Center for Reproductive Medicine • Advanced Reproductive Technologies
www.ivfminnesota.com

Recessive Disease Screening

Each of us carries many mutations for many recessive diseases, some of which are trivial and some are life threatening. This is not a problem unless we inherit the same recessive disease gene from both of our parents.

Genetic screening, therefore, is an attempt to determine whether both parents carry the same recessive mutation which could then cause a serious disease in their child. Various diseases have been chosen for screening because of the frequency of the mutations in the population, the seriousness of the genetic condition, the ability to screen for the majority of the mutations, or some combination of these three criteria.

The experts in our national professional organizations have recommended that screening for two diseases, Cystic Fibrosis and Spinal Muscular Atrophy, be offered to every couple considering a pregnancy. The chance that you both carry the same mutation for one of these conditions is approximately 1/450. If you do carry the same mutation for these conditions as your partner any child you have together would have a ¼ (25%) chance of having the disease.

If you are found to carry the same recessive mutation you could do IVF with PGD to avoid transferring an embryo that would be affected by the condition, or conceive a pregnancy and then do prenatal testing to determine whether the pregnancy is affected, followed by either termination of the pregnancy or appropriate intervention after delivery depending on the condition.

If you would like to be screened for these recessive diseases the cost of the screening blood test is $160. If one partner is positive, the other partner would be screened to be sure the same mutation is not shared. The genetic screening test is generally not covered by your insurance.

Please indicate your preference to be screened or to decline screening at your new patient visit.

I choose to be screened ______________________ ______________________
(Patient) (Partner)

I decline genetic screening ______________________ ______________________
(Patient) (Partner)

Do you wish to delay treatment until screening results are known? ☐ Yes ☐ No

Date______________

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Minneapolis, MN 55407
p. 612.863.5390 f. 612.863.2697

991 Sibley Memorial Highway #100
Saint Paul, MN 55118
p. 651.379.3110 f. 651.379.3111

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New Patient Questionnaire

Name ______________________ DOB ____________ Age ________

Marital Status: ◯ Single ◯ Married ◯ Partnered ◯ Separated ◯ Divorced ◯ Remarried Occupation ______________

Partner's name ______________________ DOB ____________ Age ________

What is your travel time/distance to the Center for Reproductive Medicine? ____________ Occupation ______________

Prior Physician History

Dates	MD	Clinic Address

Do you need a referral to come here? ◯ Yes ◯ No Referring Doctor: ______________________

Do you want a letter sent to your referring physician? ◯ Yes ◯ No

Reason for today's visit? ◯ Infertility ◯ Recurrent Pregnancy Loss ◯ Other______________

Are you interested in genetic screening? ◯ Yes ◯ No

When did you begin attempting pregnancy? ______________________

Pregnancy History

Term Pregnancy: ________ Preterm: ____________AB: ______________ Living:____________ Adopted: __________

PAST PREGNANCIES (include miscarriages and abortions)

Date Mo/Yr	Weeks of Gestation At Delivery	Infertility Treatment	How Long to Conceive	Sex M/F	Type of Delivery	Current Partner	Comments/Complications
						Y / N	
						Y / N	
						Y / N	
						Y / N	
						Y / N	

◯ None

Surgical History (List all prior surgeries in chronological order)

Date	Procedure	Comments

PATIENT PAST MEDICAL HISTORY

	No	Yes		No	Yes
1. Hospitalizations	◯	◯	16. Genetic Abnormalities	◯	◯
2. Anesthesia Complications	◯	◯	17. Congenital Abnormalities	◯	◯
3. Diabetes	◯	◯	18. Bleeding disorder	◯	◯
4. Heart Disease (MVP) (Arrhythmias)	◯	◯	19. Clotting disorder	◯	◯
5. Autoimmune Disorder (Lupus)	◯	◯	20. Pulmonary Embolism	◯	◯
6. Kidney Disease	◯	◯	21. Hypertension	◯	◯
7. Neurological Disease	◯	◯	22. AIDS	◯	◯
8. Depression	◯	◯	23. Irritable Bowel Syndrome	◯	◯
9. Eating Disorder	◯	◯	24. Ulcerative Colitis	◯	◯
10. Hepatitis/Liver Disease	◯	◯	25. Crohns Disease	◯	◯
11. Thyroid Dysfunction	◯	◯	26. Chemotherapy	◯	◯
12. History of blood transfusions	◯	◯	27. Radiation Therapy	◯	◯
13. Pulmonary Disease (Asthma)	◯	◯	28. Seizures	◯	◯
14. Exposed to TB	◯	◯	29. Other	◯	◯
15. Cancer	◯	◯			

Family History (include Parents, Siblings, Grandparents, Aunts, Uncles and Cousins)

	No	Yes	COMMENTS:
1. Infertility	◯	◯	
2. Recurrent Pregnancy Loss	◯	◯	
3. Genetic Abnormalities	◯	◯	
4. Birth Defects	◯	◯	
5. Bleeding or Clotting Disorders	◯	◯	
6. Mental Retardation	◯	◯	
7. Prior Genetic Testing	◯	◯	
8. Breast Cancer	◯	◯	
9. Ovarian Cancer	◯	◯	
10. Cystic Fibrosis	◯	◯	
11. Other	◯	◯	

Ancestry

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

Social History

	No	Yes	COMMENTS:		
1. Exposure to chemicals	◯	◯	List:		
2. Smoking	◯	◯	How many packs per day?	For how many years?	Quit?
3. Alcohol	◯	◯	How much?		
4. Recreational Drugs	◯	◯			
5. Chemical Dependency	◯	◯	When Treatment?		
6. Caffeine	◯	◯	How much?		
7. Exercise Regularly	◯	◯	Type?	Frequency?	
8. Recent Piercing	◯	◯			
9. Recent Tattoo	◯	◯			

CURRENT MEDICATIONS	
Name	Dose

ALLERGIES

- ○ None
- ○ Drug
- ○ Food
- ○ Environmental
- ○ Latex
- ○ Iodine
- ○ Shell Fish
- ○ Other ____________________

Menstrual History

Age at first period: ________ Interval between periods: ________ Length of flow: ________ ○ Regular ○ Irregular

First day of last period: ________ Height: ________ Weight: ________

Have you ever used any of the following birth control: ○ Pill ○ Depo Provera ○ Implants ○ IUD ○ Tubal Ligation ○ Vasectomy

GYN Review of Systems

	No	Yes	COMMENTS:
1. Bleeding between periods	○	○	
2. Bleeding after intercourse	○	○	
3. Unusually heavy periods	○	○	
4. Significant pain with periods	○	○	
5. Abnormal hair growth	○	○	
6. Breast Discharge	○	○	
7. Hot flashes	○	○	
8. Pelvic pain	○	○	
9. Significant weight change	○	○	

GYN History

	No	Yes	COMMENTS:
1. DES exposure	○	○	
2. Ovarian cyst	○	○	
3. Uterine Fibroid	○	○	
4. Uterine Polyp	○	○	
5. Uterine malformation	○	○	
6. Pelvic surgery	○	○	
7. Cervical surgery	○	○	
8. PID (Pelvic Inflammatory Disease)	○	○	
9. Condyloma (HPV)	○	○	
10. STD (GC, Chlamydia, Syphilis)	○	○	
11. Herpes virus	○	○	
12. Ectopic pregnancy	○	○	
13. Pelvic adhesions	○	○	
14. Endometriosis	○	○	
15. Tubal blockage	○	○	
16. Other	○	○	

MALE PARTNER INFORMATION

Name: ______________________________ Age: ____________

Do you need a separate referral to come here? ○ No ○ Yes

Have you seen an Urologist for evaluation? ○ No ○ Yes When: ______________________

Physician name: ______________________________

Have you ever fathered any prior pregnancies? ○ No ○ Yes

Outcome: ______________________________

Are you interested in genetic screening? ○ No ○ Yes

Review of Systems

	No	Yes	COMMENTS:
Testicular swelling	○	○	
Testicular pain	○	○	
Difficulty with vaginal penetration	○	○	
Inability to obtain an erection	○	○	
Inability to maintain an erection	○	○	
Problems with ejaculation	○	○	

Urologic History

	No	Yes	COMMENTS:
1. Undescended testicle	○	○	
2. Prostate infection	○	○	
3. Varicocele	○	○	
4. Vasectomy	○	○	
5. Sperm Antibodies	○	○	
6. Congenital abnormalities	○	○	
7. Genetic abnormalities	○	○	
8. Sexually transmitted disease	○	○	
9. Testicular abnormalities	○	○	
10. Spinal injury	○	○	
11. Other medical problems	○	○	

Surgical History (List all prior surgeries in chronological order)

Date	Procedure None ○	Comments

Medications (List current medications)

Name of Medication None ○	Dose

MALE PARTNER INFORMATION

Allergies (List allergies to medication or environmental allergies)

Type of Allergy	None ○	Reaction

Past Medical History (List illnesses or hospitalizations)

○ None

1. ______________________________
2. ______________________________
3. ______________________________

Social History

	No	Yes	COMMENTS:		
1. Exposure to chemicals	○	○	List:		
2. Smoking	○	○	How many packs per day?	For how many years?	Quit?
3. Alcohol	○	○	How Much?		
4. Recreational drugs	○	○			
5. Chemical Dependency	○	○	When Treatment?		
6. Excess heat exposure	○	○			
7. Recent Piercing	○	○			
8. Recent Tattoo	○	○			

Male Partner's Family History (Include parents, siblings, grandparents, aunts, uncles & cousins)

	No	Yes	COMMENTS:
1. Infertility	○	○	
2. Recurrent Pregnancy Loss	○	○	
3. Genetic Abnormalities	○	○	
4. Birth Defects	○	○	
5. Mental Retardation	○	○	
6. Prior Genetic Testing	○	○	
7. Cystic Fibrosis	○	○	
8. Bleeding or Clotting Disorder	○	○	
9. Other	○	○	

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