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

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 □ Bronchitis
□ Pneumonia □ Tuberculosis
□ 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 □ 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

Genito-Urinary:

□ Bladder infections
□ Kidney infections
□ Vaginal infections
□ Frequent urination □ Leaking urine
□ Blood in the 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
before dental procedures?) Yes___ No___
□ Other_____

□ None

Mental Health Problems:

□ Depression oAnxiety 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 _____

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**_____

Partner Release of Information Consent

The Permanente Medical Group, Inc.
Point West and Roseville Centers for Reproductive Health
(916) 614-5005

During your fertility evaluation and treatment many tests and results require action within 24 hours. To facilitate communication between members of the Point West Center for Reproductive Health staff and you and your partner/husband, we need your permission to relay test results and treatment plans with your partner/spouse over the telephone or on your designated voice mail/message recorder.

I _____ hereby authorize The Point West Fertility
NAME OF PATIENT/WIFE
Clinic Staff to disclose my medical information to my partner/husband _____
NAME OF PARTNER/HUSBAND
and/or leave information on my voice mail/message recorder at the following telephone numbers:

Home: _____

Office: _____

Cell: _____

Address:

Street: _____

Apt. #: _____

City, State, Zip: _____

SIGNATURE: _____ DATE: _____
PATIENT/WIFE

I _____ hereby authorize The Point West Fertility
NAME OF PARTNER/HUSBAND
Clinic Staff to disclose my medical information to my partner/wife _____
NAME OF PARTNER/WIFE
or leave information on my voice mail/message recorder at the following telephone numbers:

☐ Same telephone numbers as above

Home: _____

Office: _____

Cell: _____

Address:

Street: _____

Apt. #: _____

City, State, Zip: _____

SIGNATURE: _____ DATE: _____
PARTNER/HUSBAND

Revised 12/1/03 4/11/06, 2/14/07, 3/3/09

KAISER PERMANENTE®

MR #: _____

Name: _____

ETHNICITY-BASED PRENATAL GENETIC SCREENING QUESTIONNAIRE

FACILITY/DEPARTMENT	ENCOUNTER DATE

PROVIDER

IMPRINT AREA

Some babies are at higher risk to have certain genetic conditions because of their ethnicity. Ethnicity is determined by the countries and ethnic groups a person's ancestors came from. Prenatal screening is available for some genetic conditions that occur more often in certain ethnic groups. **Please read the following and answer the questions to determine what tests your provider will order for you.**

BACKGROUND INFORMATION:

A baby will only have the genetic conditions listed below if both parents are "carriers." If both parents are carriers, their baby has a 25% (1 in 4) chance to have the condition. Carriers do not usually have a family history or symptoms of the disease.

Testing starts with you, the pregnant woman. If you are found to be a carrier, the father of your baby will be offered testing. If he is a carrier, an optional procedure will be offered to test the baby before birth (CVS or amniocentesis). If prenatal testing diagnoses the condition, your options will be to continue or terminate the pregnancy (there are no prenatal treatments). Genetic testing does not determine the exact symptoms an individual baby will have, and the conditions cannot be cured. *Please see the back of page 2 for more detailed information about the conditions, including carrier rates in at-risk ethnic groups, and screening limitations.*

- These prenatal screening tests are optional and they require a blood sample.
- If the ethnicity of you or your partner is not listed below, you are at lower risk to be a carrier for the conditions listed, so you will not be screened.
- All babies born in California have *newborn* screening for cystic fibrosis, sickle cell disease, and hemoglobin E/beta thalassemia.
- If you have a family history of the conditions listed below, contact your local Genetics Department for appropriate testing (phone numbers on back).

QUESTIONNAIRE

1. If you have *any* Southeast Asian ancestry (Cambodian, Thai, Laotian, Vietnamese, Hmong), you can have screening for hemoglobin E/beta thalassemia disease.
   Do you want screening for hemoglobin E/beta thalassemia disease? ☐**YES (211427)** ☐**No**
2. If you **OR** the father of the baby have *any* African American ancestry, you can have screening for sickle cell disease.
   Do you want screening for sickle cell disease? ☐**YES (211427)** ☐**No**
3. If you **OR** the father of the baby have *any* Caucasian (White/not hispanic) ancestry, you can have screening for cystic fibrosis.
   Do you want screening for cystic fibrosis? ☐**YES (200432)** ☐**No**
4. If you **AND** the father of the baby have *any* Eastern European Jewish ancestry (i.e., if you are BOTH Ashkenazi Jewish), you can have screening for Tay-Sachs disease, Canavan disaese, and familial dysautonomia (FD).
   Do you want screening for Tay-Sachs, Canavan, and FD? ☐**YES (200452) (207307) (207313)** ☐**No**

Please write the ethnic groups/countries your ancestors came from (for example: African American, European Caucasian, Asian, Asian Indian, Native American, SE Asian, Ashkenazi Jewish, etc.)

Yourself: _____ Father of the baby: _____