Coastal Fertility Medical Center | RSMC Irvine
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Patient Infertility History Questionnaire

(Important: Please complete and return 5-7 Business days prior to your appointment)

PART I: CONTACT INFORMATION - Primary Patient (Female)

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_____ ☐ Work_____ ☐ Cell_____

Email Address:_____

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other _____

Spouse/Partner: ☐ Not Applicable

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_____ ☐ Work_____ ☐ Cell_____

Email Address:_____

Physician Notes
(for office use only)

_____
_____
_____
_____
_____
_____
_____

By whom were you referred?

☐ Physician
Name _____ Phone ( ) _____

Address _____ _____

☐ Former Patient/Friend/Relative _____
☐ Web Site _____
☐ Insurance (Name of Insurance) _____

Who is your Ob/Gyn?
Name _____ Phone ( ) _____

Address _____ _____

Who is your Primary Care Physician?
Name _____ Phone ( ) _____

Address _____

Name_____ DOB _____

PART II: FEMALE MEDICAL HISTORY AND INFORMATION (Primary Patient)

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

What are your expectations for this visit?_____

Any questions you wish to address:_____
_____

Do you have any personal, ethical, or relations 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_____

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

Pregnancy History

* 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?____ How many were stillborn?_____
* Number of 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	Months to Conception	Treatments to Conceive	Deliver 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 Cycle 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 server cramping or pelvic pain with your periods? ☐ Yes:__Always ☐ Sometimes ☐ Recently ☐In the past ☐ No

Contraceptive Methods (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
☐ Inject able contraception (Depo-Provera, Lunelle (TM), 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

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_____

Name_____ DOB _____

Pap Smear Medical History

* When was your last pap smear (month end 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
* 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 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)_____
_____
_____

Name_____ DOB _____

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
☐ Diabetes ☐ Hair 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:

Breasts:

Neurological Problems:

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

☐ Discharge (Clear? _____Bloody? ____ Milky?____)
☐ Lumps ☐ Pain ☐ Cancer
☐ Abnormal mammogram
☐ Reduction
☐ Augmentation/Breast Implants
(saline? _____ silicone? _____)
☐ Other _____
☐ None

☐ Weakness/Loss of balance
☐ Seizures/Epilepsy
☐ Headaches
☐ Migraine headaches
☐ Numbness
☐ Memory Loss
☐ Other _____]
☐ None

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

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

Skin/Extremities:
☐ Unexplained rash/inflammation
☐ Acne
☐ Skin caner
☐ 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 _____
_____
_____
_____

Name_____ DOB _____

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	_____
	☐ 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	_____

What is your Ancestry?
☐ African - American
☐ Amer.Indian/NativeAmer.
☐ Ashkenazi Jewish
☐ Asian-American
☐ Cajun/French Canadian
☐ Caucasian
☐ Eastern European
☐ Hispanic - American
☐ Northern European
☐ Southern European
☐ Other- (specify)

Disorders in Your Family

Relationship to You

Would you like to be screened for :

* Breast cancer	☐ Yes _____	☐ No	☐ Don't Know	☐ Cystic Fibrosis: ☐ Yes ☐ No
* Ovarian cancer	☐ Yes _____	☐ No	☐ Don't Know	☐ Sickle Cell Anemia:
* Ovarian cancer	☐ Yes _____	☐ No	☐ Don't Know	☐ Yes ☐ No
* Other cancer_____	☐ Yes _____	☐ No	☐ Don't Know	☐ Tay-Sachs Disease
* Diabetes	☐ Yes _____	☐ No	☐ Don't Know	☐ Yes ☐ No
*Thyroid Problems	☐ Yes _____	☐ No	☐ Don't Know	☐ Thalasemia: ☐ Yes ☐ No

* 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
* Neimann-Pick disease ☐ Yes _____ ☐ No ☐ Don't Know
* Fanconi Anemia ☐ Yes _____ ☐ No ☐ Don't Know
* Familiar 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
* 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)_____

Name_____ DOB _____

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 (date____/results_____)
☐ Day 3 blood test for FSH level (date____/results _____) ☐ Hysterosalpingogram (HSG) (date____/results_____)
☐ Laparoscopy (date____/results _____) ☐ Hysteroscopy surgery (date____/results_____)
☐ Progesterone blood test (date____/results _____) ☐ Prolactin blood test kit (date____/results_____)

Prior Treatment (Check all that apply):

	# of cycles	Dates (mo/year) (mo/year)	Outcome
☐ Intrauterine insemination:	_____	**From** ___/___ **to**___/___	☐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):	_____	_____/_____	☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant

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
☐ Frozen embryo transfers): 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
Canceled in vitro fertilization attempts (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? ☐ No ☐ Yes - for how long _____ How often?_____
* List any anti-depressant/anti - anxiety medications you are currently taking?_____
* 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**_____

Name_____ DOB _____

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable

List your current medications: _____
_____
List any current medical problem(s):_____
_____
_____

* 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 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)

* 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
* 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_____

* 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) _____
_____
_____
_

Name_____ DOB _____

Disorders in Your Family

Living	**Relationship to You**			**What is your Ancestry?**
* Cystic Fibrosis	☐ Yes _____	☐ No	☐ Don't Know	☐ African - American
* Tay-Sachs disease	☐ Yes _____	☐ No	☐ Don't Know	☐ American. Indian/NativeAmer.
* Canavan disease	☐ Yes _____	☐ No	☐ Don't Know	☐ Ashkenazi Jewish
* Bloom syndrome	☐ Yes _____	☐ No	☐ Don't Know	☐ Asian-American
* Gaucher disease	☐ Yes _____	☐ No	☐ Don't Know	☐ Cajun/French Canadian
* Neimann-Pick disease	☐ Yes _____	☐ No	☐ Don't Know	☐ Caucasian
* Fanconi Anemia	☐ Yes _____	☐ No	☐ Don't Know	☐ Eastern European
* Familiar Dysautonia	☐ Yes _____	☐ No	☐ Don't Know	☐ Hispanic - American
* Muscular Dystrophy	☐ Yes _____	☐ No	☐ Don't Know	☐ Northern European
* Paternal Grandmother	☐ Yes _____	☐ No	☐ Don't Know	☐ Southern European
* Paternal Grandfather	☐ Yes _____	☐ No	☐ Don't Know	☐ Other- (specify) (_____)
* Neurologic brain/spine	☐ Yes _____	☐ No	☐ Don't Know	
* Neural Tube Defects	☐ 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 chrom. 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
* Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know
* None of the above	☐ 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

SPOUSE/MALE PARTNER'S SIGNATURE:_____ DATE_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE:_____ DATE_____

Physician Notes (for office use only)