input type="checkbox"/>	Breast lumps <input type="checkbox"/>	Low energy <input type="checkbox"/>
Blood in stool or black stool <input type="checkbox"/>	Breast disease <input type="checkbox"/>	Past history of IV drug use <input type="checkbox"/>
Nausea, vomiting <input type="checkbox"/>	Hot flashes <input type="checkbox"/>	Rubella (German Measles) <input type="checkbox"/>
Constipation <input type="checkbox"/>	Excessive face or body hair <input type="checkbox"/>	Other <input type="checkbox"/>
Diarrhea <input type="checkbox"/>	Hair thinning or loss <input type="checkbox"/>	<input type="checkbox"/>
Hernia <input type="checkbox"/>	Fever, sweats, chills <input type="checkbox"/>	<input type="checkbox"/>

Please explain any positive responses:

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**SURGICAL HISTORY:**

Please list any major surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			

**ALLERGIES:**

Latex? Yes No If yes, specify reaction: \_\_\_\_\_

Iodine? Yes No If yes, specify reaction: \_\_\_\_\_

Medications? Yes No Which meds, specify reaction: \_\_\_\_\_

**MEDICATIONS INCLUDING: VITAMINS / HERBS / OVER THE COUNTER MEDICATION (OTC'S)**

Please list all medications or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

**SOCIAL HISTORY-FEMALE PARTNER**

Current Occupation: \_\_\_\_\_

Prior Occupation(s): \_\_\_\_\_

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? \_\_\_\_\_

In the past month, have there been times when you felt down, depressed, or hopeless? \_\_\_\_\_ Yes \_\_\_\_\_ No

Were there times during the past month when you experienced little interest or pleasure in doing things? \_\_\_\_\_ Yes \_\_\_\_\_ No

**FAMILY AND GENETIC HEALTH HISTORY-FEMALE PARTNER**

Are there any known genetic diseases or conditions that run in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which one(s) and whom? \_\_\_\_\_

Are you adopted? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Personal and Family History**

Are you or your partner of the following ethnic backgrounds? *Please check all that apply.*

- |               |             |                                             |
|---------------|-------------|---------------------------------------------|
| <b>Female</b> | <b>Male</b> |                                             |
| _____         | _____       | Asian (Chinese, Japanese, Filipino, Indian) |
| _____         | _____       | Mediterranean                               |
| _____         | _____       | Middle Eastern                              |
| _____         | _____       | Ashkenazi Jewish                            |
| _____         | _____       | African                                     |
| _____         | _____       | Hispanic or Caribbean                       |
| _____         | _____       | French Canadian or Cajun                    |
| _____         | _____       | Caucasian                                   |

**Have you or your partner had a blood test to see if you were a genetic carrier for:**

Condition	Female		Female Result	Male		Male Result
α (Alpha) Thalassemia	Yes	No		Yes	No	
β (Beta) Thalassemia	Yes	No		Yes	No	
Sickle Cell Anemia	Yes	No		Yes	No	
Tay Sach's Disease	Yes	No		Yes	No	
Cystic Fibrosis	Yes	No		Yes	No	
Spinal Muscular Atrophy	Yes	No		Yes	No	

**If you and your partner is of Eastern European Jewish ancestry (Ashkenazi), have you or your partner had blood tests to see if you were a genetic carrier for:**

Condition	Female		Female Result	Male		Male Result
Canavan Disease	Yes	No		Yes	No	
Familial Dysautonomia	Yes	No		Yes	No	
Fanconi Anemia	Yes	No		Yes	No	
Neimann-Pick Disease	Yes	No		Yes	No	
Mucopolidosis Type IV	Yes	No		Yes	No	
Bloom Syndrome	Yes	No		Yes	No	
Gaucher Disease	Yes	No		Yes	No	

**Please indicate which of the following conditions may be found in your family:**

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR Children	OTHER Relatives
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF		
Autoimmune disorder, such as lupus or rheumatoid arthritis											
Birth defects requiring surgery (cleft lip, etc)											
Bleeding disorders (hemophilia, etc.)											
Blindness											
Bone disorders											
Cancer before age 50 (specify)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											
Clotting disorders (Factor V Leiden, etc.)											
Deafness											
Diabetes (Insulin dependent)											
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)											
Epilepsy (seizures)											
Heart defects ("hole in the heart", etc)											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Hydrocephaly ("water on the brain")											
Kidney Disease											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Marfan Syndrome											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											
Muscular Dystrophy											
Neurofibromatosis											
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											
Neuromuscular diseases (muscular dystrophies, etc.)											
Phenylketonuria (PKU)											
Polycystic Kidney disease											
Skin Diseases (eczema, melanoma)											
Stillbirth or children who have died as infants											
Stroke											
Thalassemia (Cooley's anemia)											
Unusual genitals in boys or girls											
Urinary Tract abnormalities											
Women who have had multiple miscarriage											
Other serious health issues											

Please explain any positive answers: \_\_\_\_\_  
 \_\_\_\_\_

**REPRODUCTIVE HEALTH HISTORY—MALE PARTNER**

Do you have any theories as to why you have been unable to conceive? \_\_\_\_\_

List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	MOTHER ( check one )	
				Present partner	Previous partner

Have you previously conceived with another woman?  Yes  No

Have you ever been unable to conceive with anyone other than your current partner?  Yes  No

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)?  Yes  No

Have you ever consulted a urologist or male infertility specialist?  Yes  No

If yes: Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Findings / Recommendations: \_\_\_\_\_

**PREVIOUS FERTILITY EVALUATION:**

Have you had any of the following tests performed?

<u>Fertility Test:</u>			<u>Date</u>	<u>Result normal?</u>		<u>If no, describe:</u>
	Yes	No		Yes	No	
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Blood tests	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____

**GENERAL MEDICAL HISTORY—MALE PARTNER**

What is your current weight? \_\_\_\_\_ Height? \_\_\_\_\_ Usual weight? \_\_\_\_\_

Recent weight loss or gain in the past 6 months? \_\_\_\_\_

Place a check by any of the following that have been a problem for you during the last 6 months

Eye problems <input type="checkbox"/>	Diarrhea <input type="checkbox"/>	Headaches <input type="checkbox"/>
Stuffy nose, hay fever <input type="checkbox"/>	Hemorrhoids <input type="checkbox"/>	Shaking, tremor <input type="checkbox"/>
Frequent nose bleeds <input type="checkbox"/>	Hernia <input type="checkbox"/>	Anxiety <input type="checkbox"/>
Fast or irregular heartbeat <input type="checkbox"/>	Gall bladder problems <input type="checkbox"/>	Depression <input type="checkbox"/>
Heart murmur <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Anemia <input type="checkbox"/>
Dizziness, fainting <input type="checkbox"/>	Frequent urination at night <input type="checkbox"/>	Bleeding/bruising from minor injury <input type="checkbox"/>
Shortness of breath <input type="checkbox"/>	Sexual problems <input type="checkbox"/>	Poor circulation <input type="checkbox"/>
Lung disease <input type="checkbox"/>	Herpes (oral or genital) <input type="checkbox"/>	Blood clots <input type="checkbox"/>
Asthma <input type="checkbox"/>	Genital or groin injuries <input type="checkbox"/>	Blood transfusions <input type="checkbox"/>
Tuberculosis <input type="checkbox"/>	Pain in joints, arthritis <input type="checkbox"/>	Fatigue <input type="checkbox"/>
Heartburn, indigestion <input type="checkbox"/>	Acne or pimples <input type="checkbox"/>	Low energy <input type="checkbox"/>
Gas, cramps, pain <input type="checkbox"/>	Elevated prolactin <input type="checkbox"/>	Past history of IV drug use <input type="checkbox"/>

Blood in stool or black stool	<input type="checkbox"/>	Fever, sweats, chills	<input type="checkbox"/>	Other	<input type="checkbox"/>
Nausea, vomiting	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>		<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Temperature intolerance	<input type="checkbox"/>		<input type="checkbox"/>

Please give detail and dates: \_\_\_\_\_

Please list any major surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

Please list all medications including: vitamins/herbs/over the counter medication (OTC's):

Medication	Dosage	Frequency	Reason

**ALLERGIES:**

Latex?  Yes  No If yes, specify reaction: \_\_\_\_\_

Medications?  Yes  No Which meds, specify reaction: \_\_\_\_\_

**FAMILY AND GENETIC HEALTH HISTORY—MALE PARTNER**

Are there any known genetic diseases or conditions that run in your family?  Yes  No

If yes, which one(s) and whom? \_\_\_\_\_

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g., heart, mental retardation, neural tube defect (e.g., spina bifida)], or other?  Yes  No

Are you adopted?  Yes  No

Ethnic Background: \_\_\_\_\_

**Are you any of the following ethnic groups?**

**There is increased risk for:      Tested?:**

Caucasian	___ Yes	___ No	Cystic Fibrosis	___Y ___N
English, Irish	___ Yes	___ No	Neural Tube Defects	N/A
Mediterranean (Greek, Italian, Middle Eastern)	___ Yes	___ No	Thalassemia	___Y ___N
Ashkenazi Jewish	___ Yes	___ No	Tay Sachs	___Y ___N
French Canadian	___ Yes	___ No	Tay Sachs	___Y ___N
Cajun	___ Yes	___ No	Tay Sachs	___Y ___N
Asian (Southeast Asian, Chinese, Taiwanese, Filipino, Indian, etc.)	___ Yes	___ No	Thalassemia	___Y ___N
African descent	___ Yes	___ No	Sickle Cell Anemia, Thalassemia	___Y ___N

**Please indicate which of the following conditions may be found in your family:**

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR Children	OTHER Relatives
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF		
Neural tube defects (spina bifida, "open spine", anencephaly)											
Heart defects ("hole in the heart", etc.)											
Any birth defects requiring surgery (cleft lip, etc.)											
Unusual genitals in boys or girls											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											
Diabetes											
Blindness											
Deafness											
Bone disorders											
Skin Diseases (eczema, melanoma)											
Cancer before age 50 (specify)											
Heart Disease											
Kidney Disease											
High Blood Pressure											
High Cholesterol											
Epilepsy (seizures)											
Clotting disorders (Factor V Leiden, etc.)											
Bleeding disorders (hemophilia, etc.)											
Thalassemia (Cooley's anemia)											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)											

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR CHILDREN	OTHER RELATIVES
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF		
Neuromuscular diseases (muscular Dystrophies, etc.)											
Other genetic disorders (Cystic fibrosis, marfan syndrome, neurofibromatosis, sickle cell anemia, PKU, Tay-Sachs disease, Canavan disease, etc.)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											
Other serious health issue											

Please explain any positive answers: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY—MALE PARTNER**

Current Occupation: \_\_\_\_\_

Prior Occupation(s): \_\_\_\_\_

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? \_\_\_\_\_

Were there times during the past month when you experienced little interest in doing things? Yes No

In the past month, have there been times when you felt down, depressed, or hopeless? Yes No

Please comment: \_\_\_\_\_

\_\_\_\_\_