Repromed Fertility
56 Aberfoyle Crescent, Suite 300 Toronto, ON M8X 2W4
Tel: (416) 233-8111 Fax: (416) 233-8360

ReproMed FERTILITY

FERTILITY/MEDICAL HISTORY FORM

IMPORTANT:
Please complete this form and provide it prior to your appointment date.

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

Part I: Contact Information
Part II: Female Fertility History Form
Part III: Male Fertility History Form

Part I: CONTACT INFORMATION

First Name: ______________________________ Last Name: ____

Date of Birth (MM/DD/YYYY):____________________ Age: ____________ Weight: ____________ Height: ____________

OHIP # & Version Code __________________________________ Occupation ____

Home Address ____

City __________________ Province__________________ Postal Code ____________ Country ______________________

Indicate which number to call or leave messages:

☐ Home ( ) __________________ ☐ Cell ( )__________________ ☐ Other ( )__________________

Are you married? ☐ YES ☐ NO ☐ DIVORCED ☐ OTHER ____

Partners First Name : _____________________________ Last Name: ____________________________
☐ Not Applicable

Date of Birth (MM/DD/YYYY):____________________ Age: ____________

OHIP # & Version Code ________________________________ Occupation______________________________________

Home Address ____

City __________________ Province__________________ Postal Code ____________ Country ______________________

Indicate which number to call or leave messages:

☐ Home ( ) __________________ ☐ Cell ( )__________________ ☐ Other ( )__________________

WHO REFERRED YOU?
☐ Physician
Name _________________________________ Phone ( )_________________ Address ____________________________________

☐ Former Patient/Friend ______________________________________ ☐ Website ______________________________________

☐ Insurance Company _______________________________________

WHO IS YOUR OB/GYN?

Name _________________________________ Phone ( )_________________ Address ____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

Name _________________________________ Phone ( )_________________ Address ____

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Part III: RECIPIENT(S) HEALTH HISTORY

Reason for Visit: ☐ Infertility ☐ Sperm Insemination ☐ Other ____

What are your expectations for this visit? ____

____

What questions do you want answered at this visit ____

____

Do you have any personal, ethical or religious objections to any of our tests or treatment such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect semen sample, etc.? ☐ NO ☐ YES ____________________________

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

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? _______

Any pregnancies with birth defects? ☐NO ☐YES – Explain: ______________________________________

	DATE PREGNANCY ENDED/DELIVERED	MONTHS TO CONCEPTION	TREATMENTS TO CONCEIVE	DELIEVERY TYPE/D&C/ COMPLICATIONS	CURRENT PARTNER?
1.					☐ Y ☐ N
2.					☐ Y ☐ N
3.					☐ Y ☐ N
4.					☐ Y ☐ N
5.					☐ Y ☐ N
6.					☐ Y ☐ N

MENSTRUAL HISTORY

Menstrual Cycle pattern *(check all the 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. How many periods do you have per year? ________

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

Do you need medication to bring on a period? ☐NO ☐YES – What type? : ____

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? ☐NO ☐YES: ☐Always ☐Sometimes ☐Recently ☐In the past

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CONTRACEPTIVE HISTORY

☐ None ☐ Condoms – date of use ___________ ☐ Diaphragm – date of use_____________ ☐ IUD – date of use ____________

☐ Birth Control pills - date of use _______________ - complications? ______________________ ☐ Never used birth control pills

☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) - date of use _______________ - complications? ______________________

☐ Skin Patch - date of use _______________ - complications? ______________________ ☐ Foam or Jelly

☐ Tubal sterilization procedure (tubes tied) – date _____________ ☐ Tubes untied – date _____________

Did your mother take DES when she was pregnant with you? ☐ NO ☐ YES ☐ UNSURE

SEXUAL HISTORY

How many times do you have intercourse per week? ______ per week ☐ None ☐ Not Applicable

Have you used over-the-counter ovulation kits to time intercourse? ☐ NO ☐ YES

Do you have pain with intercourse? ☐ NO ☐ YES

Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ NO ☐ YES – what types? ____________________________________

Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ NO ☐ YES *(check all that apply)*:

☐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/year)? _______/_______ ☐ Normal ☐ Abnormal

When was your last abnormal pap smear (month/year)? _______/_______ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear? ☐ NO ☐ YES *(check all that apply)*:

☐Colposcopy ☐Cryosurgery (Freezing) ☐ Laser Treatment ☐Conization ☐LEEP procedure

BREAST SCREENING HISTORY

Have you ever had a mammogram? ☐ NO ☐ YES – date __________ Result ☐ Normal ☐ Abnormal – explain_________________

Do you perform breast self-exam? ☐ NO ☐ YES

MEDICAL HISTORY

Are you allergic to any medication? ☐ NO ☐ YES *(Please list and describe reactions)* ____
____

Are you allergic to any foods? ☐ NO ☐ 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? ____

Do you have any medical problems? ☐ NO ☐ YES *(Please list types, dates and treatment):*

(1) ____
(2) ____
(3) ____

Did you have any of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't Know
Other childhood diseases: ____

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VACCINATIONS

Chickenpox (Varicella):	☐ NO	☐ YES – date _______________	☐ Don't Know
MMR – Measles, Mumps and Rubella (German Measles)	☐ NO	☐ YES – date _______________	☐ Don't Know
Tetanus	☐ NO	☐ YES – date _______________	☐ Don't Know
BCG (Tuberculosis)	☐ NO	☐ YES – date _______________	☐ Don't Know
Hepatitis A	☐ NO	☐ YES – date _______________	☐ Don't Know
Hepatitis B	☐ NO	☐ YES – date _______________	☐ Don't Know
Polio	☐ NO	☐ YES – date _______________	☐ Don't Know
Influenza	☐ NO	☐ YES – date _______________	☐ Don't Know

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _______________ ☐ None

Do you smoke cigarettes? ☐ NO ☐ YES How many/day? ____________ How many years? ________ ☐ Quit – when? _____________

Do you drink alcohol? ☐ NO ☐ YES
☐Beer - #per week____________ ☐Wine - #per week____________ ☐ Liquor - #per week____________

Do you use marijuana, cocaine or any other similar drug? ☐ NO ☐ YES ____

Do you exercise? ☐ NO ☐ YES ____

Are you aware of any radiation exposures other than x-rays? ☐ NO ☐ YES ____

SURGICAL HISTORY

Have you had any surgeries? ☐ NO ☐ YES (List all surgeries in chronologic order)

YEAR	REASON AND TYPE OF SURGERY
____________	____
____________	____
____________	____
____________	____
____________	____

Did you have any anesthesia problem ☐ NO ☐ YES ____

Physician's Notes: ____

____

____

____

____

____

____

____

PHYSICAL SYMPTOMS

GENERAL:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Other ______________
- ☐ None

HEAD, EYES, EARS, NOSE & THROAT:
- ☐ Dizziness
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Hearing loss/deafness
- ☐ Other ______________
- ☐ None
- ☐ Loss of sense of smell
- ☐ Chronic nasal congestion
- ☐ Ringing ears

RESPIRATORY:
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Pneumonia
- ☐ Bloody cough
- ☐ Other ______________
- ☐ None
- ☐ Bronchitis
- ☐ Tuberculosis

ENDOCRINE/HORMONAL:
- ☐ Diabetes
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Other ______________
- ☐ None
- ☐ Temperature intolerance – hot flashes or feeling cold
- ☐ Hair Loss

BREASTS:
- ☐ Discharge (☐ clear? ☐ bloody? ☐ milky?)
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants (☐ saline? ☐silicone?)
- ☐ Other ______________________
- ☐ None
- ☐ Cancer
- ☐ Pain
- ☐ Lumps

NEUROLOGICAL PROBLEMS:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Other ________________
- ☐ None
- ☐ Memory loss
- ☐ Numbness

GASTROINTESTINAL:
- ☐ Nausea/Vomiting
- ☐ Blood in your stools
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Other ______________________
- ☐ None
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation

GENITO-URINARY:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination
- ☐ Leaking urine
- ☐ Other _________________
- ☐ None
- ☐ Herpes
- ☐ Blood in the urine

SKIN/EXTREMITIES:
- ☐ Skin cancer
- ☐ Unexplained rash/inflammation
- ☐ Brain injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other ______________________
- ☐ None
- ☐ Acne

MUSCULOSKELETAL:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other _______________________
- ☐ None

HEMATOLOGIC:
- ☐ Sickle Cell Anemia
- ☐ Blood clotting disorder/Blood clot
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons____________________)
- ☐ Other _______________________
- ☐ None
- ☐ Thrombophlebitis

CARDIOVASCULAR:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (Need antibiotics before dental procedure) ☐ YES ☐ NO
- ☐ Other _______________________
- ☐ None
- ☐ Heart attack
- ☐ Murmurs
- ☐ Stroke

MENTAL HEALTH PROBLEMS:
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Other ______________
- ☐ None
- ☐ Schizophrenia

FAMILY HISTORY

	LIVING	AGE AT DEATH/ CAUSE OF DEATH
Mother	☐ YES Age_______	☐ NO ________________________
Father	☐ YES Age_______	☐ NO ________________________
Sibling 1	☐ YES Age_______	☐ NO ________________________
Sibling 2	☐ YES Age_______	☐ NO ________________________
Sibling 3	☐ YES Age_______	☐ NO ________________________
Sibling 4	☐ YES Age_______	☐ NO ________________________
Maternal Grandmother	☐ YES Age_______	☐ NO ________________________
Maternal Grandfather	☐ YES Age_______	☐ NO ________________________
Paternal Grandmother	☐ YES Age_______	☐ NO ________________________
Paternal Grandfather	☐ YES Age_______	☐ NO ________________________

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What is your Ancestry?

☐ African-American ☐ American Indian/Native American ☐ Ashkenazi Jewish ☐ Asian-American
☐ Cajun/French Canadian ☐ Caucasian ☐ Eastern European ☐ Hispanic/Caribbean
☐ Northern European ☐ Southern European ☐ Other (specify) ______________________________

Would you like to be screened for:

Cystic Fibrosis ☐ NO ☐ YES Sickle Cell Anemia ☐ NO ☐ YES Tay-Sachs Disease ☐ NO ☐ YES Thalassemia ☐ NO ☐ YES

DISORDERS IN YOUR FAMILY

☐ NONE OF THE BELOW

		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 40 years	☐ YES	______________	☐ NO	☐ Don't Know
Birth defects	☐ YES	______________	☐ NO	☐ Don't Know
Cystic Fibrosis	☐ YES	______________	☐ NO	☐ Don't Know
Tay-Sachs	☐ 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
Colour Blindness	☐ YES	______________	☐ NO	☐ Don't Know
Hemochromatosis	☐ YES	______________	☐ NO	☐ Don't Know

☐ OTHER (Specify) ______________________________

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PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere? ☐ NO ☐ YES

PRIOR TESTS *(check all the apply)*

☐ 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__________

☐ Basal body temperature chart - date__________/ results____

PRIOR TREATMENT (check all the apply)	# of cycles	Dates (mm/yy) to (mm/yy)	Outcome
☐ Intrauterine insemination	____	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
☐ Daily fertility drug injections with insemination *Maximum # tablets per day?* ________	____	From ______ to ______	☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
☐ Completed in vitro fertilization cycle(s)			
1.# eggs ____ # embryo transferred ____ # frozen ____	____	From ______ to ______	☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
2.# eggs ____ # embryo transferred ____ # frozen ____	____	From ______ to ______	☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
3.# eggs ____ # embryo transferred ____ # frozen ____	____	From ______ to ______	☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
☐ Frozen embryo transfer(s):			
1.# embryos transferred _____	____	From ______ to ______	☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
2.# embryos transferred _____	____	From ______ to ______	☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
3.# embryos transferred _____	____	From ______ to ______	☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant

Cancelled in vitro fertilization attempts: ________________________

Any other prior treatment *(describe)*: ____

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, martial or sexual problems cause by your infertility. ____

____

____

PATIENT'S SIGNATURE____ DATE_______________________________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE____ DATE_______________________________

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Part III: MALE FERTILITY HISTORY

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? ☐ NO ☐ YES *(check all that apply)*:
☐Chlamydia – date________ ☐Gonorrhea – date________ ☐ Herpes – date________ ☐Genital warts/HPV – date________
☐Syphilis – date________ ☐HIV/AIDS – date________ ☐ Hepatitis – date________ ☐Other ____________ – date________
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
☐ Multiple Sclerosis ☐ YES ☐ NO
☐ Prostatic infections ☐ YES ☐ NO
☐ High Blood Pressure ☐ YES ☐ NO If yes, any medications? ____
☐ Cancer ☐ YES ☐ NO
☐ Other neurologic problems ☐ YES ☐ NO
☐ Urinary infections ☐ YES ☐ NO

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 a 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
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? ☐ NO ☐ YES (Please list and describe reactions) ____
____
List your current medications: ____
List any current medical problems: ____

How many caffeinated beverages do you drink per day? _______ ☐ None
Do you smoke cigarettes? ☐ NO ☐ YES How many/day _______ How many years? _______ ☐ Quit – when? ______________
Do you drink alcohol? ☐ NO ☐ YES Beer - # per week _______ Wine - # per week _______ Liquor - # per week _______
Do you use marijuana, cocaine, or any other similar drug? ☐ NO ☐ YES (Please list and describe) ____________________________________
Do you use herbal medicines/vitamins or health food store supplements? ☐ NO ☐ YES (Please list and describe_____________________________
Are you aware of any radiation/toxic materials exposure? ☐ YES ☐ NO
Do you use hot tub 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 ____

Physician’s Notes:
____
____
____

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What is your Ancestry?

☐ African-American ☐ American Indian/Native American ☐ Ashkenazi Jewish ☐ Asian-American
☐ Cajun/French Canadian ☐ Caucasian ☐ Eastern European ☐ Hispanic/Caribbean
☐ Northern European ☐ Southern European ☐ Other (specify) ____________________

Would you like to be screened for:

Cystic Fibrosis ☐ NO ☐ YES Sickle Cell Anemia ☐ NO ☐ YES Tay-Sachs Disease ☐ NO ☐ YES Thalassemia ☐ NO ☐ YES

DISORDERS IN YOUR FAMILY ☐ NONE BELOW

		RELATIONSHIP TO YOU		
Cystic Fibrosis	☐ YES	________	☐ NO	☐ Don't Know
Tay-Sachs	☐ 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
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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
Colour Blindness	☐ YES	________	☐ NO	☐ Don't Know
Hemochromatosis	☐ YES	________	☐ NO	☐ Don't Know

☐ OTHER (Specify) ____________________

PATIENT'S SIGNATURE____________________ DATE____________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE____________________ DATE____________

Physician's Notes: