

MicroSort

Division of the Genetics & IVF Institute

Medical History Form

Date completed _____

Please complete all sections of this questionnaire to the best of your ability. Your confidential answers will be reviewed by a clinician and will help to give you the best possible care. Mail or fax (703-995-4928) the completed form to MicroSort, 3015 Williams Dr., Suite 101, Fairfax, VA 22031.

What is the primary reason for your consultation (circle)? **Family Balancing**, **Genetic Disease Prevention** or **Other** (list) _____

Desired Gender: Female [] Male []

Please list other physicians or practices that you have consulted. _____

Comments: _____

(To be completed by **both** partners)

Wife

(Print Name)

(date of birth) (age)

Address _____

City/State/Zip _____

Occupation _____

Preferred Pharmacy _____

Tel #: _____

Phone (day) _____

(eve) _____

(cellular) _____

(e-mail) _____

(voice mail) _____

(pager) _____

(FAX) _____

Primary Care Physician or GYN

Print Name _____

(address) _____

(city) _____

(state, zip code) _____

(phone) _____

(FAX) _____

(medical specialty) _____

Husband

(Print Name)

(date of birth) (age)

Address _____

City/State/Zip _____

Occupation _____

Preferred Pharmacy _____

Tel #: _____

(day) _____

(eve) _____

(cellular) _____

(e-mail) _____

(voice mail) _____

(pager) _____

(FAX) _____

Primary Care Physician

Print Name _____

(address) _____

(city) _____

(state, zip code) _____

(phone) _____

(FAX) _____

(medical specialty) _____

Who should we send a summary letter to? [] Primary Care Physician [] OB/GYN

Date of Marriage: _____

Contraceptive practices:	(yes)	(no)	(dates)
Condoms/Diaphragm	_____	_____	_____
Depo-Provera	_____	_____	_____
Norplant	_____	_____	_____
Intrauterine device (IUD)	_____	_____	_____
Oral contraceptives	_____	_____	_____
Rhythm/withdrawal	_____	_____	_____
Other methods	_____	_____	_____

Pregnancies (Wife):

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive?	Gender	Is current husband the father? (Yes/No)	Health of Child	Outcome (miscarriage, termination, ectopic, vaginal delivery, Cesarean section, or stillbirth)	Complications (high blood pressure, eclampsia, preeclampsia, diabetes, small for dates, placenta previa, infection, excessive blood loss, preterm labor, premature membrane rupture, early or late delivery, transfusion, Rh sensitization, multiples, etc.)
First							
Second							
Third							
Fourth							
Fifth							

Husband: Pregnancies from previous marriage(s) or partner(s), if any

Pregnancy (include all)	When? (Year)	How long to conceive?	Gender	Date of Birth	Health of Child	Outcome (miscarriage, termination, ectopic, vaginal delivery, Cesarean section, or stillbirth) and list complications, if any
First						
Second						
Third						

Husband and Wife: All Adopted Children

Adopted Children	Gender of Child	Date of Birth of Child	Health of Child
First			
Second			

Male History

Erectile function difficulties:

(yes)

(no)

collecting semen for testing

Growth and development:

undescended testicles

delayed puberty

breast enlargement

Testicular injury:

(date)

torsion (twisted)

painful swelling

severe trauma

Toxicant exposure:

alcohol

_____ drinks/week

recreation drugs

smoking

_____ packs/day

pesticides

other chemicals

radiation

Varicocele:

Sexually transmitted infections:

chlamydia

genital warts (HPV)

gonorrhea

herpes

_____ episodes/year

HIV

syphilis

Urinary tract infections:

bladder infection

kidney infection

prostatitis

Recent high fever:

Hot tub use:

_____ times/week

Male History (cont.)

List all medication you take now (prescription, vitamin and over the counter preparations):

(drug)

(date)

(dose)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all allergic reactions you have had:

(drug or allergen)

(date)

_____	_____
_____	_____
_____	_____

List all surgery you have had:

(type of surgery)

(date)

_____	_____
_____	_____
_____	_____
_____	_____

List all other serious illnesses for which you have been under the care of a physician:

(illness)

(date)

_____	_____
_____	_____
_____	_____

List all blood transfusions you have had:

(number of units)

(date)

_____	_____
_____	_____

Male Family History

Country of origin: Mother _____ Father _____

Ethnic background (circle): African-American Asian Asian-Indian Caucasian Hispanic Jewish American-Indian
Mediterranean Middle East Other _____

Ethnic group (Check all that apply)	Have you been tested for?	Yes	No	Date	Result
African, African/American	sickle cell trait				
Asian, Mediterranean or Hispanic	thalassemia				
Caucasian, Jewish	cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Canavan				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)? _____

Is there anyone in the family who has had any of the following illnesses?

	Yes	Relationship		Yes	Relationship
abnormal breasts			learning problems		
abnormal genitals			mental retardation		
birth defects			metabolic disorder		
chromosomal disorders			miscarriages (2 or more)		
delayed development			short stature		
early puberty			testicular cancer		
hormone disorders			undescended testicles		
pituitary tumor			infertility		
lack of sense of smell			genetic (inherited) disorders		

Comments: _____

Female History

Menstrual History

Age at first menstrual period _____ Date of last menstrual period _____

of days from the beginning of one period to the beginning of the next: average ____ shortest ____ longest ____

If your cycles are irregular, how many cycles do you usually have in a year? _____

Average duration of your menstrual flow (days)? _____

	Mild/Light	Moderate	Severe/Heavy
Severity of menstrual cramps	_____	_____	_____

Amount of menstrual flow	_____	_____	_____
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Medication taken for cramps:	drug _____	amount _____	frequency _____
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Do you have midcycle:	(yes)	(no)
spotting	_____	_____
pain	_____	_____
cervical mucus	_____	_____

Does the cramping or bleeding prevent you from:	(yes)	(no)
going to work	_____	_____
participating in fun activities	_____	_____

When was your last Pap smear? _____ Result _____

When was your last mammogram? _____ Result _____

Do you have or have you ever had (check all that apply):

Infectious Problems		Medical Problems	
positive HIV test	contact with cats or mice	anemia	kidney disease
chicken pox (varicella)	chlamydia	bleeding disorders	kidney infection
chicken pox immunization	gonorrhea	blood clots	liver problems
hepatitis A, B or C	syphilis (RPR)	blood transfusion	lost 15 lbs last year
hepatitis A vaccination	pelvic infection (PID)	diabetes	gained 15 lbs last year
hepatitis B vaccination	nongonococcal urethritis	cancer	lung disease
German measles (rubella)	condyloma (venereal warts)	appendicitis	asthma
Rubella immunization	herpes: genital	heart disease	recurrent urinary infections
rheumatic fever	herpes: oral	high blood pressure	thyroid problems
chronic bronchitis	trichomoniasis	mitral valve prolapse	arthritis
Neurological Problems	Gynecologic Problems		
severe headaches	abnormal mammogram	endometriosis	breast discharge
seizures (epilepsy)	abnormal pap smear	uterine anomalies	excess hair growth
	blocked fallopian tubes	cervical stenosis	hot flashes or night sweats
	pelvic adhesions	DES exposure	Rh sensitized

Comments: _____

Female History (cont.)

Weight _____ Height _____

Particular food diet or any special dietary habits? _____

How much do you exercise? _____

Toxicant exposure:	(yes)	(no)	(date last exposed)
alcohol	_____ drinks/week	_____	_____
recreation drugs	_____	_____	_____
smoking	_____ packs/day	_____	_____
pesticides	_____	_____	_____
other chemicals	_____	_____	_____
radiation	_____	_____	_____

List all medication you take now (prescription, vitamins and over the counter preparations):

(drug)	(date)	(dose)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking prenatal vitamins? _____

List all allergic reactions you have had:

(drug or allergen)	(date)
_____	_____
_____	_____

Are you allergic to egg yolk? _____

Do you have a known allergy to Hoechst 33342 dye? Yes [] No []

List all surgery you have had (cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.):

(type of surgery)	(date)
_____	_____
_____	_____
_____	_____
_____	_____

List all other serious illnesses for which you have been under the care of a physician:

(illness)	(date)
_____	_____
_____	_____

Family History of Female

Country of origin: Mother _____ Father _____

Ethnic background (circle): African/American Asian Asian Indian Caucasian Hispanic Jewish Indian Mediterranean Middle East Other _____

Ethnic group (Check all that apply)	Have you been tested for?	Yes	No	Date	Result
African, African/American	sickle cell trait				
Asian, Mediterranean or Hispanic	thalassemia				
Caucasian, Jewish	cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Canavan				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)? _____

Is there anyone in the family who has had any of the following illnesses?

	Yes	Relationship		Yes	Relationship
abnormal genitals			learning problems		
birth defects			mental retardation		
bleeding disorders			early menopause <age 40		
breast cancer			metabolic disorder		
chromosomal disorders			ovarian cancer		
delayed development			pituitary tumor		
early puberty			hormone disorders		
endometriosis			2 or more miscarriages		
excess body hair			other inherited disorders		
infertility					

Comments: _____

To assist us in reviewing and interpreting any prior tests, please complete this section to the best of your ability. Pertinent records should also be obtained so the results can be confirmed.

Previous female fertility tests:	(result)	(date)
basal body temperature	_____	_____
ovulation predictor kits	_____	_____
endometrial biopsy	_____	_____
post-coital test	_____	_____
HSG	_____	_____
hysterosonogram	_____	_____
hysteroscopy	_____	_____
laparoscopy	_____	_____
ultrasound, pelvic	_____	_____
other	_____	_____

Previous male fertility tests:	(result)	(date)
semen analysis	conc _____ motility _____ morphology _____	_____
	conc _____ motility _____ morphology _____	_____
	conc _____ motility _____ morphology _____	_____
post-coital test	_____	_____
antisperm antibodies (semen)	_____	_____
antisperm antibodies (serum)	_____	_____
other	_____	_____

Previous hormonal tests:	<u>Male</u>		<u>Female</u>	
	Result	Date	Result	Date
testosterone	_____	_____	_____	_____
prolactin	_____	_____	_____	_____
TSH	_____	_____	_____	_____
FSH (random)	_____	_____	_____	_____
FSH (day 3)	_____	_____	_____	_____
FSH (day 10)	_____	_____	_____	_____
progesterone	_____	_____	_____	_____
DHEAS	_____	_____	_____	_____

Infectious disease

Male

Female

	Result	Date	Result	Date
HIV-1	_____	_____	_____	_____
hepatitis B surface Antigen	_____	_____	_____	_____
rubella IgG	_____	_____	_____	_____
varicella IgG (Chicken Pox)	_____	_____	_____	_____
toxoplasmosis IgG	_____	_____	_____	_____

Medical screening tests:

blood group and Rh	_____	_____	_____	_____
CBC	_____	_____	_____	_____
chemistry panel	_____	_____	_____	_____
chest x-ray (CXR)	_____	_____	_____	_____
cholesterol (lipid profile)	_____	_____	_____	_____
EKG	_____	_____	_____	_____
fasting glucose	_____	_____	_____	_____
PT/PTT	_____	_____	_____	_____
urinalysis	_____	_____	_____	_____

Previous fertility treatments:

	(yes)	(no)	# cycles	Comments
clomiphene	_____	_____	_____	_____
dopamine agonist*	_____	_____	_____	_____
glucocorticoids (Dex)	_____	_____	_____	_____
insemination (IUI)	_____	_____	_____	_____
clomiphene and IUI	_____	_____	_____	_____
FSH and IUI	_____	_____	_____	_____
IVF or ICSI	_____	_____	_____	_____
other:	_____	_____	_____	_____
Comments:	_____			

* dopamine agonist - bromocriptine (Parlodel), pergolide mesylate (Permax), cabergoline (Dostinex)

** FSH - Pergonal, Humegon, Repronex, Metrodin, Fertinex, Gonal-F, and/or Follistim

INFECTIOUS DISEASE RISK QUESTIONNAIRE

HUSBAND:

PLEASE ANSWER THE FOLLOWING QUESTIONS (circle yes or no):

Have you ever been refused as a blood donor? Yes No
If yes, why? _____

Have you ever been tested for AIDS? Yes No
If yes, why? _____

Have you ever received Pituitary-derived Human Growth Hormone? Yes No
If yes, what year? _____

Have you ever had Creutzfeldt-Jacob disease? Yes No

In the last 12 months, have you

Had a blood transfusion? Yes No

Had a tattoo? Yes No

Had your body pierced? Yes No

Received non-viral inactivated Factor VIII or Factor IX concentrate? Yes No

Been exposed to known or suspected HIV-infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane? Yes No

Had Hepatitis B or C? Yes No
If yes, which one? _____ When? _____

Sexual History:

In the last 12 months, have you had sex with

A person other than your current spouse? Yes No
If yes, vaginal, anal, and/or oral? _____

A person having non-medical intravenous, intramuscular, or subcutaneous injections of drugs? Yes No

A person having engaged in sex in exchange for money or drugs? Yes No

A person that has been diagnosed as positive for the HIV virus? Yes No

A person who has had sex with another partner described in any of the above? Yes No

I certify that the information contained in this questionnaire, to the best of my knowledge, is true and complete.

Husband NAME: _____

DATE: _____

SIGNATURE: _____

FOR CLINICAL USE ONLY:

LR HR

S NS

12M 1M

INFECTIOUS DISEASE RISK QUESTIONNAIRE

WIFE:

PLEASE ANSWER THE FOLLOWING QUESTIONS (circle yes or no):

Have you ever been refused as a blood donor? Yes No
If yes, why? _____

Have you ever been tested for AIDS? Yes No
If yes, why? _____

Have you ever received Pituitary-derived Human Growth Hormone? Yes No
If yes, what year? _____

Have you ever had Creutzfeldt-Jacob disease? Yes No

In the last 12 months, have you

Had a blood transfusion? Yes No

Had a tattoo? Yes No

Had your body pierced? Yes No

Received non-viral inactivated Factor VIII or Factor IX concentrate? Yes No

Been exposed to known or suspected HIV-infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane? Yes No

Had Hepatitis B or C? Yes No
If yes, which one? _____ When? _____

Sexual History:

In the last 12 months, have you had sex with

A person other than your current spouse? Yes No
If yes, vaginal, anal, and/or oral? _____

A person having non-medical intravenous, intramuscular, or subcutaneous injections of drugs? Yes No

A person having engaged in sex in exchange for money or drugs? Yes No

A person that has been diagnosed as positive for the HIV virus? Yes No

A person who has had sex with another partner described in any of the above? Yes No

I certify that the information contained in this questionnaire, to the best of my knowledge, is true and complete.

Wife NAME: _____

DATE: _____

SIGNATURE: _____

FOR CLINICAL USE ONLY:

LR HR
S NS
12M 1M
