UCSF Medical Center
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 UCSF 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)

FOR OFFICE USE ONLY

PART I: CONTACT INFORMATION

Age _______

Legal First Name ____________________________ **Middle Initial** ____ **Last Name** ____________________________

Date of Birth (MM/DD/YY) _____/_____/___________ Occupation _________________________________ Social Security #______________

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/Male Partner's First Name _____________________ **Middle Initial** ___ **Last Name** ___________________

☐Not Applicable

Date of Birth (MM/DD/YY) _____/_____/___________ Occupation ____________________________________ Social Security #____________

Home Street Address ____

City ________________________ State _____ Zip/Postal Code _______________ Country ___________________

Indicate which number to call or leave messages.

☐Home Telephone ( ) ________________ ☐ Work Telephone ( ) ________________ ☐ Cell Phone ( ) _______________

Who referred you?

☐ 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 ____

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, 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)____
- __________ (6)____
- 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 □ Constipation
□ 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 American
☐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):

☐ Natural cycle:	**# of cycles** _____	**Dates (mo/year) (mo/year)** From__/__ to__/__	**Outcome** __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 American
- ☐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**___________________

UCSF CENTER FOR REPRODUCTIVE HEALTH ETHNICITY QUESTIONNAIRE

A. Female Patient
1. What is your Ancestry?
..African-American
..African-Country of Origin: __________________
.. 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: ____________________
..Brazilian
..Cajun
..Caribbean
..Caucasian-Northern European
..Caucasian-Eastern European
..Caucasian-Russian
..Caucasian-Southern European
..French Canadian
..Greek
..Italian
..Portuguese
..Hispanic – Mexican
..Hispanic – South America Country of Origin: _________________
..Hispanic – Central American Country of Origin: ________________
..Hispanic – Spain
..Middle Eastern-Country of Origin:__________________
..Other (specify__________________)
2. Were you born in the United States? ..Yes ..No
3. If not, what country were you born in? _________________________
4. Is English your native language? ..Yes ..No
5. If not, what is your native language? _________________________

B. Male Partner (If applicable)
1. What is your Ancestry?
..African-American
..African-Country of Origin: __________________
.. 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: ____________________
..Brazilian
..Cajun
..Caribbean
..Caucasian-Northern European
..Caucasian-Eastern European
..Caucasian-Russian
..Caucasian-Southern European
..French Canadian
..Greek
..Italian
..Portuguese
..Hispanic – Mexican
..Hispanic – South America Country of Origin: _________________
..Hispanic – Central American Country of Origin: ________________
..Hispanic – Spain
..Middle Eastern-Country of Origin:__________________
..Other (specify__________________)
2. Were you born in the United States? ..Yes ..No
3. If not, what country were you born in? _________________________
4. Is English your native language? ..Yes ..No
5. If not, what is your native language? _________________________