



Seattle Reproductive Medicine[®]

A N I N T E G R A M E D[®] A F F I L I A T E

MEDICAL AND REPRODUCTIVE HISTORY—INFERTILITY

Today's date ____/____/____

Date of appointment ____/____/____

FEMALE PATIENT:

(Legal) Last name: _____ **(Legal)** First name: _____ Middle initial _____

Age: _____ Date of Birth: ____/____/____ Soc. Security #: ____-____-____

Marital Status: ____ single ____ married ____ domestic partner Length of Relationship: ____ years

PARTNER:

(Legal) Last name: _____ **(Legal)** First name: _____ Middle initial _____

Age: _____ Date of Birth: ____/____/____ Soc. Security #: ____-____-____

MAILING ADDRESS:

Street: _____ City: _____

State/Providence: _____ Zip/Postal Code: _____ Country: _____

Home Phone Number: (____)____-____ OK to leave message? Yes No Best # to reach you:

Female Work Phone Number: (____)____-____ Yes No

Partner Work Phone Number: (____)____-____ Yes No

Female Cell Phone Number: (____)____-____ Yes No

Partner Cell Phone Number: (____)____-____ Yes No

Female Email Address: _____ Partner Email Address: _____

How did you hear about SRM?

- Family/Friend
- Internet
- Radio
- Medical office/physician referral (Name) _____
- Other _____

Would you like medical notes sent to your other healthcare providers

- Yes
- No

If yes, please indicate which provider(s) you would like us to send medical notes to:

| Provider Name | Address | Please indicate provider type: | | |
|---------------|---------|--------------------------------|--------|-------|
| | | Primary care | OB/Gyn | Other |
| | | | | |
| | | | | |

Reason for visit: _____

FERTILITY HISTORY

Do you have any theories as to why you have been unable to conceive? _____

PREGNANCY HISTORY: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

| Pregnancy # | Preg. Ended (mo./yr.) | Preg. Length (weeks, months) | Outcome | FATHER (check one) | |
|-------------|-----------------------|------------------------------|---------|----------------------|------------------|
| | | | | Present partner | Previous partner |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Time since contraception last used? _____

How long have you been trying to conceive? _____

If you previously have been pregnant, how long has it been since the most recent pregnancy? _____

Have you experienced any difficulty conceiving for a year or more with any man other than your current partner? Yes No

PREVIOUS FERTILITY EVALUATION:

Have you had any of the following tests performed?

| <u>Fertility Test:</u> | | | <u>Date</u> | <u>Result normal?</u> | | <u>If no, describe:</u> |
|------------------------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|-------------------------|
| | Yes | No | | Yes | No | |
| Day 3 FSH level | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Day 3 Estradiol level | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Antimullerian hormone | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Antral Follicle Count (AFC) | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Progesterone level(s) | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Endometrial Biopsy | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hysterosalpingogram (HSG) | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sonohysterogram (SHG or SIS) | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hysteroscopy | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid blood test | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Prolactin blood test | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Fasting blood glucose | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Testosterone level | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Post Coital Test | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

PRIOR TREATMENTS: (check all that apply)

| Treatment | #of cycles | Dates: (mo./year) to (mo./year) | Outcome (baby, miscarriage, etc.) |
|---|-------------------------|---|-----------------------------------|
| Intrauterine inseminations (no medication): | _____ | from: ___/___ to: ___/___ | |
| Clomid-maximum # of tablets per day _____ with timed intercourse with intrauterine inseminations with Metformin | _____ _____ _____ | from: ___/___ to: ___/___ from: ___/___ to: ___/___ from: ___/___ to: ___/___ | |
| Letrozole/Femara-maximum # per day _____ with timed intercourse with intrauterine inseminations | _____ _____ | from: ___/___ to: ___/___ from: ___/___ to: ___/___ | |
| Gonadotropins (Follistim, Gonal F, Menopur, Repronex, Bravelle) with intrauterine inseminations | _____ | from: ___/___ to: ___/___ | |
| Acupuncture | _____ | from: ___/___ to: ___/___ | |
| Chinese Herbs | _____ | from: ___/___ to: ___/___ | |
| Complete in vitro fertilization (IVF) cycle(s): 1. # eggs _____ # fertilized _____ # transferred _____ # frozen _____ 2. # eggs _____ # fertilized _____ # transferred _____ # frozen _____ 3. # eggs _____ # fertilized _____ # transferred _____ # frozen _____ | _____ _____ _____ | from: ___/___ to: ___/___ from: ___/___ to: ___/___ from: ___/___ to: ___/___ | |
| Frozen embryo transfers: 1. #embryos transferred _____ 2. #embryos transferred _____ 3. #embryos transferred _____ | _____ _____ _____ | _____/_____ _____/_____ _____/_____ | |
| Canceled in vitro fertilization attempt(s) | _____ | from: ___/___ to: ___/___ | |

REPRODUCTIVE HEALTH HISTORY-FEMALE PARTNER

MENSTRUAL HISTORY:

Age when you had your first menstrual period: _____ years old

The first day of your most recent menstrual period: ____ / ____ / ____

Menstrual cycle pattern without hormones or oral contraceptive pills (OCP's)-- (check all that apply):

- Regular periods
- Irregular periods
- No periods
- Spotting between periods
- Heavy periods
- Light periods

How many days from the first day of one period to the first day of the next? _____ days

How many days of bleeding do you usually have? _____ days

Do you need medication to bring on a period? Yes No If yes, what type? _____

Do you have cramping or pelvic pain with your periods? (check one)

- Always
- Sometimes
- Recently
- In the past
- No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: getting better getting worse staying the same

If you do not have periods, at what age did you stop having them? _____ years old

When was your last Pap smear? ____ / ____ Was it normal? Yes No

Have you ever had an abnormal Pap smear? Yes No If "Yes," date and treatment: _____

Did your mother take DES while pregnant with you? Yes No Don't know

Have you ever had a mammogram? Yes No If yes, when was the last one? ____ / ____

Was your mammogram normal? Yes No

CONTRACEPTIVE METHOD HISTORY:

| Type | Years Used |
|---|------------|
| <input type="checkbox"/> Birth Control Pill / Patch | |
| <input type="checkbox"/> Depo-Provera, Lunelle | |
| <input type="checkbox"/> Nuva Ring | |
| <input type="checkbox"/> Norplant/Implanon | |
| <input type="checkbox"/> Diaphragm | |
| <input type="checkbox"/> IUD | |
| <input type="checkbox"/> Condoms | |
| <input type="checkbox"/> Tubal Sterilization | |
| <input type="checkbox"/> Vasectomy | |
| <input type="checkbox"/> Rhythm (natural method) | |
| <input type="checkbox"/> Other | |

SEXUAL HISTORY:

How many times per week do you have intercourse? _____

How many times do you have intercourse mid-cycle? _____

Any pain with intercourse? Yes No

Do you regularly use lubricant with intercourse? Yes No If yes, what type? _____

Have you ever had any sexually transmitted infections? (please check all that apply)

- | | | | |
|------------------------------------|--|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Trichomonas | _____ |
| <input type="checkbox"/> HIV | <input type="checkbox"/> HPV | <input type="checkbox"/> Hepatitis | |

Have you ever had pelvic inflammatory disease? Yes No

If yes, when? _____ Were you hospitalized? _____

GENERAL MEDICAL HISTORY-FEMALE PARTNER

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain in the past 6 months? _____

Approximately how much did you weigh at age 18? _____

Are you currently being treated or being seen for any medical condition(s)? Yes No

If yes, please describe: _____

REVIEW OF SYSTEMS:

Check any of the following that you are presently having or have had in the past:

- | | | |
|--|---|--|
| Eye problems <input type="checkbox"/> | Gall bladder problems <input type="checkbox"/> | Excessive thirst <input type="checkbox"/> |
| Stuffy nose, hay fever <input type="checkbox"/> | Liver disease <input type="checkbox"/> | Temperature intolerance <input type="checkbox"/> |
| Frequent nose bleeds <input type="checkbox"/> | Frequent urination at night <input type="checkbox"/> | Headaches <input type="checkbox"/> |
| Fast or irregular heartbeat <input type="checkbox"/> | Vaginal discharge,itching,pain <input type="checkbox"/> | Shaking, tremor <input type="checkbox"/> |
| Heart murmur <input type="checkbox"/> | Pelvic pain <input type="checkbox"/> | Anxiety <input type="checkbox"/> |
| Mitral valve prolapse <input type="checkbox"/> | Sexual problems <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Dizziness, fainting <input type="checkbox"/> | Endometriosis <input type="checkbox"/> | Bulimia or anorexia <input type="checkbox"/> |
| Shortness of breath <input type="checkbox"/> | Ovarian tumor <input type="checkbox"/> | Anemia <input type="checkbox"/> |
| Lung disease <input type="checkbox"/> | Dark skin on neck, armpits <input type="checkbox"/> | Easy bleeding or bruising <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Acne or pimples <input type="checkbox"/> | Poor circulation <input type="checkbox"/> |

| | | |
|--|--|--|
| Tuberculosis <input type="checkbox"/> | Enlarged or painful breasts <input type="checkbox"/> | Blood transfusion <input type="checkbox"/> |
| Heartburn, indigestion <input type="checkbox"/> | Discharge from nipples <input type="checkbox"/> | Fatigue <input type="checkbox"/> |
| Gas, cramps, pain <input type="checkbox"/> | Breast lumps <input type="checkbox"/> | Low energy <input type="checkbox"/> |
| Blood in stool or black stool <input type="checkbox"/> | Breast disease <input type="checkbox"/> | Past history of IV drug use <input type="checkbox"/> |
| Nausea, vomiting <input type="checkbox"/> | Hot flashes <input type="checkbox"/> | Rubella (German Measles) <input type="checkbox"/> |
| Constipation <input type="checkbox"/> | Excessive face or body hair <input type="checkbox"/> | Other <input type="checkbox"/> |
| Diarrhea <input type="checkbox"/> | Hair thinning or loss <input type="checkbox"/> | <input type="checkbox"/> |
| Hernia <input type="checkbox"/> | Fever, sweats, chills <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any positive responses:

SURGICAL HISTORY:

Please list any major surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

| | Mo. / Year | Procedure | Reason |
|---|------------|-----------|--------|
| 1 | | | |
| 2 | | | |
| 3 | | | |

ALLERGIES:

Latex? Yes No If yes, specify reaction: _____

Iodine? Yes No If yes, specify reaction: _____

Medications? Yes No Which meds, specify reaction: _____

MEDICATIONS INCLUDING: VITAMINS / HERBS / OVER THE COUNTER MEDICATION (OTC'S)

Please list all medications or treatments you are currently taking:

| Medication | Dosage | Frequency | Reason | Start Date |
|------------|--------|-----------|--------|------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

SOCIAL HISTORY-FEMALE PARTNER

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

| | Never | Not in the last 3 months | Yes | List amount, type and frequency (how often-per day / per week) |
|--------------|--------------------------|--------------------------|--------------------------|--|
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Social drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

In the past month, have there been times when you felt down, depressed, or hopeless? _____ Yes _____ No

Were there times during the past month when you experienced little interest or pleasure in doing things? _____ Yes _____ No

FAMILY AND GENETIC HEALTH HISTORY-FEMALE PARTNER

Are there any known genetic diseases or conditions that run in your family? _____ Yes _____ No

If yes, which one(s) and whom? _____

Are you adopted? _____ Yes _____ No

Personal and Family History

Are you or your partner of the following ethnic backgrounds? *Please check all that apply.*

- | | | |
|-------|-------|---|
| _____ | _____ | Asian (Chinese, Japanese, Filipino, Indian) |
| _____ | _____ | Mediterranean |
| _____ | _____ | Middle Eastern |
| _____ | _____ | Ashkenazi Jewish |
| _____ | _____ | African |
| _____ | _____ | Hispanic or Caribbean |
| _____ | _____ | French Canadian or Cajun |
| _____ | _____ | Caucasian |

Have you or your partner had a blood test to see if you were a genetic carrier for:

| Condition | Female | | Female Result | Male | | Male Result |
|-------------------------|--------|----|---------------|------|----|-------------|
| α (Alpha) Thalassemia | Yes | No | | Yes | No | |
| β (Beta) Thalassemia | Yes | No | | Yes | No | |
| Sickle Cell Anemia | Yes | No | | Yes | No | |
| Tay Sach's Disease | Yes | No | | Yes | No | |
| Cystic Fibrosis | Yes | No | | Yes | No | |
| Spinal Muscular Atrophy | Yes | No | | Yes | No | |

If you and your partner is of Eastern European Jewish ancestry (Ashkenazi), have you or your partner had blood tests to see if you were a genetic carrier for:

| Condition | Female | | Female Result | Male | | Male Result |
|-----------------------|--------|----|---------------|------|----|-------------|
| Canavan Disease | Yes | No | | Yes | No | |
| Familial Dysautonomia | Yes | No | | Yes | No | |
| Fanconi Anemia | Yes | No | | Yes | No | |
| Neimann-Pick Disease | Yes | No | | Yes | No | |
| Mucopolidosis Type IV | Yes | No | | Yes | No | |
| Bloom Syndrome | Yes | No | | Yes | No | |
| Gaucher Disease | Yes | No | | Yes | No | |

Please indicate which of the following conditions may be found in your family:

| MEDICAL PROBLEM | Yourself | PARENTS | | SIBLINGS | | MATERNAL GRANDPARENTS | | PATERNAL GRANDPARENTS | | YOUR Children | OTHER Relatives |
|--|----------|---------|--------|----------|----------|-----------------------|----|-----------------------|----|---------------|-----------------|
| | | Mother | Father | Sisters | Brothers | GM | GF | GM | GF | | |
| Autoimmune disorder, such as lupus or rheumatoid arthritis | | | | | | | | | | | |
| Birth defects requiring surgery (cleft lip, etc) | | | | | | | | | | | |
| Bleeding disorders (hemophilia, etc.) | | | | | | | | | | | |
| Blindness | | | | | | | | | | | |
| Bone disorders | | | | | | | | | | | |
| Cancer before age 50 (specify) | | | | | | | | | | | |
| Chromosome Problems (Down syndrome, Klinefelter syndrome) | | | | | | | | | | | |
| Clotting disorders (Factor V Leiden, etc.) | | | | | | | | | | | |
| Deafness | | | | | | | | | | | |
| Diabetes (Insulin dependent) | | | | | | | | | | | |
| Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia) | | | | | | | | | | | |
| Epilepsy (seizures) | | | | | | | | | | | |
| Heart defects ("hole in the heart", etc) | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | |
| Hydrocephaly ("water on the brain") | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | |
| Limb defects (missing or extra fingers, toes, shorten arms or legs) | | | | | | | | | | | |

| MEDICAL PROBLEM | Yourself | PARENTS | | SIBLINGS | | MATERNAL GRANDPARENTS | | PATERNAL GRANDPARENTS | | YOUR | OTHER |
|---|----------|---------|--------|----------|----------|-----------------------|----|-----------------------|----|----------|-----------|
| | | Mother | Father | Sisters | Brothers | GM | GF | GM | GF | Children | Relatives |
| Marfan Syndrome | | | | | | | | | | | |
| Mental Illness (schizophrenia, bipolar, etc) | | | | | | | | | | | |
| Mental retardation, autism or learning disabilities | | | | | | | | | | | |
| Muscular Dystrophy | | | | | | | | | | | |
| Neurofibromatosis | | | | | | | | | | | |
| Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc) | | | | | | | | | | | |
| Neuromuscular diseases (muscular dystrophies, etc.) | | | | | | | | | | | |
| Phenylketonuria (PKU) | | | | | | | | | | | |
| Polycystic Kidney disease | | | | | | | | | | | |
| Skin Diseases (eczema, melanoma) | | | | | | | | | | | |
| Stillbirth or children who have died as infants | | | | | | | | | | | |
| Stroke | | | | | | | | | | | |
| Thalassemia (Cooley's anemia) | | | | | | | | | | | |
| Unusual genitals in boys or girls | | | | | | | | | | | |
| Urinary Tract abnormalities | | | | | | | | | | | |
| Women who have had multiple miscarriage | | | | | | | | | | | |
| Other serious health issues | | | | | | | | | | | |

Please explain any positive answers: _____

REPRODUCTIVE HEALTH HISTORY—MALE PARTNER

Do you have any theories as to why you have been unable to conceive? _____

List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

| Pregnancy # | Preg. Ended (mo./yr.) | Preg. Length (weeks, months) | Outcome | MOTHER (check one) | |
|-------------|-----------------------|------------------------------|---------|----------------------|------------------|
| | | | | Present partner | Previous partner |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Have you previously conceived with another woman? ____ Yes ____ No

Have you ever been unable to conceive with anyone other than your current partner? ____ Yes ____ No

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? ____ Yes ____ No

Have you ever consulted a urologist or male infertility specialist? ____ Yes ____ No

If yes: Year: _____ Reason: _____

Findings / Recommendations: _____

PREVIOUS FERTILITY EVALUATION:

Have you had any of the following tests performed?

| <u>Fertility Test:</u> | | | <u>Date</u> | <u>Result normal?</u> | | <u>If no, describe:</u> |
|------------------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|-------------------------|
| | Yes | No | | Yes | No | |
| Semen Analysis | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hormone Blood tests | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

GENERAL MEDICAL HISTORY—MALE PARTNER

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain in the past 6 months? _____

Place a check by any of the following that have been a problem for you during the last 6 months

| | | |
|--|--|--|
| Eye problems <input type="checkbox"/> | Diarrhea <input type="checkbox"/> | Headaches <input type="checkbox"/> |
| Stuffy nose, hay fever <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> | Shaking, tremor <input type="checkbox"/> |
| Frequent nose bleeds <input type="checkbox"/> | Hernia <input type="checkbox"/> | Anxiety <input type="checkbox"/> |
| Fast or irregular heartbeat <input type="checkbox"/> | Gall bladder problems <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Heart murmur <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Anemia <input type="checkbox"/> |
| Dizziness, fainting <input type="checkbox"/> | Frequent urination at night <input type="checkbox"/> | Bleeding/bruising from minor injury <input type="checkbox"/> |
| Shortness of breath <input type="checkbox"/> | Sexual problems <input type="checkbox"/> | Poor circulation <input type="checkbox"/> |
| Lung disease <input type="checkbox"/> | Herpes (oral or genital) <input type="checkbox"/> | Blood clots <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Genital or groin injuries <input type="checkbox"/> | Blood transfusions <input type="checkbox"/> |
| Tuberculosis <input type="checkbox"/> | Pain in joints, arthritis <input type="checkbox"/> | Fatigue <input type="checkbox"/> |
| Heartburn, indigestion <input type="checkbox"/> | Acne or pimples <input type="checkbox"/> | Low energy <input type="checkbox"/> |
| Gas, cramps, pain <input type="checkbox"/> | Elevated prolactin <input type="checkbox"/> | Past history of IV drug use <input type="checkbox"/> |

| | | | | | |
|-------------------------------|--------------------------|-------------------------|--------------------------|-------|--------------------------|
| Blood in stool or black stool | <input type="checkbox"/> | Fever, sweats, chills | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Nausea, vomiting | <input type="checkbox"/> | Excessive thirst | <input type="checkbox"/> | | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | Temperature intolerance | <input type="checkbox"/> | | <input type="checkbox"/> |

Please give detail and dates: _____

Please list any major surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

| | Mo. / Year | Procedure | Reason |
|---|------------|-----------|--------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |

Please list all medications including: vitamins/herbs/over the counter medication (OTC's):

| Medication | Dosage | Frequency | Reason | Start Date |
|------------|--------|-----------|--------|------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

ALLERGIES:

Latex? _____ Yes _____ No If yes, specify reaction: _____

Medications? _____ Yes _____ No Which meds, specify reaction: _____

FAMILY AND GENETIC HEALTH HISTORY—MALE PARTNER

Are there any known genetic diseases or conditions that run in your family? _____ Yes _____ No

If yes, which one(s) and whom? _____

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g., heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? _____ Yes _____ No

Are you adopted? _____ Yes _____ No

Ethnic Background: _____

Are you any of the following ethnic groups?

There is increased risk for: Tested?:

| | | | | |
|---|---------|--------|---------------------------------|-----------|
| Caucasian | ___ Yes | ___ No | Cystic Fibrosis | ___Y ___N |
| English, Irish | ___ Yes | ___ No | Neural Tube Defects | N/A |
| Mediterranean (Greek, Italian, Middle Eastern) | ___ Yes | ___ No | Thalassemia | ___Y ___N |
| Ashkenazi Jewish | ___ Yes | ___ No | Tay Sachs | ___Y ___N |
| French Canadian | ___ Yes | ___ No | Tay Sachs | ___Y ___N |
| Cajun | ___ Yes | ___ No | Tay Sachs | ___Y ___N |
| Asian (Southeast Asian, Chinese, Taiwanese, Filipino, Indian, etc.) | ___ Yes | ___ No | Thalassemia | ___Y ___N |
| African descent | ___ Yes | ___ No | Sickle Cell Anemia, Thalassemia | ___Y ___N |

Please indicate which of the following conditions may be found in your family:

| MEDICAL PROBLEM | Yourself | PARENTS | | SIBLINGS | | MATERNAL GRANDPARENTS | | PATERNAL GRANDPARENTS | | YOUR Children | OTHER Relatives |
|--|----------|---------|--------|----------|----------|-----------------------|----|-----------------------|----|---------------|-----------------|
| | | Mother | Father | Sisters | Brothers | GM | GF | GM | GF | | |
| Neural tube defects (spina bifida, "open spine", anencephaly) | | | | | | | | | | | |
| Heart defects ("hole in the heart", etc.) | | | | | | | | | | | |
| Any birth defects requiring surgery (cleft lip, etc.) | | | | | | | | | | | |
| Unusual genitals in boys or girls | | | | | | | | | | | |
| Limb defects (missing or extra fingers, toes, shorten arms or legs) | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | |
| Blindness | | | | | | | | | | | |
| Deafness | | | | | | | | | | | |
| Bone disorders | | | | | | | | | | | |
| Skin Diseases (eczema, melanoma) | | | | | | | | | | | |
| Cancer before age 50 (specify) | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | |
| Epilepsy (seizures) | | | | | | | | | | | |
| Clotting disorders (Factor V Leiden, etc.) | | | | | | | | | | | |
| Bleeding disorders (hemophilia, etc.) | | | | | | | | | | | |
| Thalassemia (Cooley's anemia) | | | | | | | | | | | |
| Mental Illness (schizophrenia, bipolar, etc) | | | | | | | | | | | |
| Mental retardation, autism or learning disabilities | | | | | | | | | | | |
| Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc) | | | | | | | | | | | |
| Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia) | | | | | | | | | | | |

| MEDICAL PROBLEM | Yourself | PARENTS | | SIBLINGS | | MATERNAL GRANDPARENTS | | PATERNAL GRANDPARENTS | | YOUR CHILDREN | OTHER RELATIVES |
|--|----------|---------|--------|----------|----------|-----------------------|----|-----------------------|----|---------------|-----------------|
| | | Mother | Father | Sisters | Brothers | GM | GF | GM | GF | | |
| Neuromuscular diseases (muscular Dystrophies, etc.) | | | | | | | | | | | |
| Other genetic disorders (Cystic fibrosis, marfan syndrome, neurofibromatosis, sickle cell anemia, PKU, Tay-Sachs disease, Canavan disease, etc.) | | | | | | | | | | | |
| Chromosome Problems (Down syndrome, Klinefelter syndrome) | | | | | | | | | | | |
| Other serious health issue | | | | | | | | | | | |

Please explain any positive answers: _____

SOCIAL HISTORY—MALE PARTNER

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

| | Never | Not in the last 3 months | Yes | List amount, type and frequency (how often-per day / per week) |
|--------------|--------------------------|--------------------------|--------------------------|--|
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Social drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

Were there times during the past month when you experienced little interest in doing things? Yes No

In the past month, have there been times when you felt down, depressed, or hopeless? Yes No

Please comment: _____
