The Johns Hopkins University School of Medicine
Division of Reproductive Endocrinology
Department of Gynecology and Obstetrics
Fertility Center and IVF Program
10753 Falls Road, Suite 335
Lutherville, Maryland 21093
(410) 583-2749

HUSBAND AND WIFE MEDICAL HISTORY PACKET

Reason for Referral: _____ **Infertility** _____ **Gynecology**

Wife's Information:

Name: _____ Date of Birth: _____/_____/_____

Height: _____ Weight _____lbs.

Gynecologist's Name:
_____

Address:
_____

_____

Phone: _____ Fax: _____

Husband's Information:

Name: _____ Date of Birth _____/_____/_____

Height: _____ Weight: _____lbs.

Urologist's Name:
_____

Address:
_____

_____

Phone: _____ Fax:

_____

Please answer all questions as honestly and accurately as possible. All information will be kept confidential.
If you have any questions, please don't hesitate to ask one of the nurses.

The Johns Hopkins University School of Medicine
Division of Reproductive Endocrinology
NEW PATIENT PRE-REGISTRATION FORM

Date: _____

Name:
_____
___

Husband's Name:
_____

Address:
_____

Home #: _____ ***Work #:***
_____

SSN: _____ ***DOB:***
_____

Insurance Co. Primary
_____
Policy Holder
_____
ID #: _____ ***Group #***_____
Secondary
_____
Policy Holder of Secondary Insurance _____
Secondary ID #: _____ ***Group #***
_____

Referral: _____ ***YES (patient to bring referral)*** _____***NO***

Referral Source: _____ ***Media*** _____ ***Relative/Friend***_____***Former Patient***
_____ ***Seminar*** _____ ***Internet*** _____
_____ ***Physician (name)***
_____
_____ ***Other***
_____

FEMALE MEDICAL HISTORY

ALLERGIES: _____ ***Blood Type:*** _____

CURRENT MEDICATIONS AND DOSES:_____

1.	Have you been seen by a physician or hospitalized in the past two years? If so, list the physician, hospital, and psychiatric or long-term facility._____	ρ Yes ρ No ρ Unknown
2.	Please name any surgical procedures you have had in the past. _____ _____ _____	ρ Yes ρ No ρ Unknown
3.	What medications, if any, do you take on a regular basis: _____ _____ _____	ρ Yes ρ No ρ Unknown
4.	Do you use tobacco products? List type and how many per day. _____	ρ Yes ρ No ρ Unknown
5.	Do you drink alcohol? List quantity and type of alcohol. _____ _____	ρ Yes ρ No ρ Unknown
6.	Have you ever been exposed to toxic substances, i.e., lead, pesticides?	ρ Yes ρ No ρ Unknown
7.	In the past three years, have you traveled outside of the United States (except Canada)? Describe. _____ _____ _____ Have you taken anti-malarial drugs or had malaria?	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
8.	Do you have any history of heart disease, high blood pressure, or chest pain? Do you have poor circulation in the legs? Have you taken medications for heart or blood pressure problems? List: _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown

FEMALE MEDICAL HISTORY

NAME: _____

9.	Have you suffered from any type of liver disease, yellow jaundice, or Hepatitis? Have you ever had a positive test for Hepatitis? Have you ever had close contact with persons diagnosed with viral hepatitis in the past 12 months?	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
10.	Have you ever been vaccinated for Hepatitis B?	ρ Yes ρ No ρ Unknown
11.	Have you ever received blood transfusions or blood products? Type: _____ Amount _____ Date _____	ρ Yes ρ No ρ Unknown
12.	Have you ever been refused as a blood donor or told not to donate blood? Why? _____	ρ Yes ρ No ρ Unknown
13.	Have you ever received an organ or tissue transplant, i.e., cornea, skin, heart, or kidney? (circle)	ρ Yes ρ No ρ Unknown
14.	In the past 12 months, have you had a tattoo, ear/body piercing, acupuncture, or accidental needle stick? (circle)	ρ Yes ρ No ρ Unknown
15.	Have you had any kidney-related diseases, kidney stones, frequent infections, or been treated with kidney dialysis? (circle)	ρ Yes ρ No ρ Unknown
16.	Do you have a history of digestive or intestinal problems? Have you ever had bloody stools, intestinal surgery or intestinal cancer? Where and when? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
17.	Have you ever experienced any periods of explained or unexplained weight loss? Describe: _____ _____	ρ Yes ρ No ρ Unknown
18.	Do you have a history of diabetes? Have you ever been treated with oral medication, insulin injections? How long? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown

FEMALE MEDICAL HISTORY

NAME:_____

19.	Do you have a history of asthma, emphysema, or any lung disease? Have you ever had a positive skin test for tuberculosis? Have you ever been treated for tuberculosis? Where/When? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
20.	Have you ever had cancer or received radiation therapy or drugs for cancer? When? _____	ρ Yes ρ No ρ Unknown
21.	Have you ever used non-prescribed drugs or other substances, i.e., cocaine, marijuana, steroids, inhalants? (circle)	ρ Yes ρ No ρ Unknown
22.	Have you ever suffered from any type of neurologic or brain disease such as Alzheimer's, seizure, periods of confusion or recent memory loss? (circle) Do you have a history of brain tumor? If so, where/when? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
23.	Do you have any history of arthritis, bone or joint disease? Do you have a history of broken bones? Do you have any complaints of stiff or sore joints?	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
24.	In the past 12 months, have you ever been vaccinated or immunized for any reason? What for? _____ When? _____	ρ Yes ρ No ρ Unknown
25.	Have you ever been given human growth hormones?	ρ Yes ρ No ρ Unknown
26.	Have you recently exhibited flu-like symptoms, such as: cough, colds, swollen lymph nodes, nausea, vomiting, persistent diarrhea or fever > 100°F? (circle) Have you ever demonstrated blue spots on the skin? Are you currently taking antibiotics? What kind? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
27.	In the past 12 months, have you been treated for any sexually transmitted diseases such as syphilis, gonorrhea, chlamydia, herpes, or pelvic inflammatory disease? (circle)	ρ Yes ρ No ρ Unknown

FEMALE MEDICAL HISTORY

NAME:_____

28.	Have you ever had a positive test for HIV or been tested for HIV?	ρ Yes ρ No ρ Unknown
29.	Is your husband bisexual?	ρ Yes ρ No ρ Unknown
30.	In the past 5 years, have you used a needle to inject drugs into your veins, muscle, or under your skin for non-medical use?	ρ Yes ρ No ρ Unknown
31.	Have you received human-derived clotting factor concentrates for hemophilia or related clotting disorders?	ρ Yes ρ No ρ Unknown
32.	Have you engaged in sex in exchange for money or drugs in the past 5 years?	ρ Yes ρ No ρ Unknown
33.	Have you ever been exposed to known or suspected viral Hepatitis or HIV-infected blood through accidental needle stick or through contact with an open wound, non-intact skin, or mucous membrane in the past 12 months? (circle)	ρ Yes ρ No ρ Unknown
34.	Have you ever been an inmate of a correctional system or jail, or released from a correctional system or jail in the past 12 months? (circle)	ρ Yes ρ No ρ Unknown
35.	Have you had sex in the past 12 months with any person known or suspected to have viral Hepatitis or HIV infection (AIDS), or any person described in above questions #26-31?	ρ Yes ρ No ρ Unknown

INFERTILITY HISTORY (WIFE)

NAME: _____
__

How long have you been trying for a pregnancy? _____ Years

What cause of infertility has been diagnosed? _____

*Which of the following **tests** have been performed? (Check all that apply)*

4		***DATES***	***RESULTS***
	BBT		
	Semen Analysis		
	Post Coital Test		
	Female Hormone Studies		
	Endometrial Biopsy		
	Hysterosalpingogram (HSG) (x-ray of the womb)		
	Hamster Egg Test		
	Sperm Antibodies (Female)		
	Sperm Antibodies (Male)		
	Mycoplasma / Chlamydia Cultures		
	Laparoscopy / Hysteroscopy		
	Other (Specify) _____		

Have you had ***surgery*** for any of the following? (Give dates and Surgeon***)***

PROCEDURE	***DATES***	***SURGEON***
Tubal Sterilization Reversal		
Lysis of Pelvic Adhesions		
Endometriosis		
Tubal Blockage		
Ectopic Pregnancy		
Ovarian Cysts		
Other Surgery (List) _____		

INFERTILITY HISTORY (WIFE)

NAME: _____
__

Have you had any of the following ***infertility treatment***? (Give Dates and Number of Cycles)

TREATMENT	***DATES***	***# OF CYCLES***
Intrauterine insemination (IUI)		
Donor sperm inseminations (AID)		
Clomid or Serophene		
Progesterone Suppositories		
Pergonal/Humegon		
Metrodin (pure FSH)		
Prednisone		
Parlodel		
Danazol		
In Vitro Fertilization (IVF)		
In Vitro Fertilization Associated to Intracytoplasmic Sperm Injection (IVF/ICSI)		
GIFT/ZIFT		
Other, such as Lupron, etc. (Specify)		

MENSTRUAL HISTORY

Age of first period? _____ Are your periods regular? _____ ρ Yes ρ No

What is the usual number of days between the first day of one period and the first day of the next? _____ days.

How long does your period last? _____ days. Do you experience cramps? ρ Yes ρ No

Do you take medication to alleviate your cramps? ρ Yes ρ No What kind? _____

Do you bleed ρ Yes ρ No or spot between periods? ρ Yes ρ No

Did your mother takes DES when she was pregnant with you? ρ Yes ρ No

INFERTILITY HISTORY (WIFE)

NAME: _____
_____

Date of last PAP smear_____ Result _____
Date of last mammogram: _____ Result _____

MARITAL HISTORY

1. Wife's first marriage? ρ Yes ρ No. If not, number of times married. ρ 2 ρ 3 ρ 4+

2. Husband's first marriage? ρ Yes ρ No. If not, number of times married. ρ 2 ρ 3 ρ 4+

3. How many times per week do you have intercourse? _____ Is it painful? ρ Yes ρ No

4. Do you use lubricants? ρ Yes ρ No. What kind?
_____

5. Do you douche before or after intercourse? ρ Yes ρ No.

6. Do you use contraception? ρ Yes ρ No. What kind?
_____

7. Reason for stopping use of contraception: _____

8. Does your husband have any problems with erection? ρ Yes ρ No.

9. Does your husband have any problems with ejaculation? ρ Yes ρ No.

10. Does your husband have any children from a previous marriage? ρ Yes ρ No.
If yes, give ages and gender:

NAME	*AGE*	*MALE*	*FEMALE*

PREGNANCY HISTORY

DATE					
Outcome – spontaneous or induced abortion, ectopic, stillborn, live birth.					
Gestation (weeks)					
Weight					
Was infertility treatment required?					
How long to conceive?					
Is current partner the father?					
Complications					

FAMILY HISTORY (WIFE)
PATERNAL ANCESTRY

NAME: _____
_____

Father (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Paternal grandfather (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Paternal grandmother (if living)	Age	Health Status
If deceased, age at death:		Cause of death

PATERNAL* Aunts & Uncles *– Living

Name	*Gender*	*Age*	*Health*

PATERNAL* Aunts & Uncles *– Deceased
Include neonatal and childhood deaths

Name	*Gender*	*Age at Death*	*Cause of Death*
COMMENTS:			

PATERNAL* First Cousins *- Deceased

Name	*Gender*	*Age at Death*	*Cause of Death* *Neonatal/Birth Defects (Be specific)*

FAMILY HISTORY (WIFE)
MATERNAL ANCESTRY

NAME:_

_____

_____

Father (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Maternal grandfather (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Maternal grandmother (if living)	Age	Health Status
If deceased, age at death:		Cause of death

MATERNAL* Aunts & Uncles *– Living

Name	*Gender*	*Age*	*Health*

MATERNAL* Aunts & Uncles *– Deceased
Include neonatal and childhood deaths

Name	*Gender*	*Age at Death*	*Cause of Death*
COMMENTS:			

MATERNAL* First Cousins *- Deceased

Name	*Gender*	*Age at Death*	*Cause of Death* *Neonatal/Birth Defects (Be specific)*

FAMILY HISTORY (WIFE)

NAME: _____
_____

WIFE'S Brothers and Sisters

Name	*Gender*	*Living*		*Age*	*Health*
		Yes	*No*		

WIFE'S Brothers and Sisters – Deceased

Name	*Gender*	*Age at Death*	*Cause of Death Neonatal/Birth Defects (Be specific)*

WIFE'S Children

Name	*Gender*	*Living*		*Age*	*Health*
		Yes	*No*		

WIFE'S Children – Deceased

Name	*Gender*	*Age at Death*	*Cause of Death Neonatal/Birth Defects (Be specific)*

GENETIC HISTORY (WIFE)

2. Has any member of your family had one or more children with serious birth defects?
   ρ Yes ρ No How many? _____
3. Has any female member of your family had an excessive number of spontaneous miscarriages?
   ρ Yes ρ No How many? _____
4. Do you or any members of your family have any of the following medical conditions?

CONDITION		*YES*	*NO*	*YOU*	*FAMILY MEMBER (Who?)*
A.	Down's Syndrome (Mongolism)				
B.	Cleft lip or cleft palate				
C	Club foot				
D.	Congenital heart disease				
E.	Pyloric stenosis				
F.	Neural tube defects (spina bifida, meningocele)				
G.	Cystic fibrosis, PKU or inherited metabolic disorders				
H.	Progressive kidney disorder				
I.	Diabetes mellitus requiring insulin therapy				
J.	Diabetes mellitus *not* requiring insulin therapy				
K.	Premature degeneration of any organ system				
L.	Cataracts before age 40				
M.	Deafness before age 60				
N.	Loss of muscle coordination				
O.	Schizophrenia				
P.	Manic depressive psychosis				
Q.	Mental deterioration or senility before age 50				
R.	Premature death				
S.	Huntington's chorea				
T.	Epilepsy or a seizure disorder				
U.	Tay Sach's Disease				
V.	Sickle cell anemia				
W.	Do you have any coffee colored spots on your skin about the size of a quarter? How many?				
X.	Is there a history of early deaths in the family (Heart attacks, etc.) How many?				

GENETIC HISTORY (WIFE)

If you answered YES to questions A – X, please elaborate: _____

_____

_____

_____

MALE MEDICAL HISTORY

NAME _____ Wife's Name _____

ALLERGIES: _____ Blood Type: _____

CURRENT MEDICATIONS AND DOSES:_____

1.	Have you been seen by a physician or hospitalized in the past two years? If so, list the physician, hospital, and psychiatric or long-term facility._____	ρ Yes ρ No ρ Unknown
2.	Please name any surgical procedures you have had in the past. _____ _____ _____	ρ Yes ρ No ρ Unknown
3.	What medications, if any, do you take on a regular basis: _____ _____ _____	ρ Yes ρ No ρ Unknown
4.	Do you use tobacco products? List type and how many per day. _____	ρ Yes ρ No ρ Unknown
5.	Do you drink alcohol? List quantity and type of alcohol. _____ _____	ρ Yes ρ No ρ Unknown
6.	Have you ever been exposed to toxic substances, i.e., lead, pesticides?	ρ Yes ρ No ρ Unknown
7.	In the past three years, have you traveled outside of the United States (except Canada)? Describe. _____ _____ _____ Have you taken anti-malarial drugs or had malaria?	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
8.	Do you have any history of heart disease, high blood pressure, or chest pain? Do you have poor circulation in the legs? Have you taken medications for heart or blood pressure problems? List: _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown

MALE MEDICAL HISTORY

NAME: _____

9.	Have you suffered from any type of liver disease, yellow jaundice, or Hepatitis? Have you ever had a positive test for Hepatitis? Have you ever had close contact with persons diagnosed with viral hepatitis in the past 12 months?	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
10.	Have you ever been vaccinated for Hepatitis B?	ρ Yes ρ No ρ Unknown
11.	Have you ever received blood transfusions or blood products? Type: _____ Amount _____ Date _____	ρ Yes ρ No ρ Unknown
12.	Have you ever been refused as a blood donor or told not to donate blood? Why? _____	ρ Yes ρ No ρ Unknown
13.	Have you ever received an organ or tissue transplant, i.e., cornea, skin, heart, or kidney? (circle)	ρ Yes ρ No ρ Unknown
14.	In the past 12 months, have you had a tattoo, ear/body piercing, acupuncture, or accidental needle stick? (circle)	ρ Yes ρ No ρ Unknown
15.	Have you had any kidney-related diseases, kidney stones, frequent infections, or been treated with kidney dialysis? (circle)	ρ Yes ρ No ρ Unknown
16.	Do you have a history of digestive or intestinal problems? Have you ever had bloody stools, intestinal surgery or intestinal cancer? Where and when? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
17.	Have you ever experienced any periods of explained or unexplained weight loss? Describe: _____ _____	ρ Yes ρ No ρ Unknown
18.	Do you have a history of diabetes? Have you ever been treated with oral medication, insulin injections? How long? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown

MALE MEDICAL HISTORY

NAME:_____

19.	Do you have a history of asthma, emphysema, or any lung disease? Have you ever had a positive skin test for tuberculosis? Have you ever been treated for tuberculosis? Where/When? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
20.	Have you ever had cancer or received radiation therapy or drugs for cancer? When? _____	ρ Yes ρ No ρ Unknown
21.	Have you ever used non-prescribed drugs or other substances, i.e., cocaine, marijuana, steroids, inhalants? (circle)	ρ Yes ρ No ρ Unknown
22.	Have you ever suffered from any type of neurologic or brain disease such as Alzheimer's, seizure, periods of confusion or recent memory loss? (circle) Do you have a history of brain tumor? If so, where/when? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
23.	Do you have any history of arthritis, bone or joint disease? Do you have a history of broken bones? Do you have any complaints of stiff or sore joints?	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
24.	In the past 12 months, have you ever been vaccinated or immunized for any reason? What for? _____ When? _____	ρ Yes ρ No ρ Unknown
25.	Have you ever been given human growth hormones?	ρ Yes ρ No ρ Unknown
26.	Have you recently exhibited flu-like symptoms, such as: cough, colds, swollen lymph nodes, nausea, vomiting, persistent diarrhea or fever > 100°F? (circle) Have you ever demonstrated blue spots on the skin? Are you currently taking antibiotics? What kind? _____	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
27.	In the past 12 months, have you been treated for any sexually transmitted diseases such as syphilis, gonorrhea, chlamydia, herpes, or pelvic inflammatory disease? (circle)	ρ Yes ρ No ρ Unknown

MALE MEDICAL HISTORY

NAME:_____

28.	Have you ever had a positive test for HIV or been tested for HIV?	ρ Yes ρ No ρ Unknown
29.	Is your wife bisexual? Are you?	ρ Yes ρ No ρ Unknown ρ Yes ρ No ρ Unknown
30.	In the past 5 years, have you used a needle to inject drugs into your veins, muscle, or under your skin for non-medical use?	ρ Yes ρ No ρ Unknown
31.	Have you received human-derived clotting factor concentrates for hemophilia or related clotting disorders?	ρ Yes ρ No ρ Unknown
32.	Have you engaged in sex in exchange for money or drugs in the past 5 years?	ρ Yes ρ No ρ Unknown
33.	Have you ever been exposed to known or suspected viral Hepatitis or HIV-infected blood through accidental needle stick or through contact with an open wound, non-intact skin, or mucous membrane in the past 12 months? (circle)	ρ Yes ρ No ρ Unknown
34.	Have you ever been an inmate of a correctional system or jail, or released from a correctional system or jail in the past 12 months? (circle)	ρ Yes ρ No ρ Unknown
35.	Have you had sex in the past 12 months with any person known or suspected to have viral Hepatitis or HIV infection (AIDS), or any person described in above questions #26-31?	ρ Yes ρ No ρ Unknown

INFERTILITY HISTORY (HUSBAND)

Have you had ***surgery***? (Give dates and Surgeon***)***

PROCEDURE	*DATES*	*SURGEON*

FAMILY HISTORY (HUSBAND)
PATERNAL ANCESTRY

NAME:

_____

_____

Father (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Paternal grandfather (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Paternal grandmother (if living)	Age	Health Status
If deceased, age at death:		Cause of death

PATERNAL Aunts & Uncles – Living

Name	*Gender*	*Age*	*Health*

PATERNAL Aunts & Uncles – Deceased
Include neonatal and childhood deaths

Name	*Gender*	*Age at Death*	*Cause of Death*
COMMENTS:			

PATERNAL* First Cousins *- Deceased

Name	*Gender*	*Age at Death*	*Cause of Death* *Neonatal/Birth Defects (Be specific)*

FAMILY HISTORY (HUSBAND)
MATERNAL ANCESTRY

NAME:

_____

_____

Father (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Maternal grandfather (if living)	Age	Health Status
If deceased, age at death:		Cause of death
Maternal grandmother (if living)	Age	Health Status
If deceased, age at death:		Cause of death

MATERNAL* Aunts & Uncles *– Living

Name	*Gender*	*Age*	*Health*

MATERNAL* Aunts & Uncles *– Deceased
Include neonatal and childhood deaths

Name	*Gender*	*Age at Death*	*Cause of Death*

COMMENTS:

FAMILY HISTORY (HUSBAND)

NAME:

_____

_____

MATERNAL First Cousins - Deceased

Name	*Gender*	*Age at Death*	*Cause of Death Neonatal/Birth Defects (Be specific)*

HUSBAND'S Brothers and Sisters

Name	*Gender*	*Living*		*Age*	*Health*
		Yes	*No*		

HUSBAND'S Brothers and Sisters – Deceased

Name	*Gender*	*Age at Death*	*Cause of Death Neonatal/Birth Defects (Be specific)*

HUSBAND'S Children

Name	*Gender*	*Living*		*Age*	*Health*
		Yes	*No*		

HUSBAND'S Children – Deceased

Name	*Gender*	*Age at Death*	*Cause of Death Neonatal/Birth Defects (Be specific)*

GENETIC HISTORY (HUSBAND)

5. Has any member of your family had one or more children with serious birth defects?
   ρ Yes ρ No How many? _____
6. Has any female member of your family had an excessive number of spontaneous miscarriages?
   ρ Yes ρ No How many? _____
7. Do you or any members of your family have any of the following medical conditions?

CONDITION		*YES*	*NO*	*YOU*	*FAMILY MEMBER (Who?)*
A.	Down's Syndrome (Mongolism)				
B.	Cleft lip or cleft palate				
C	Club foot				
D.	Congenital heart disease				
E.	Pyloric stenosis				
F.	Neural tube defects (spina bifida, meningocele)				
G.	Cystic fibrosis, PKU or inherited metabolic disorders				
H.	Progressive kidney disorder				
I.	Diabetes mellitus requiring insulin therapy				
J.	Diabetes mellitus *not* requiring insulin therapy				
K.	Premature degeneration of any organ system				
L.	Cataracts before age 40				
M.	Deafness before age 60				
N.	Loss of muscle coordination				
O.	Schizophrenia				
P.	Manic depressive psychosis				
Q.	Mental deterioration or senility before age 50				
R.	Premature death				
S.	Huntington's chorea				
T.	Epilepsy or a seizure disorder				
U.	Tay Sach's Disease				
V.	Sickle cell anemia				
W.	Do you have any coffee colored spots on your skin about the size of a quarter? How many?				
X.	Is there a history of early deaths in the family (Heart attacks, etc.) How many?				

GENETIC HISTORY (HUSBAND))

If you answered YES to questions A – X, please elaborate: _____

_____

_____

_____