

COLORADO REPRODUCTIVE ENDOCRINOLOGY  
4600 EAST HALE PARKWAY  
DENVER, CO 80220  
303-321-7115 FAX 303-321-9519  
**PATIENT HISTORY FORM**

**PATIENT NAME:**  
**MRN:**  
**PHYSICIAN:**

Please answer the following questions to the best of your ability. The information obtained will enable us to provide you with optimal medical care. If you do not know the answer to any questions, you may leave it blank. This form should take about 15-20 minutes to complete and can be completed on the computer then printed out or printed out and filled in by hand. To fill this out online, simply use your mouse and click on the grey shaded areas. Clicking on a "check box" will put an "X" in that box or will remove an "X" placed there by mistake. The rectangular grey shaded boxes require you to type in the information. Click on that box and begin typing.

**IDENTIFYING INFORMATION**

**DATE OF VISIT:**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date of last period: \_\_\_\_\_  
Marital status:  Married  Separated  Divorced  Remarried  Single  
Phone number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Home address: Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Emergency contact, alternate address and phone number (where we can reach you if any tests come back abnormal or in an emergency, if different than above):

Physician who referred you:  
Referring physician's address:  
Referring physician's phone #:  
Gynecologist's name:

Are you currently employed?  Yes  No  
If Yes, what type of work do you do?  
Do you have any allergies to medication?  Yes  No  
If Yes, list:

**Why would you like to be evaluated at Colorado Reproductive Endocrinology?** (check all that apply)

- Unable to get pregnant for \_\_\_\_\_ years
- Recurrent miscarriages
- Endometriosis
- Excessive hair growth or loss
- Premature menopause or menopause
- Irregular or abnormal period
- Birth control/family planning
- In vitro fertilization
- Routine check-up
- Other:

**PLEASE DESCRIBE AS THOROUGHLY AS POSSIBLE YOUR PRESENT PROBLEM:**

**MENSTRUAL HISTORY**

Age at first period: \_\_\_\_\_ When did your **most** recent period begin? \_\_\_\_\_  
Are your periods regular?  Yes  No  
If No, how many times per year do you have your period? \_\_\_\_\_  
Have you ever gone more than 3 months without a period (except for pregnancy)?  Yes  No  
If Yes, list approximate dates: \_\_\_\_\_  
What is the usual number of days from the beginning of one period to the beginning of the next? \_\_\_\_\_  
How many days do you usually bleed during your period? Days of bleeding: \_\_\_\_\_ Days of spotting: \_\_\_\_\_  
How would you describe your bleeding?  Light  Average  Heavy  
Does the amount of bleeding vary from month to month?  Yes  No  
If Yes, please explain: \_\_\_\_\_  
Are cramps present before, during, or after your period?  Yes  No  
Are your cramps:  Mild  Moderate  Severe  
Do you have to take pain medication for cramps?  Yes  No

Do you have premenstrual symptoms such as breast tenderness, bloating, etc. that let you know your period is due?  Yes  No  
 Have you noticed a change in your periods recently?  Yes  No  
 Do you bleed or spot between periods or after intercourse?  Yes  No  
 Do you have hot flashes or sweats?  Yes  No  
 Has your mother or your sisters had difficulty with conception or pregnancy?  Unknown  Yes  No  
 Did your mother take diethylstilbestrol (DES) when she was pregnant with you?  Unknown  Yes  No

**CONTRACEPTIVE/SEXUAL/MARITAL HISTORY**

Are you currently trying to get pregnant?  Yes  No  
 If Yes, how long have you tried to conceive?                      Years                      Months

What form of contraceptive have you used in the past? (check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Sponge	<input type="checkbox"/> Norplant/implants
<input type="checkbox"/> Foam/jellies	<input type="checkbox"/> Rhythm	<input type="checkbox"/> Depo Provera injection
<input type="checkbox"/> Birth control pills	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Male sterilization (vasectomy)
<input type="checkbox"/> Mucous check	<input type="checkbox"/> Tubal ligation	<input type="checkbox"/> Other:
<input type="checkbox"/> Birth control patches	<input type="checkbox"/> Diaphragm	
<input type="checkbox"/> IUD	<input type="checkbox"/> Condom	

Did you ever have problems while using birth control (i.e., high blood pressure, allergy to condoms, etc.)?  Yes  No  
 How often did you and your partner have sexual relations during the past month?                      times  
 Have you ever had unprotected intercourse (for more than 6months) with another partner and failed to achieve pregnancy?  Yes  No  
 How many sexual partners have you had in the past 2 years?  
 none  1  2  fewer than 5  fewer than 10  greater than 10  
 Is your sexual partner  male or  female?  
 Have you been exposed sexually or shared needles with someone with AIDS or HIV?  Yes  No  
 Do you notice any pain with intercourse?  Yes  No  
 Do you use lubricants for intercourse?  Yes  No  
 Do you have difficulty having an orgasm?  Yes  No  
 Have you had changes in your libido?  Yes  No  
 Would you like to discuss any sexual problems or concerns?  Yes  No  
 If Yes, explain:  
 Have you ever had a sexually transmitted disease or pelvic inflammatory disease?  Yes  No  
 Do you have regular gynecologic exams?  Yes  No  
 Date of last PAP smear:                      Was this PAP smear normal?  Yes  No  
 Have you ever had an abnormal PAP smear?  Yes  No  
 Do you perform monthly self-breast exams?  Yes  No  
 Have you ever noticed breast discharge or a breast lump?  Yes  No  
 Do you have any pain you wish to discuss with your doctor?  Yes  No

**PREGNANCY HISTORY**

How many times have you been pregnant (including miscarriages and abortions)?  
 # of term deliveries:                      # of preterm deliveries:                      # of miscarriages:  
 # of ectopic pregnancies:                      # of therapeutic abortions:

**PLEASE COMPLETE THE FOLLOWING CHART:**

	YEAR	OUTCOME (SEE CHOICES BELOW*)	WAS INFERTILITY THERAPY NEEDED	HOW LONG TO CONCEIVE	IS THE CURRENT OR PAST PARTNER THE FATHER OF THE CHILD?	SEX	WEIGHT
1 <sup>st</sup> Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb.    oz.
2 <sup>nd</sup> Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb.    oz.
3 <sup>rd</sup> Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb.    oz.
4 <sup>th</sup> Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb.    oz.

\*VAGINAL DELIVERY (V), C-SECTION (CS), MISCARRIAGE (M), ABORTION (A), ECTOPIC PREGNANCY (EP)

Were there any complications during or after your pregnancies?  Yes  No  
 If Yes, explain (i.e., preterm labor, bleeding, gestational diabetes, high blood pressure):

Were any of your deliveries induced?  Yes  No

**HISTORY OF FERTILITY TESTING AND THERAPY**

If applicable, check all of the following medications that you have taken in the past in an attempt to conceive:

- Clomiphene Citrate (Serophene, Clomid)  Progesterone suppositories/oral progesterone/progesterone injection  
 How many cycles?
- hMG (Pergonal, Humegon, Repronex, Follistim, Gonal-F)  Prednisone (or cortisone-like drugs)  
 How many cycles?
- hCG (Profasi, APL, Pregnyl)  GnRH agonists (Lupron, Synarel, Zoladex)
- Estrogens (Premarin, Estrace, Ortho-Est, Estratest, Ogen)  GnRH or LHRH pulsatile (Factrel, Lutrepulse)
- Bromocriptine ( Parlodel)  Other:
- Danazol (Danocrine)  Never utilized fertility therapy
- Antibiotics

Have you had any of the following tests performed (check all that apply):

PROCEDURE	DATE	RESULTS
<input type="checkbox"/> Husband semen analysis		
<input type="checkbox"/> Temperature charts		
<input type="checkbox"/> Clomid Challenge Test		
<input type="checkbox"/> Postcoital tests		
<input type="checkbox"/> Endometrial biopsy		
<input type="checkbox"/> X-ray of tubes (Hysterosalpingogram, HSG)		
<input type="checkbox"/> Laparoscopy		
<input type="checkbox"/> Hysteroscopy		
<input type="checkbox"/> Day 3 FSH/estradiol level		
<input type="checkbox"/> Blood tests		
<input type="checkbox"/> Chromosomal analysis		

**URINARY/VAGINAL SYMPTOMS**

- Have you had problems with vaginal dryness or irritation?  Yes  No
- Have you noticed a vaginal discharge?  Yes  No
- Do you have frequent or recurrent vaginal infections?  Yes  No
- Do you experience pain or difficulties with urination?  Yes  No
- Do you have episodes of loss of urine (especially when coughing, sneezing, or lifting)?  Yes  No
- Have you ever noticed blood in your urine?  Yes  No

**MEDICAL HISTORY**

Height:              Weight:              Blood type (if known):

Do you have any allergies to medications?  Yes  No  
 If Yes, list:

Within the last year, have you taken any prescription medications?  Yes  No

If Yes, list all the medications and problems for which you were taking them.

MEDICATION	DOSAGE	DATE STARTED	DATE STOPPED



Is there a family history of hereditary disorders (in yourself, your parents, or your children): (check all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Chromosomal defects | <input type="checkbox"/> Neural tube defects (open spine) | <input type="checkbox"/> Cystic fibrosis        | <input type="checkbox"/> Muscular dystrophy  |
| <input type="checkbox"/> Tay Sach's disease  | <input type="checkbox"/> Extra fingers/toes               | <input type="checkbox"/> Recurrent miscarriages | <input type="checkbox"/> Huntington's chorea |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Down syndrome                    | <input type="checkbox"/> Hearing defects        | <input type="checkbox"/> Other:              |
| <input type="checkbox"/> Bleeding disorders  | <input type="checkbox"/> Mental retardation               | <input type="checkbox"/> Cleft lip/palate       |  |

**SOCIAL AND DIETARY HISTORY**

(If you feel more comfortable not writing these answers down, please discuss this directly with your physician. Your answers to the below questions are confidential.)

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

- |                                     |   |                                  |            |
|-------------------------------------|---|----------------------------------|------------|
| <input type="checkbox"/> Alcohol    | How many glasses per week do you usually drink? Wine: | Beer:                            | Cocktails: |
| <input type="checkbox"/> Cigarettes | Number of cigarettes per day:                         | Number of years you have smoked: |            |
| <input type="checkbox"/> Caffeine   | Number of cups per day:                               |                                  |            |

- |  |                               |                             |
|--|-------------------------------|-----------------------------|
| Have you ever used illicit or recreational drugs (marijuana, cocaine, crack, etc.)?  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Have you ever been the victim of sexual or physical abuse?   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| If Yes, have you talked to someone about this?   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Would you like to talk to somebody about this?   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Has your weight changed more than 15 lbs. in the last year?  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Do you follow a particular food diet?  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| If Yes, specify (i.e., vegetarian, low salt, low cholesterol):   |                               |                             |
| Do you feel that you eat a well-balanced diet?   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Do you take calcium supplements?   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Do you eat less than two servings of dairy products per day?   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Do you take vitamins or iron supplements?  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Have you ever been diagnosed with an eating disorder such as anorexia nervosa or bulimia?  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| List the forms and frequency of regular vigorous exercise (swimming, cycling, running; if you do not exercise on a regular basis, check "none"): | <input type="checkbox"/> None |                             |
| Do you often feel sad, depressed, or irritable?  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Do you have difficulty sleeping?   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No |

<b>REVIEW OF SYSTEMS</b>	
<b>DO YOU HAVE OR HAVE YOU EVER HAD: (check all that apply)</b>	
<p><b>NEUROLOGICAL</b></p> <input type="checkbox"/> Seizure <input type="checkbox"/> Migraines <input type="checkbox"/> Other:	<p><b>ENDOCRINE</b></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Excessive hair growth or hair loss <input type="checkbox"/> Rapid weight gain or loss <input type="checkbox"/> Excessive hunger or thirst <input type="checkbox"/> Other:
<p><b>EENT</b></p> <input type="checkbox"/> Eye disorders <input type="checkbox"/> Blurry or double vision <input type="checkbox"/> Problem with the sense of smell <input type="checkbox"/> Other:	<p><b>MUSCULOSKELETAL</b></p> <input type="checkbox"/> Unusual muscle weakness <input type="checkbox"/> Muscle aches/joint pain <input type="checkbox"/> Decreased stamina <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus erythematosus <input type="checkbox"/> Other:
<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Heart valve disorders <input type="checkbox"/> High blood pressure <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Other:	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Blood/mucus in stool/rectal bleeding <input type="checkbox"/> Liver disease/hepatitis/jaundice <input type="checkbox"/> Constipation <input type="checkbox"/> Gastric or intestinal ulcers <input type="checkbox"/> Gallbladder disease <input type="checkbox"/> Spastic colon/ulcerative colitis <input type="checkbox"/> Hernia <input type="checkbox"/> Other:

<b>RESPIRATORY</b> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis/TB exposure <input type="checkbox"/> Cough producing blood <input type="checkbox"/> Other:	<b>HEMATOLOGIC</b> <input type="checkbox"/> Blood clotting disorder <input type="checkbox"/> Anemia/blood disorder <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Thrombophlebitis <input type="checkbox"/> Blood transfusion <input type="checkbox"/> AIDS/HIV infection <input type="checkbox"/> Other:
<b>GENITO-URINARY</b> <input type="checkbox"/> Bladder infections <input type="checkbox"/> Kidney infections <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Frequent or painful urination <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Chlamydia/gonorrhea/venereal disease/PID <input type="checkbox"/> Syphilis/herpes <input type="checkbox"/> Genital warts/HPV <input type="checkbox"/> Other:	<b>SKIN</b> <input type="checkbox"/> Unexplained rashes <input type="checkbox"/> Acne <input type="checkbox"/> Skin cancer <input type="checkbox"/> Burns/injuries <input type="checkbox"/> Dermatitis/infections <input type="checkbox"/> Other:
<b>MENTAL HEALTH</b> <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Hospitalizations for mental illness <input type="checkbox"/> Other:	<b>ALLERGIC/AUTOIMMUNE</b> <input type="checkbox"/> Autoimmune diseases <input type="checkbox"/> Hay fever/allergic rhinitis <input type="checkbox"/> Shellfish allergy <input type="checkbox"/> Other:
<b>OTHER</b> <input type="checkbox"/> Cancer <input type="checkbox"/> Headaches <input type="checkbox"/> Other:	<input type="checkbox"/> <b>NONE OF THE ABOVE</b>

## MALE PARTNER HISTORY

Please have your partner complete these questions to the best of his ability.

### MALE PARTNER IDENTIFYING INFORMATION

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Partner's (wife's) name: \_\_\_\_\_  
 Your occupation: \_\_\_\_\_

### MEDICAL HISTORY

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Blood type (if known): \_\_\_\_\_

Allergies:

Do you have any medical problems?  Yes  No  
 If Yes, list: \_\_\_\_\_

Have you ever had surgery?  Yes  No  
 If Yes, specify year, type of surgery, and location of surgery: \_\_\_\_\_

YEAR	TYPE OF SURGERY	HOSPITAL/CITY

Have you ever had x-rays of the pelvic area?  Yes  No  
 If Yes, explain: \_\_\_\_\_

Are you or have you ever been exposed to any of the following during recreation, employment, or military service?

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Extreme heat | <input type="checkbox"/> Toxic fumes       | <input type="checkbox"/> Sauna/steam baths |
| <input type="checkbox"/> Chemicals    | <input type="checkbox"/> Nuclear radiation | <input type="checkbox"/> Hot tubs          |

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Prostatitis      |
| <input type="checkbox"/> Blood transfusion  | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Breast discharge   | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Syphilis         |
| <input type="checkbox"/> Gonorrhea          | <input type="checkbox"/> Kidney infection         | <input type="checkbox"/> Testes infection |
| <input type="checkbox"/> Chlamydia          | <input type="checkbox"/> Liver problems/hepatitis | <input type="checkbox"/> Testes injury    |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Mumps, age:              | <input type="checkbox"/> Testes tumor     |
| <input type="checkbox"/> Cystic fibrosis    | <input type="checkbox"/> Neurological problems    | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Parasitic infection      | <input type="checkbox"/> Cancer, specify: |

Within the last year, have you taken any prescription medications?  Yes  No

If Yes, list all prescriptions and problems for which you were taking them:

MEDICATION	DOSAGE	DATE STARTED	REASON FOR TAKING

Are you taking any nonprescription medications on a regular basis?  Yes  No  
(including medicines such as aspirin, Tylenol, laxatives, etc.)

If Yes, list all medications:

Have you ever been treated for cancer?  Yes  No

If Yes, explain:

Have you had a high fever (over 102°F) during the past three months?  Yes  No

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

- |   |   |                                  |       |            |
|---|---|----------------------------------|-------|------------|
| <input type="checkbox"/> Alcohol  | How many glasses per week do you usually drink? | Wine:                            | Beer: | Cocktails: |
| <input type="checkbox"/> Cigarettes   | Number of cigarettes per day:                   | Number of years you have smoked: |       |            |
| <input type="checkbox"/> Caffeine   | Number of cups per day:                         |                                  |       |            |
| <input type="checkbox"/> Illicit or recreational drugs (marijuana, cocaine, etc.) |   |                                  |       |            |

### SEXUAL HISTORY

Are you circumcised?  Yes  No

When you were a child, were both testes descended into the scrotum?  Yes  No

At what age did you begin shaving regularly or start to grow a beard?

How many times have you been married?

How many pregnancies have you produced with your current partner?

Have you ever produced a pregnancy with another partner?  Yes  No

If Yes, how long did it take to conceive?

Did that pregnancy result in:  child  miscarriage  termination

Were you ever treated for infertility or have difficulty conceiving with a previous partner?  Yes  No

Do you have trouble getting an erection?  Yes  No

Do you have trouble maintaining an erection?  Yes  No

Do you feel that most of your ejaculate is deposited in the vagina?  Yes  No

Do you ever have orgasms without ejaculation during masturbation?  Yes  No

Do you have any discharge from the penis?  Yes  No

Have you ever had any rashes or sores on your penis?  Yes  No

How many times per week do you and your partner now have intercourse?

How many times do you have intercourse around ovulation?

Have you noticed a change in your sexual drive recently?  Yes  No

### HISTORY OF FERTILITY THERAPY

Have you ever been treated for urological problems or infertility before?  Yes  No

If Yes, who was your physician?

What problem was diagnosed?

Have you taken any of these drugs in the past? (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Clomiphene citrate | <input type="checkbox"/> hCG (Profasi, APL)            | <input type="checkbox"/> Bromocriptine               |
| <input type="checkbox"/> hMG (Pergonal)     | <input type="checkbox"/> Fluoxymesterone (Halotestin)  | <input type="checkbox"/> Urofollitropin/FSH/Metrodin |
| <input type="checkbox"/> Tamoxifen          | <input type="checkbox"/> GnRH or LHRH (Factrel)        | <input type="checkbox"/> None                        |
| <input type="checkbox"/> Testolactone       | <input type="checkbox"/> Testosterone or male hormones |  |

Have you ever had varicocele repair?

Yes  No

Have you ever had a vasectomy, vasectomy reversal or repair?

Yes  No

Have you and your partner ever tried artificial insemination?

Yes  No

If Yes, using:  your sperm  donor sperm

Have you and your partner ever tried In Vitro Fertilization or GIFT?

Yes  No

Which of the following tests have you had performed? (check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Semen analysis      | <input type="checkbox"/> Chromosome tests              | <input type="checkbox"/> Hamster egg test |
| <input type="checkbox"/> Chlamydia test      | <input type="checkbox"/> Testicular biopsy             | <input type="checkbox"/> Thyroid tests    |
| <input type="checkbox"/> Mycoplasma test     | <input type="checkbox"/> X-ray or ultrasound of testes | <input type="checkbox"/> Other:           |
| <input type="checkbox"/> Sperm antibody test | <input type="checkbox"/> Hormonal tests                |   |

### MALE PARTNER'S FAMILY HISTORY

Is there a family history of: (check all that apply)

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Infertility     | <input type="checkbox"/> Heart disease                    | <input type="checkbox"/> Diabetes/sugar              | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Endometriosis   | <input type="checkbox"/> Breast cancer                    | <input type="checkbox"/> Colon cancer                | <input type="checkbox"/> Other:           |
| <input type="checkbox"/> Prostate cancer | <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Excessive hair growth       |   |
| <input type="checkbox"/> Stroke          | <input type="checkbox"/> Ovarian cancer                   | <input type="checkbox"/> Osteoporosis/bone fractures |   |

Is there a family history of hereditary disorders (in yourself, your parents, your partner, or your children): (check all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Chromosomal defects | <input type="checkbox"/> Neural tube defects (open spine) | <input type="checkbox"/> Cystic fibrosis        | <input type="checkbox"/> Muscular dystrophy  |
| <input type="checkbox"/> Tay Sach's disease  | <input type="checkbox"/> Extra fingers/toes               | <input type="checkbox"/> Recurrent miscarriages | <input type="checkbox"/> Huntington's chorea |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Down syndrome                    | <input type="checkbox"/> Hearing defects        | <input type="checkbox"/> Other:              |
| <input type="checkbox"/> Bleeding disorders  | <input type="checkbox"/> Mental retardation               | <input type="checkbox"/> Cleft lip/palate       |  |

**OTHER ISSUES YOU OR YOUR PARTNER WISH TO ADDRESS WITH YOUR PHYSICIAN:**