Rocky Mountain
CENTER FOR REPRODUCTIVE MEDICINE PC
Creating a spark of life®

PATIENT INFORMATION *(i.e. person desiring pregnancy)*

(Please Print and fill out COMPLETELY)

Any numbers listed below will be used to facilitate communication regarding your healthcare.

Last Name	First Name	Middle Initial	Marital Status: S / M / W / D / SEP	DOB	Age	Social Security Number
Street/Mailing Address			City/State/Zip			Home Phone #
Patient's Employer			Occupation (Indicate if Student)			Business Phone #
Employers Address			City/State/Zip			Cell Phone #
			Email Address			
Family Physician			Address/City/State/Zip			Phone #
OBGYN			Address/City/State/Zip			Phone #
Emergency Contact	Relationship		Address/City/State/Zip			Phone #
How were you referred to our office? ☐ Physician ☐ Friend/Patient ☐ Other Please specify:_______________						
Insurance Name			Claims mailing address			
Phone # for benefits & eligibility			Employer that insurance is with			
Identification #			Group #		Insured person(owner of policy)	
If insurance requires a referral, do you have it with you? ☐ No ☐ Yes ☐ Not applicable Do you have secondary insurance? ☐ No ☐ Yes Primary:__________ Secondary:__________						

Spouse/Partner Information (Please Print and fill out COMPLETELY)

Spouse/Partner Name		DOB	Social Security Number
Street/Mailing Address	City/State/Zip		Home Phone #
Employer	Occupation		Business Phone #
Employer's Address	City/State/Zip		Cell Phone #
	Email Address		
Insurance Name	Claims mailing address		
Phone # for benefits & eligibility	Identification #		Group #

I hereby authorize Rocky Mountain Center for Reproductive Medicine, P.C. to furnish information to insurance carriers concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance. By my signature below, I affirm that I have reviewed this information and attest to its accuracy and completeness.

Date:__________ Patient Signature:____

PLEASE COMPLETE AND MAIL BACK PRIOR TO APPOINTMENT

FEMALE MEDICAL HISTORY AND INFORMATION

HEIGHT_______ WEIGHT________

Reason for Visit: ☐ Infertility Evaluation ☐ Infertility treatment ☐ Other____________________________________

What are you 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 test 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? ________

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 (greater than 37 weeks) Deliveries: __ Of these, how many were live birth? __ How many still born? __
- Number of Premature (less than 37 weeks) Deliveries:_____
- 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 ☐ No periods
  ☐ Spotting before periods: x___days ☐ 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 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/side effects? ___________ ☐ 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 Screen History

Have you ever had a mammogram? ☐ Yes – date _____ Result: ☐ Normal ☐ Abnormal – explain__________ ☐ No

Do you perform breast self-exams? ☐ Yes ☐ No

Medical History

- Are you allergic to any medications? ☐ Yes ☐ No
  If yes, please is and describe reactions:____
  ____
- Are you allergic to any foods (peanuts, eggs, etc.)? ☐ Yes ☐ No
  If yes, please list and describe reaction:____
  ____
- 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, date, and treatments) ☐ No
  1. ____
  2. ____
  3. ____
  4. ____
  5. ____

Surgical History

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

	Year	Reason and Type of Surgery
1.	________	____________________________________
2.	________	____________________________________
3.	________	____________________________________
4.	________	____________________________________
5.	________	____________________________________

- 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 used marijuana, cocaine, or any other similar drugs? ☐ Yes – describe_______________ ☐ No
- Do you exercise? ☐ Yes - describe____ ☐ No
- Are you aware of any radiation exposure other than X-rays? ☐ Yes – describe_________________ ☐ No
- Do you feel safe in your own home? ☐ Yes ☐ No – describe_________________________________

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 ☐ Tuberculosis
☐ Pneumonia ☐ Bronchitis
☐ 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 ☐ Constipation
☐ Blood in stools ☐ Diarrhea
☐ 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 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 prior to dental procedure? Yes__ No__)
☐ Other___________________
☐ None

Mental Health Problems:
☐ Depression ☐ Anxiety disorder
☐ Schizophrenia
☐ Other____________________
☐ None

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, no of Hispanic Origin
☐ Hispanic
☐ White, not of Hispanic Origin
☐ Other (specify________________)

Disorders in You/Your Family: **PLEASE GIVE SPECIFIC DETAILS IF KNOWN**.

		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
• 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

Disorders in You/Your Family (cont.): **PLEASE GIVE SPECIFIC DETAILS IF KNOWN**.

- 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
- Other (specify ____)

☐ None of the above

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): ☐ AMH test (date/results_____________________________)

	# of cycles	Dates (mm/year) (mm/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_________________________

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: How many times? __ ☐ No: Birth control used? ☐ Yes ☐ 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 of 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 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 ☐ No
- Are you aware of any solvent/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, no of Hispanic Origin
- ☐ Hispanic
- ☐ White, not of Hispanic Origin
- ☐ Other (specify_________________)

Disorders in You/Your Family: **PLEASE GIVE SPECIFIC DETAILS IF KNOWN**

	Self or 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

- Other (specify ____)

☐ None of the above

Spouse/Male Partner's Signature_________________________________ Date______________________________

I confirm that I have reviewed the information above.
Physician's Signature____ Date______________________________

Records Request Confirmations

To ensure that we have all your medical history please list below the practices/doctors that you have requested records and/or images from.

Practice/Doctor	Phone Number	Date of Request

1.____

2.____

3.____

4.____

5.____