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 spouse/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 ( ) _____

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

Spouse/ Partner
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)

PART II: FEMALE HISTORY AND INFORMATION

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

What are your expectations for this visit? _____

What questions do you 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.? ☐ No ☐ Yes _____

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

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? _____
* 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. _____	_____	_____	_____	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: _____/_____/_____; _____/_____/_____
* 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

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? ☐ No ☐ Yes – date_____ Result: ☐ normal ☐ abnormal – explain_____
Do you perform breast self 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 every 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)_____
_____
_____
_____

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

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

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

Musculoskeletal:
☐ Unusual muscle weakness
☐ Decreased energy/stamina
☐ Rheumatoid arthritis
☐ Lupus Erythematosus
☐ Myasthenia gravis
☐ Other_____
☐ None

Mental Health Problems:
☐ Depression ☐ Anxiety disorder
☐ Schizophrenia
☐ 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

Breasts:
☐ Discharge (clear?__ bloody?__ milky?)
☐ Lumps ☐ Pain ☐ Cancer
☐ Abnormal mammogram
☐ Reduction
☐ Augmentation/Breast implants (saline?___ silicone?___)
☐ Other_____
☐ None

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

Hematologic:
☐ Blood clotting disorder/Blood clot
☐ Sickle Cell Anemia ☐ Thrombophlebitis
☐ Easy bruising
☐ Swollen glands/lymph nodes
☐ Blood transfusions (dates/reasons_____)
☐ Other_____
☐ None

Respiratory:
☐ Shortness of breath
☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Tuberculosis
☐ Bloody cough
☐ Other_____
☐ None

Neurological Problems:
☐ Weakness/Loss of balance
☐ Seizures/Epilepsy
☐ Headaches
☐ Migraine headaches
☐ Numbness
☐ Memory loss
☐ Other_____
☐ None

Skin/Extremities:
☐ Unexplained rash/inflammation
☐ Acne
☐ Skin cancer
☐ Burn injury
☐ Moles changing in appearance
☐ Excessive hair growth
☐ 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?) Y N
☐ 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	_____

Disorders in Your Family

		Relationship to You		
* Breast cancer	☐ Yes	_____	☐ No	☐ Don't Know
* Ovarian cancer	☐ Yes	_____	☐ No	☐ Don't Know
* Colon cancer	☐ Yes	_____	☐ No	☐ Don't Know
* Other cancer	☐ Yes	_____	☐ No	☐ Don't Know
* Diabetes	☐ Yes	_____	☐ No	☐ Don't Know
* Thyroid problems	☐ Yes	_____	☐ No	☐ Don't Know
* 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
* Niemann-Pick disease	☐ Yes	_____	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
* Familial 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
* Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
* Down syndrome	☐ Yes	_____	☐ No	☐ Don't Know
* Other chromosome 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
* Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know

☐ None of the above

☐ 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_____)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No

____ Sickle Cell Anemia: __Yes __No

____ Tay-Sachs Disease: __Yes __No

____ Thalassemia: __Yes __No

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/yr) (mo/yr)**	**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? ☐ No ☐ Yes – For how long? _____ How often? _____
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** _____

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
* 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 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 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? ☐ 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_____

Physician Notes (for office use only)
_____
_____

Disorders in Your Family

		Relationship to You		
* 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
* Niemann-Pick disease	☐ Yes	_____	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
* Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
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* Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
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* Down syndrome	☐ Yes	_____	☐ No	☐ Don't Know
* Other chromosome 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
* Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know

☐ None of the above

☐ 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_____)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No

____ Sickle Cell Anemia: __Yes __No

____ Tay-Sachs Disease: __Yes __No

____ Thalassemia: __Yes __No

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) _____