KAISER CENTER FOR REPRODUCTIVE HEALTH
Infertility History Form

IMPORTANT: Please complete this form prior to your visit.

This form was developed by the American Society for Reproductive Medicine and Kaiser CRH to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

Part I: Contact information
Part II: Your medical history
Part III: Your spouse/male partner's medical history (if applicable)

PART I: CONTACT INFORMATION

Legal First Name _____ **Middle Initial** ____ **Last Name** _____ **Age** _____

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____ Medical Record #_____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.

☐ Home Telephone ( ) _____ ☐ Work Telephone ( ) _____ ☐ Cell Phone ( ) _____

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other_____

Age _____

Spouse/ Partner's First Name _____ **Middle Initial** ___ **Last Name** _____
☐Not Applicable

☐Kaiser member: Medical Record #_____ Non-member ☐

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____

Home Street Address (if different) _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.
☐Home Telephone ( ) _____ ☐ Work Telephone ( ) _____ ☐ Cell Phone ( ) _____

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

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

What are your expectations for this visit?_____

What questions do want answered at this visit?_____

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, selective reduction, etc.
☐Yes_____☐ No

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

How many months have you been actively trying to conceive? _____

Pregnancy Summary

- Total Number of ALL Pregnancies: _____ □ Number of Miscarriages (less than 20 weeks): _____
- Number of Ectopic/Tubal Pregnancies: _____ □ Number of Elective Terminations (Abortions): _____
- Number of Full Term Deliveries: _____ Of these, how many were live births? ___ How many were stillborn? ___
- Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ___ How many were stillborn? ___
- Any Pregnancies with Birth Defects? ☐ Yes - explain _____ ☐ No

	Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Wt	Sex	Current Partner?
1.	_____	_____	_____	_____	_____	☐ B ☐ G	☐ Y ☐ N
2.	_____	_____	_____	_____	_____	☐ B ☐ G	☐ Y ☐ N
3.	_____	_____	_____	_____	_____	☐ B ☐ G	☐ Y ☐ N
4.	_____	_____	_____	_____	_____	☐ B ☐ G	☐ Y ☐ N
5.	_____	_____	_____	_____	_____	☐ B ☐ G	☐ Y ☐ N
6.	_____	_____	_____	_____	_____	☐ B ☐ G	☐ 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
- At what age did your mother go through menopause: _____

Sexual History

- How many times do you have intercourse per week? _____times per week □ None □ Not applicable
- Have you used over-the-counter ovulation kits to time intercourse? □ Yes □ No
- Do you have pain with intercourse? □ Yes □ No
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse? □ Yes - what types?_____ □ No

Have you had any of the following sexually transmitted diseases or pelvic infections? □ Yes (check all that apply) □ No

☐ Chlamydia - date_____ □ Gonorrhea - date_____ □ Herpes - date_____ Genital warts/HPV - date_____
☐ Syphilis - date_____ □ HIV/AIDS - date_____ □ Hepatitis - date_____ Other - date_____

Pap Smear History

- When was your last pap smear (month and year)?_____/_____ □ Normal □ Abnormal
- When was your last abnormal pap smear? _____ □ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

□ Yes (check all that apply) □ No

□Colposcopy □ Cryosurgery (Freezing) □ Laser treatment □ Conization □ LEEP procedure

Breast Screening History

Have you ever had a mammogram? □ 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 (Please list and describe reactions) _____

_____

_____

- Are you allergic to any foods (peanuts, eggs, etc.)? □ Yes □ No (If 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? □ Yes □ No (Please list)_____

_____

- Do you have any medical problem(s)? □ Yes (Please list type, dates, and treatments.) □ No
  - (1)_____
  - (2)_____
  - (3)_____
  - (4)_____
  - (5)_____
- Did you have either of these childhood illnesses? □ Chickenpox (Varicella) □ German Measles (Rubella) □ Don't know
- Other childhood diseases:_____

Surgical History

- Have you had any surgeries? □ Yes (List all surgeries in chronologic order.) □ No

Year Reason and Type of Surgery

- _____ (1)_____
- _____ (2)_____
- _____ (3)_____
- _____ (4)_____
- _____ (5)_____
- Did you have any anesthesia problems? □ Yes (describe _____) □ No

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ □ None
- Do you smoke cigarettes? □ Yes □ No How many/day?____ How many years?_____ □ Quit - when?_____ Second-hand Exp □ Yes □ No
  - Do you drink alcohol? □ Yes □ No
  - □ Beer - # per week_____ □ Wine- # per week_____ □ Liquor - # per week_____
- Do you use marijuana, cocaine, or any other similar drug? □ Yes (describe_____) □ No
- Do you exercise? □ Yes □ No Regularly? □ Yes □ No
- How many hours of moderate exercise per week (i.e. walking, yoga) _____ How many hours of vigorous per week (i.e. running) _____
- Are you aware of any radiation exposures other than X-rays? □ Yes (describe_____) □ No
- Do you feel safe in your own home? □ Yes (describe_____□ No

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 □ C o n s t i p a t i o n
□ 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 oAnxiety disorder
□ Schizophrenia
□ Other_____
□ None

Head, Eyes, Ears, Nose, and Throat:

□ Dizziness □ Loss of sense of smell
□ Headaches □ Chronic nasal congestion
□ Blurred vision □ Ringing ears
□ Hearing loss/deafness
□ Other_____
□ None

Breasts:

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

Genito-Urinary:

□ Bladder infections
□ Kidney infections
□ Vaginal infections
□ Frequent urination □ Leaking urine
□ Blood in the urine
□ Herpes
□ Other_____
□ None

Hematologic:

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

Respiratory:

□ Shortness of breath
□ Asthma □ Bronchitis
□ Pneumonia □ Tuberculosis
□ Bloody cough
□ Other_____
□ None

Neurological Problems:

□ Weakness/Loss of balance
□ Seizures/Epilepsy
□ Headaches
□ Migraine headaches
□ Numbness
□ Memory loss
□ Other_____
□ None

Skin/Extremities:

□ Unexplained rash/inflammation
□ Acne
□ Skin cancer
□ Burn injury
□ Moles changing in appearance
□ 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

Family History

	Living	Cause of Death/Age at Death
• Mother	☐Yes - age___	☐No _____
• Father	☐Yes - age___	☐No _____
• Brother(s)	☐Yes - age___	☐No _____
	☐Yes - age___	☐No _____
• Sister(s)	☐Yes - age___	☐No _____
	☐Yes - age___	☐No _____
• Maternal Grandmother	☐Yes - age___	☐No _____
• Maternal Grandfather	☐Yes - age___	☐No _____
• Paternal Grandmother	☐Yes - age___	☐No _____
• Paternal Grandfather	☐Yes - age___	☐No _____

Disorders in Your Family

Relationship to You			
• Breast cancer	☐Yes _____	☐No	☐Don't Know
• Ovarian cancer	☐Yes _____	☐No	☐Don't Know
• Colon cancer	☐Yes _____	☐No	☐Don't Know
• Other cancer_____	☐Yes _____	☐No	☐Don't Know
• Diabetes	☐Yes _____	☐No	☐Don't Know
• Thyroid problems	☐Yes _____	☐No	☐Don't Know
• Heart disease	☐Yes _____	☐No	☐Don't Know
• Blood clots	☐Yes _____	☐No	☐Don't Know
• Obesity	☐Yes _____	☐No	☐Don't Know
• Psychiatric problems	☐Yes _____	☐No	☐Don't Know
• Tuberculosis	☐Yes _____	☐No	☐Don't Know
• Endometriosis	☐Yes _____	☐No	☐Don't Know
• Infertility	☐Yes _____	☐No	☐Don't Know
• Menopause before age 40	☐Yes _____	☐No	☐Don't Know
• Birth defects	☐Yes _____	☐No	☐Don't Know
• Cystic Fibrosis	☐Yes _____	☐No	☐Don't Know
• Tay-Sachs disease	☐Yes _____	☐No	☐Don't Know
• Canavan disease	☐Yes _____	☐No	☐Don't Know
• Bloom syndrome	☐Yes _____	☐No	☐Don't Know
• Gaucher disease	☐Yes _____	☐No	☐Don't Know
• Niemann-Pick disease	☐Yes _____	☐No	☐Don't Know
• Fanconi Anemia	☐Yes _____	☐No	☐Don't Know
• Familial Dysautonia	☐Yes _____	☐No	☐Don't Know
• Muscular Dystrophy	☐Yes _____	☐No	☐Don't Know
• Neurologic (brain/spine)	☐Yes _____	☐No	☐Don't Know
• Neural Tube Defects	☐Yes _____	☐No	☐Don't Know
• Bone/Skeletal Defects	☐Yes _____	☐No	☐Don't Know
• Dwarfism	☐Yes _____	☐No	☐Don't Know
• Developmental delay	☐Yes _____	☐No	☐Don't Know
• Learning problems	☐Yes _____	☐No	☐Don't Know
• Polycystic kidney disease	☐Yes _____	☐No	☐Don't Know
• Heart defect from birth	☐Yes _____	☐No	☐Don't Know
• Down syndrome	☐Yes _____	☐No	☐Don't Know
• Other chromosome defects	☐Yes _____	☐No	☐Don't Know
• Marfan syndrome	☐Yes _____	☐No	☐Don't Know
• Hemophilia	☐Yes _____	☐No	☐Don't Know
• Sickle Cell Anemia	☐Yes _____	☐No	☐Don't Know
• Thalassemia	☐Yes _____	☐No	☐Don't Know
• Galactosemia	☐Yes _____	☐No	☐Don't Know
• Deafness/Blindness	☐Yes _____	☐No	☐Don't Know
• Color Blindness	☐Yes _____	☐No	☐Don't Know
• Hemochromatosis	☐Yes _____	☐No	☐Don't Know
• High blood pressure	☐Yes _____	☐No	☐Don't Know
• Glaucoma	☐Yes _____	☐No	☐Don't Know
• Gallstones	☐Yes _____	☐No	☐Don't Know
• Hepatitis	☐Yes _____	☐No	☐Don't Know

• ☐None of the above ☐☐Other (Specify _____

What is your Ancestry?

☐African-American
☐Native A m e r i c a n
☐Ashkenazi Jewish
☐Asian-Chinese
☐Asian-Japanese
☐Asian-Korean
☐Asian-Indian
☐Asian-Filipino
☐Asian-Vietnamese
☐Asian-Other: _____
☐Caucasian-Northern European
☐Caucasian-Russian
☐Caucasian-Southern European
☐Hispanic – Mexican
☐Hispanic – South America Country of Origin: _____
☐Hispanic – Central American Country of Origin: _____
☐Hispanic – Spain
☐Middle Eastern-Country of Origin:_____
☐African-Country of Origin: _____
☐Other (specify_____)

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): (Please obtain all medical records if not performed at Kaiser)

	# of cycles	Dates (mo/year) (mo/year)	Outcome
□ Natural cycle:	_____	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
□ Letrazole (Femara) with insemination: maximum # tablets per day?_____	_____	From__/__ to__/__	_Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
□ Daily fertility drug injections with insemination: maximum # vials per day?_____	_____	From__/__ to__/__	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
□ Completed in vitro fertilization cycle(s): 1. # eggs___ #embryos transferred___ #frozen___ 2. # eggs___ #embryos transferred___ #frozen___ 3. # eggs___ #embryos transferred___ #frozen___ 4. # eggs___ #embryos transferred___ #frozen___	_____	___/___ ___/___ ___/____ ___/____	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
□ Frozen embryo transfers: 1. # embryos transferred_____ 2. # embryos transferred_____ 3. # embryos transferred_____ 4. # embryos transferred_____	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
Canceled in vitro fertilization attempt(s):	_____		
□ Any other prior treatment (describe): _____			

• Additional Information/Complications: _____
_____

EMOTIONAL STATUS

• On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. _____
• Do you see a counselor? ☐No ☐ Yes - For how long? _____ How often? _____
• List any antidepressant/antianxiety medications you are currently taking._____
• Describe any emotional, marital, or sexual problems caused by your infertility. _____
_____

PATIENT'S SIGNATURE_____ **DATE**_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ **DATE**_____

PART III: 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
• Do you have difficulty with erections? ☐Yes ☐No
• Do you have retrograde ejaculation of sperm into the bladder? ☐Yes ☐No
• Have you had any of the following sexually transmitted diseases or pelvic infections? ☐Yes (check all that apply) ☐No
☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ Genital warts/HPV - date_____
☐ Syphilis - date_____ ☐ HIV/AIDS - date_____ ☐ Hepatitis - date_____ Other_____
• Have you had a history of undescended testicles? ☐Yes - One side___ Both___ ☐No
• Do you have scrotal or testicular pain? ☐Yes ☐No
• Did you have 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
• Have you had any other surgeries? ☐Yes ☐No List: (year, type)_____
• 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? ☐Yes (Please list and describe reactions) _____☐No
_____
_____

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 ☐No If yes, How many/day?_____ How many years?_____ ☐Quit - when?_____
• Do you drink alcohol? ☐Yes ☐No, If yes,
☐ Beer - # per week_____ ☐ Wine- # per week_____ ☐ Liquor - # per week_____
• Do you use marijuana, cocaine, or any other similar drug? ☐Yes (describe_____) ☐No
• Do you use herbal medicines/vitamins or health food store supplements? ☐Yes (describe_____) ☐No
• Are you aware of any radiation/toxic materials exposure? ☐Yes ☐No

• Do you use hot tubs regularly? ☐Yes ☐No
• Did your mother take DES during pregnancy to prevent miscarriage? ☐Yes ☐No ☐Don't know
• Have any of your immediate family members had difficulty conceiving a child? ☐Yes ☐No
If yes, please describe_____

Family History

Living	**Cause of Death/Age at Death**	
• Mother	☐Yes - age___	☐No _____
• Father	☐Yes - age___	☐No _____
• Brother(s)	☐Yes - age___	☐No _____
	☐Yes - age___	☐No _____
• Sister(s)	☐Yes - age___	☐No _____
	☐Yes - age___	☐No _____
• Maternal Grandmother	☐Yes - age___	☐No _____
• Maternal Grandfather	☐Yes - age___	☐No _____
• Paternal Grandmother	☐Yes - age___	☐No _____
• Paternal Grandfather	☐Yes - age___	☐No _____

Disorders in Your Family

Relationship to You		
• 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
• 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

• ☐None of the above ☐Other (Specify _____

What is your Ancestry?

☐African-American
☐Native A m e r i c a n
☐Ashkenazi Jewish
☐Asian-Chinese
☐Asian-Japanese
☐Asian-Korean
☐Asian-Indian
☐Asian-Filipino
☐Asian-Vietnamese
☐Asian-Other: _____
☐Caucasian-Northern European
☐Caucasian-Russian
☐Caucasian-Southern European
☐Hispanic – Mexican
☐Hispanic – South America Country of Origin: _____
☐Hispanic – Central American Country of Origin: _____
☐Hispanic – Spain
☐Middle Eastern-Country of Origin:_____
☐African-Country of Origin: _____
☐Other (specify_____)

SPOUSE/MALE PARTNER'S SIGNATURE_____ **DATE**_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ **DATE**_____