# 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 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 (  )_____

Do you have a male partner? ☐ Yes ☐ No

**Male 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 (  )_____

**By whom were you referred?**

☐ 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 MEDICAL HISTORY AND INFORMATION

**Reason for Visit:** ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other_____

**How many months** have you been trying to conceive (unprotected intercourse or inseminations)? _____

**Pregnancy Summary**

- Total Number of ALL Pregnancies: _____
- 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? ___
- Number of Miscarriages (less than 20 weeks): _____
- Number of Ectopic/Tubal Pregnancies: _____
- Number of Elective Terminations (Abortions): _____
- 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

Any prior exposure to 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_____

**Physician Notes (for office use only)** _____

**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 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 |
| • 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 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 any 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
☐ Herpes
☐ Blood in the urine
☐ 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
☐ Excess 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? Yes___ No___
☐ 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 yourAncestry?**

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

**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 _____)

## PRIOR INFERTILITYTESTING 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) | Pregnant |
|---|---|---|---|
| ☐ Intrauterine insemination: | _____ | From_____/_____ to_____/_____ | Yes___ No___ |
| ☐ Clomiphene citrate with timed intercourse: maximum # tablets per day?_____ | _____ | From_____/_____ to_____/_____ | Yes___ No___ |
| ☐ Clomiphene citrate with insemination: maximum # tablets per day?_____ | _____ | From_____/_____ to_____/_____ | Yes___ No___ |
| ☐ Daily fertility drug injections with insemination: maximum # vials per day?_____ | _____ | From_____/_____ to_____/_____ | Yes___ No___ |
| ☐ Completed in vitro fertilization cycle(s):<br>1. # eggs___ #embryos transferred___ #frozen___<br>2. # eggs___ #embryos transferred___ #frozen___<br>3. # eggs___ #embryos transferred___ #frozen___<br>4. # eggs___ #embryos transferred___ #frozen___ | _____ | _____/_____<br>_____/_____<br>_____/_____<br>_____/_____ | Yes___ No___<br>Yes___ No___<br>Yes___ No___<br>Yes___ No___ |
| ☐ Frozen embryo transfers:<br>1. # embryos transferred_____<br>2. # embryos transferred_____<br>3. # embryos transferred_____<br>4. # embryos transferred_____ | _____ | _____/_____<br>_____/_____<br>_____/_____<br>_____/_____ | Yes___ No___<br>Yes___ No___<br>Yes___ No___<br>Yes___ No___ |
| Canceled in vitro fertilization attempt(s) | _____ | | |

• 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 ☐ No

• 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 PARTNER 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: 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
- Any prior exposure to sexually transmitted diseases or infections?

☐ Yes (check all that apply) ☐ No

☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ Genital warts/HPV - date_____

☐ Syphilis - date_____ ☐ HIV/AIDS - date_____ ☐ Hepatitis - date_____

- 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) _____

_____

_____

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 any 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? ☐ No ☐ Yes

- 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 |
| • 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 yourAncestry?**

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

MALE PARTNER'S SIGNATURE_____ DATE_____

**I confirm that I have reviewed the information above.**

PHYSICIAN'S SIGNATURE_____ DATE_____

**Physician Notes (for office use only)**