



AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

Infertility History Form

FOR OFFICE USE ONLY

IMPORTANT:

Please complete this form and bring it with you to your scheduled visit.

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

Part I: Contact information

Part II: Your medical history

Part III: Your male partner's medical history (if applicable)

PART I: CONTACT INFORMATION

First Name _____ Middle Initial ____ Last Name _____ Age _____

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 Telephone () _____ Work Telephone () _____ Cell Phone () _____

Do you have a male partner? Yes No

Male Partner's First Name _____ Middle Initial ____ 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 Telephone () _____ Work Telephone () _____ Cell Phone () _____

By whom were you referred?

Physician

Name _____ Phone () _____

Address _____

Former Patient/Friend _____

Web Site _____

Insurance (Name of Insurance) _____

Who is your Ob/Gyn?

Name _____ Phone () _____

Address _____

Who is your Primary Care Physician?

Name _____ Phone () _____

Address _____

**Physician Notes
(for office use only)**

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: Infertility Evaluation Sperm Insemination Other _____

How many months have you been trying to conceive (unprotected intercourse or inseminations)? _____

Pregnancy Summary

- Total Number of ALL Pregnancies: _____
- Number of Full Term Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? ____
- Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? ____
- Number of Miscarriages (less than 20 weeks): _____
- Number of Ectopic/Tubal Pregnancies: _____
- Number of Elective Terminations (Abortions): _____
- Any Pregnancies with Birth Defects? No Yes - explain _____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/Complications	Current Partner?
1. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
2. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
3. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
4. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
5. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
6. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

Menstrual History

- Menstrual cycle pattern (check all that apply): Regular periods Irregular periods Spotting before periods No periods
 Heavy periods Light periods Bleeding between 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
- Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____
- 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__ In the past__ No

Contraceptive History

- None Condoms - dates of use _____ Diaphragm - dates of use _____ IUD - dates of use _____
- Birth control pills - dates of use _____ - complications? _____ Never used birth control pills
- Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use _____ - complications? _____
- Skin patch - dates of use _____ - complications? _____ Foam or Jelly
- Tubal sterilization procedure (tubes tied) - date (month/year) ____/____ Tubes untied - date (month/year) ____/____

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

Any prior exposure to 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 _____

Physician Notes (for office use only) _____

Pap Smear History

- When was your last pap smear (month and year)? ____/____/____ 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? No Yes - date ____ Result: normal abnormal - explain _____
- Do you perform self breast exams? Yes No

Medical History

- Are you allergic to any medications? No Yes (Please list and describe reactions) _____
- Are you allergic to any foods (peanuts, eggs, etc.)? No Yes (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 store supplements? No Yes (Please list) _____
- Do you have any medical problem(s)? No Yes (Please list type, dates, and treatments.)
 - (1) _____
 - (2) _____
 - (3) _____
 - (4) _____
 - (5) _____
- Did you have either of these childhood illnesses? Chickenpox (Varicella) German Measles (Rubella) Don't know
Other childhood diseases: _____

Vaccinations

- Chickenpox (Varicella): No Yes (dates _____) Don't know
- MMR - Measles, Mumps, and Rubella (German Measles): 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

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? ____ None
- Do you smoke cigarettes? No Yes How many/day? ____ How many years? ____ Quit - when? _____
- Do you drink alcohol? No Yes
 - Beer - # per week ____ Wine- # per week ____ Liquor - # per week ____
- Do you use any marijuana, cocaine, or any other similar drug? No Yes (describe _____)
- Do you exercise? No Yes (describe _____)
- Are you aware of any radiation exposures other than X-rays? No Yes (describe _____)

Physician Notes (for office use only) _____

Surgical History

• Have you had any surgeries? No Yes (List all surgeries in chronologic order.)

Year	Reason and Type of Surgery
_____	(1) _____
_____	(2) _____
_____	(3) _____
_____	(4) _____
_____	(5) _____
_____	(6) _____
_____	(7) _____

• Did you have any anesthesia problems? No Yes (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 feeling cold
- 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
- Herpes
- Blood in the urine
- 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
- Mitral valve prolapse (Need antibiotics before dental procedures? Yes___ No___)
- Other _____
- None

Mental Health Problems:

- Depression Anxiety disorder
- Schizophrenia
- Other _____
- None

Physician Notes (for office use only) _____

Family History

	<u>Living</u>		<u>Cause of Death/Age at Death</u>
• Mother	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• 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	_____

What is your Ancestry?
<input type="checkbox"/> African-American
<input type="checkbox"/> American Indian/Native American
<input type="checkbox"/> Ashkenazi Jewish
<input type="checkbox"/> Asian-American
<input type="checkbox"/> Cajun/French Canadian
<input type="checkbox"/> Caucasian
<input type="checkbox"/> Eastern European
<input type="checkbox"/> Hispanic/Caribbean
<input type="checkbox"/> Northern European
<input type="checkbox"/> Southern European
<input type="checkbox"/> Other (specify _____)

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
• Gaucher 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
• Developmental delay	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Learning problems	<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
• Down syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Other chromosome 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 _____)	_____	

PRIOR INFERTILITY TESTING AND TREATMENT

• 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):

	# of cycles	Dates (mo/year) (mo/year)	Pregnant
<input type="checkbox"/> <u>Intrauterine insemination:</u>	_____	From____/____ to____/____	Yes___ No___
<input type="checkbox"/> <u>Clomiphene citrate with timed intercourse:</u> maximum # tablets per day?_____	_____	From____/____ to____/____	Yes___ No___
<input type="checkbox"/> <u>Clomiphene citrate with insemination:</u> maximum # tablets per day?_____	_____	From____/____ to____/____	Yes___ No___
<input type="checkbox"/> <u>Daily fertility drug injections with insemination:</u> maximum # vials per day?_____	_____	From____/____ to____/____	Yes___ No___
<input type="checkbox"/> <u>Completed in vitro fertilization cycle(s):</u> 1. # eggs___ #embryos transferred___ #frozen___ 2. # eggs___ #embryos transferred___ #frozen___ 3. # eggs___ #embryos transferred___ #frozen___ 4. # eggs___ #embryos transferred___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	Yes___ No___ Yes___ No___ Yes___ No___ Yes___ No___
<input type="checkbox"/> <u>Frozen embryo transfers:</u> 1. # embryos transferred___ 2. # embryos transferred___ 3. # embryos transferred___ 4. # embryos transferred___	_____	_____/_____ _____/_____ _____/_____ _____/_____	Yes___ No___ Yes___ No___ Yes___ No___ Yes___ No___
Canceled in vitro fertilization attempt(s)	_____		

• 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
 • Describe any emotional, marital, or sexual problems caused by your infertility. _____

PATIENT'S SIGNATURE _____	DATE _____
I confirm that I have reviewed the information above.	
PHYSICIAN'S SIGNATURE _____	DATE _____

PART III: MALE PARTNER 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
 - Do you have difficulty with erections? Yes No
 - Do you have retrograde ejaculation of sperm into the bladder? Yes No
 - Any prior exposure to sexually transmitted diseases or infections?
 - Yes (check all that apply) No
 - Chlamydia - date_____ Gonorrhea - date_____ Herpes - date_____ Genital warts/HPV - date_____
 - Syphilis - date_____ HIV/AIDS - date_____ Hepatitis - date_____
 - Have you had a history of undescended testicles? Yes - One side___ Both___ 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___ Cancer - Yes___ No___
 - Multiple Sclerosis - Yes___ No___ Other neurologic problems - Yes___ No___
 - Prostatic infections - Yes___ No___ Urinary infections - Yes___ No___
 - High Blood Pressure - Yes___ No___ If yes, any medications? _____

 - 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? No Yes (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? No Yes How many/day? _____ How many years? _____ Quit - when? _____
 - Do you drink alcohol? No Yes
 - Beer - # per week _____ Wine- # per week _____ Liquor - # per week _____
 - Do you use any marijuana, cocaine, or any other similar drug? No Yes (describe _____)
 - Do you use herbal medicines/vitamins or health food store supplements? No Yes (describe _____)
 - Are you aware of any radiation/toxic materials exposure? No Yes

 - 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 Notes (for office use only) _____

Disorders in Your Family

	<u>Relationship to You</u>		
• 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
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• Familial Dysautonomia	<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
• Developmental delay	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Learning problems	<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
• Down syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Other chromosome 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 _____)		

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 _____)

MALE PARTNER'S SIGNATURE _____	DATE _____
I confirm that I have reviewed the information above.	
PHYSICIAN'S SIGNATURE _____	DATE _____

Physician Notes (for office use only) _____
