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

New Patient Questionnaire

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 (   )______________

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other____

Spouse/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 (   )______________

Who referred you?
☐ 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)
____
____
____
____
____
____
____

2828 Chicago Avenue South #400
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

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Insemination ☐ Other ______________________________

What are your expectations for this visit?______________________________

What questions do 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.? ☐ Yes______________________________ ☐ No

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

Pregnancy Summary

- Total 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? ☐ Yes - explain ______________________________ ☐ No

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery 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 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: _____/_____/_____; _____/_____/_____
- 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
- Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

Contraceptive History

☐ None ☐ Condoms - dates of use__________ ☐ Diaphragm - dates of use __________ ☐ Foam or Jelly
☐ 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?____________________ ☐ IUD - dates of use__________
☐ Tubal sterilization procedure (tubes tied) - date (month/year)_____/_____ ☐ Tubes untied - date (month/year)_____/_____

Sexual History

- Are you sexually active? ☐ Yes ☐ No Is your partner ☐ Male ☐ Female
- 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 - date______________

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? ☐ Yes - date_____ Result: ☐ normal ☐ abnormal - explain ___________________ ☐ No

Do you perform breast self exams?

Medical History

- Are you allergic to any medications? ☐ Yes ☐ No

  If yes, please list and describe reactions:____

  ____
- Are you allergic to any foods (peanuts, eggs, etc.)? ☐ Yes ☐ No

  If 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? ☐ Yes ☐ No

  If yes, please list :____

  ____
- Do you have any medical problem(s)? ☐ Yes (Please list type, dates, and treatments.) ☐ No

  (1)____

  (2)____

  (3)____

  (4)____

  (5)____

Surgical History

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

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

- Did you have any problems with anesthesia? ☐ Yes (describe ________________________________) ☐ No
- Have you had either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know

  Other childhood diseases:____

Vaccinations

• Chickenpox (Varicella):	☐ Yes (dates_________)	☐ No	☐ Don't know
• MMR - Measles, Mumps, and Rubella (German Measles):	☐ Yes (dates_________)	☐ No	☐ Don't know
• BCG (Tuberculosis):	☐ Yes (dates_________)	☐ No	☐ Don't know
• Hepatitis B:	☐ Yes (dates_________)	☐ No	☐ Don't know
• Polio:	☐ Yes (dates_________)	☐ No	☐ Don't know
• Hepatitis A:	☐ Yes (dates_________)	☐ No	☐ Don't know
• Tetanus:	☐ Yes (dates_________)	☐ No	☐ Don't know
• Influenza:	☐ Yes (dates_________)	☐ No	☐ Don't know

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ ☐ None
- Do you smoke cigarettes? ☐ Yes How many/day?_____ How many years?_____ ☐ Quit - when?_______________ ☐ No
- Do you drink alcohol? ☐ Yes ☐ No
  If yes, how many drinks per week?_______________
- Have you casually used marijuana, cocaine, or any other similar drug? ☐ Yes (describe_______________) ☐ No
- Do you exercise? ☐ Yes (describe_______________) ☐ No
- Are you aware of any radiation exposures other than X-rays? ☐ Yes (describe_______________) ☐ No
- Do you feel safe in your own home? ☐ Yes (describe_______________) ☐ No

Review of 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
☐ Blood in the urine
☐ Herpes
☐ 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

	Living		Cause of Death/Age at Death
• Mother	☐Yes - age___	☐No	______________
• Father	☐Yes - age___	☐No	______________
• Brother(s)	☐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?

☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander

☐ Black, not of Hispanic Origin

☐ Hispanic

☐ White, not of Hispanic Origin

☐ Other (specify___________)

Disorders in You/Your Family

		Self or Relationship to You		
• Birth defects	☐Yes	______________	☐No	☐Don't Know
• Blood clots	☐Yes	______________	☐No	☐Don't Know
• Bloom syndrome	☐Yes	______________	☐No	☐Don't Know
• Bone/Skeletal Defects	☐Yes	______________	☐No	☐Don't Know
• Canavan disease	☐Yes	______________	☐No	☐Don't Know
• Cancer				
• Breast cancer	☐Yes	______________	☐No	☐Don't Know
• Colon cancer	☐Yes	______________	☐No	☐Don't Know
• Ovarian cancer	☐Yes	______________	☐No	☐Don't Know
• Other cancer______	☐Yes	______________	☐No	☐Don't Know
• Color Blindness	☐Yes	______________	☐No	☐Don't Know
• Cystic Fibrosis	☐Yes	______________	☐No	☐Don't Know
• Deafness/Blindness	☐Yes	______________	☐No	☐Don't Know
• Developmental delay	☐Yes	______________	☐No	☐Don't Know
• Diabetes	☐Yes	______________	☐No	☐Don't Know
• Down syndrome	☐Yes	______________	☐No	☐Don't Know
• Other chromosome defects	☐Yes	______________	☐No	☐Don't Know
• Dwarfism	☐Yes	______________	☐No	☐Don't Know
• Endometriosis	☐Yes	______________	☐No	☐Don't Know
• Familial Dysautonia	☐Yes	______________	☐No	☐Don't Know
• Fanconi Anemia	☐Yes	______________	☐No	☐Don't Know
• Galactosemia	☐Yes	______________	☐No	☐Don't Know
• Gaucher disease	☐Yes	______________	☐No	☐Don't Know
• Heart defect from birth	☐Yes	______________	☐No	☐Don't Know
• Heart disease	☐Yes	______________	☐No	☐Don't Know
• Hemochromatosis	☐Yes	______________	☐No	☐Don't Know
• Hemophilia	☐Yes	______________	☐No	☐Don't Know
• Infertility	☐Yes	______________	☐No	☐Don't Know
• Learning problems	☐Yes	______________	☐No	☐Don't Know
• Marfan syndrome	☐Yes	______________	☐No	☐Don't Know
• Menopause before age 40	☐Yes	______________	☐No	☐Don't Know
• Muscular Dystrophy	☐Yes	______________	☐No	☐Don't Know
• Neural Tube Defects	☐Yes	______________	☐No	☐Don't Know
• Neurologic (brain/spine)	☐Yes	______________	☐No	☐Don't Know
• Niemann-Pick disease	☐Yes	______________	☐No	☐Don't Know
• Obesity	☐Yes	______________	☐No	☐Don't Know
• Polycystic kidney disease	☐Yes	______________	☐No	☐Don't Know
• Psychiatric problems	☐Yes	______________	☐No	☐Don't Know
• Sickle Cell Anemia	☐Yes	______________	☐No	☐Don't Know
• Tay-Sachs disease	☐Yes	______________	☐No	☐Don't Know
• Thalassemia	☐Yes	______________	☐No	☐Don't Know
• Thyroid problems	☐Yes	______________	☐No	☐Don't Know
• Tuberculosis	☐Yes	______________	☐No	☐Don't Know
• High blood pressure	☐Yes	______________	☐No	☐Don't Know
• Glaucoma	☐Yes	______________	☐No	☐Don't Know
• High cholesterol	☐Yes	______________	☐No	☐Don't Know
• Gallstones	☐Yes	______________	☐No	☐Don't Know
• Hepatitis	☐Yes	______________	☐No	☐Don't Know

☐ None of the above ☐ 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)	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): 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
☐ 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
Canceled in vitro fertilization attempt(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? ☐ Yes - For how long? __________________ How often? _________________________ ☐ No

• List any antidepressant/antianxiety 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**____________________

PART III: MALE 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___ ☐ Yes: How many times?_____ ☐ No: Birth control used? No___
- Have you had a semen analysis? ☐ Yes ☐ No

Date	Volume	Count	Motility	Morphology
1.				
2.				
3.				

- Do you have difficulty with erections? ☐ Yes ☐ No
- Are you able to ejaculate inside your partner's vagina? ☐ ☐ 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 severe testicular pain?
  ☐ 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
- Have you ever had torsion/twisting of the testicles? ☐ Yes ☐ No
- Did you have mumps after puberty? ☐ Yes ☐ No
- Have you had injury to your testicles requiring an ER visit or 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 fever (>101° F) 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 varicocele surgery? ☐ Yes ☐ No
- Have you had hernia surgery? ☐ Yes ☐ No
- Have you had other surgery to the scrotum or groin area? ☐ 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 or radiation for cancer? ☐ Yes ☐ No
- • Are you allergic to any medications? ☐ Yes ☐ No
  If 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? ☐ Yes How many/day?_____ How many years?_____ ☐ Quit - when?_______________ ☐ No
- Do you drink alcohol? ☐ Yes ☐ No
  If yes, how many drinks per week?______________________________________
- Have you casually used marijuana, cocaine, or any other similar drug? ☐ Yes (describe_______________________________) ☐ No
- Do you use herbal medicines/vitamins or health food store supplements? ☐ Yes (describe__________________________) ☐ No
- Are you aware of any solvents/toxic materials exposure? ☐ Yes ☐ No
- 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____

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	______________
• 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?

☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander

☐ Black, not of Hispanic Origin

☐ Hispanic

☐ White, not of Hispanic Origin

☐ Other (specify___________)

Disorders in Your Family

		Relationship to You		
• Bloom syndrome	☐Yes	______________	☐No	☐Don't Know
• Bone/Skeletal Defects	☐Yes	______________	☐No	☐Don't Know
• Canavan disease	☐Yes	______________	☐No	☐Don't Know
• Color Blindness	☐Yes	______________	☐No	☐Don't Know
• Cystic Fibrosis	☐Yes	______________	☐No	☐Don't Know
• Deafness/Blindness	☐Yes	______________	☐No	☐Don't Know
• Developmental delay	☐Yes	______________	☐No	☐Don't Know
• Down syndrome	☐Yes	______________	☐No	☐Don't Know
• Other chromosome defects	☐Yes	______________	☐No	☐Don't Know
• Dwarfism	☐Yes	______________	☐No	☐Don't Know
• Familial Dysautonia	☐Yes	______________	☐No	☐Don't Know
• Fanconi Anemia	☐Yes	______________	☐No	☐Don't Know
• Galactosemia	☐Yes	______________	☐No	☐Don't Know
• Gaucher disease	☐Yes	______________	☐No	☐Don't Know
• Heart defect from birth	☐Yes	______________	☐No	☐Don't Know
• Hemochromatosis	☐Yes	______________	☐No	☐Don't Know
• Hemophilia	☐Yes	______________	☐No	☐Don't Know
• Learning problems	☐Yes	______________	☐No	☐Don't Know
• Marfan syndrome	☐Yes	______________	☐No	☐Don't Know
• Muscular Dystrophy	☐Yes	______________	☐No	☐Don't Know
• Neural Tube Defects	☐Yes	______________	☐No	☐Don't Know
• Neurologic (brain/spine)	☐Yes	______________	☐No	☐Don't Know
• Niemann-Pick disease	☐Yes	______________	☐No	☐Don't Know
• Polycystic kidney disease	☐Yes	______________	☐No	☐Don't Know
• Sickle Cell Anemia	☐Yes	______________	☐No	☐Don't Know
• Tay-Sachs disease	☐Yes	______________	☐No	☐Don't Know
• Thalassemia	☐Yes	______________	☐No	☐Don't Know
• High blood pressure	☐Yes	______________	☐No	☐Don't Know
• Glaucoma	☐Yes	______________	☐No	☐Don't Know
• High cholesterol	☐Yes	______________	☐No	☐Don't Know
• Gallstones	☐Yes	______________	☐No	☐Don't Know
• Hepatitis	☐Yes	______________	☐No	☐Don't Know

☐ None of the above ☐ Other (Specify ____________________________

SPOUSE/MALE PARTNER'S SIGNATURE______________________________ **DATE**______________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE______________________________ **DATE**______________