AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

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)

Page 1
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

<table>
<thead>
<tr>
<th>Date Pregnancy Ended or Delivered</th>
<th>Months to Conception</th>
<th>Treatments to Conceive</th>
<th>Delivery Type/D&amp;C/Complications</th>
<th>Current Partner?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
</tbody>
</table>

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:
• Polio:
• Hepatitis A:
• Tetanus:
• 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 ________)
Surgical History
• Have you had any surgeries?  □ No  □ Yes (List all surgeries in chronologic order.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason and Type of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td>(7)</td>
<td></td>
</tr>
</tbody>
</table>

• 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/simina
□ 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 (date/reasons____________________)
□ 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

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)

Page 4
## Family History

<table>
<thead>
<tr>
<th>Relation</th>
<th>Living</th>
<th>Cause of Death/Age at Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Disorders in Your Family

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Colon cancer</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other cancer</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Thyroid problems</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood clots</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Psychiatric problems</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Endometriosis</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Menopause before age 40</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Birth defects</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Tay-Sachs disease</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Canavan disease</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Bloom syndrome</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gaucher disease</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Niemann-Pick disease</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fanconi Anemia</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Familial Dysautonnia</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Neurologic (brain/spine)</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Neural Tube Defects</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Bone/Skeletal Defects</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dwarfism</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Developmental delay</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Learning problems</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Polycystic kidney disease</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Heart defect from birth</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Down syndrome</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other chromosome defects</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Marfan syndrome</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hemophilia</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Thalassemia</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Galactosemia</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Deafness/Blindness</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Color Blindness</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hemochromatosis</td>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

- **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) 

- **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_)
- ☐ Oxytocin test kit (date_/results_)
- ☐ Hysterosalpingogram (HSG) (date_/results_)
- ☐ Hysteroscopy surgery (date_/results_)
- ☐ Laparoscopy surgery (date_/results_)
- ☐ Progesterone blood test (date_/results_)

**Prior Treatment (check all that apply):**

<table>
<thead>
<tr>
<th></th>
<th># of cycles</th>
<th>Dates (mo/year) (mo/year)</th>
<th>Pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Intrauterine insemination:</td>
<td>___</td>
<td>From__/____ to__/____</td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>☐ Clomiphene citrate with timed intercourse: maximum # tablets per day?</td>
<td>___</td>
<td>From__/____ to__/____</td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>☐ Clomiphene citrate with insemination: maximum # tablets per day?</td>
<td>___</td>
<td>From__/____ to__/____</td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>☐ Daily fertility drug injections with insemination: maximum # vials per day?</td>
<td>___</td>
<td>From__/____ to__/____</td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>☐ Completed in vitro fertilization cycle(s):</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>1. # eggs ___ #embryos transferred ___ #frozen ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>2. # eggs ___ #embryos transferred ___ #frozen ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>3. # eggs ___ #embryos transferred ___ #frozen ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>4. # eggs ___ #embryos transferred ___ #frozen ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>☐ Frozen embryo transfers:</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>1. # embryos transferred ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>2. # embryos transferred ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>3. # embryos transferred ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
<tr>
<td>4. # embryos transferred ___</td>
<td>___</td>
<td></td>
<td>Yes___ No___</td>
</tr>
</tbody>
</table>

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**

I confirm that I have reviewed the information above.

**PHYSICIAN'S SIGNATURE**

---
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

- 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 Dysautonomy  □ 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 ______________________)

---

**Male Partner's Signature** ____________________________  **Date** ____________________________

I confirm that I have reviewed the information above.

**Physician's Signature** ____________________________  **Date** ____________________________

---

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

---