

Advanced Reproductive Medicine and Surgery, P.C.
4190 Telegraph Rd., Suite 1500
Bloomfield Hills, MI 48302

REPRODUCTIVE GENETIC HISTORY QUESTIONNAIRE

Patient Name _____ Date of Birth _____

MEDICAL HISTORY

YES	NO	DO YOU...	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	1. Have diabetes?	_____
<input type="checkbox"/>	<input type="checkbox"/>	2. Have seizures or epilepsy?	_____
<input type="checkbox"/>	<input type="checkbox"/>	3. Have kidney disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	4. Or your husband/partner have a history of cancer treatment?	_____
<input type="checkbox"/>	<input type="checkbox"/>	5. Have any skin disorders including moles, acne, light or dark patches of skin?	_____
<input type="checkbox"/>	<input type="checkbox"/>	6. Have rheumatoid arthritis or systematic lupus erythematosus (SLE)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	7. Have a history of being on a special diet as a baby or small child? (You may need to ask your parents)	_____
<input type="checkbox"/>	<input type="checkbox"/>	8. Know the results of routine prenatal blood test for Rubella (German measles) susceptibility and if yes, check: <input type="checkbox"/> Immune <input type="checkbox"/> Susceptible (not immune)	_____
<input type="checkbox"/>	<input type="checkbox"/>	9. Have any other medical condition not mentioned?	_____

FAMILY HISTORY

YES	NO	DO YOU...	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	10. Are you 34 years old or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	11. Is your husband/partner 55 years old or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	12. Are you and your husband/partner blood relatives (e.g. cousins)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	13. Are you and your husband/partner of <input type="checkbox"/> Jewish, <input type="checkbox"/> Black, <input type="checkbox"/> Mediterranean descent?	_____
<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had a stillbirth or miscarriage?	_____

DO YOU OR YOUR HUSBAND / PARTNER...

<input type="checkbox"/>	<input type="checkbox"/>	15. Have any birth defects, handicapping condition, or disorder that may be hereditary?	_____
<input type="checkbox"/>	<input type="checkbox"/>	16. Have any previous children with birth defects, handicaps, or genetic diseases?	_____
<input type="checkbox"/>	<input type="checkbox"/>	17. Have any children who died (other than an accident)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	18. Have any relatives who have had a stillborn infant or multiple miscarriages?	_____
<input type="checkbox"/>	<input type="checkbox"/>	19. Have a brother, sister or parent with a handicap, birth defects, or genetic diseases?	_____
<input type="checkbox"/>	<input type="checkbox"/>	20. Have uncles, cousins, nieces, nephews, grandparents, or grandchildren with birth defects or genetic diseases?	_____
<input type="checkbox"/>	<input type="checkbox"/>	21. Know any family member with mental retardation (even mild) or learning disabilities?	_____

SOME EXAMPLES OF BIRTH DEFECTS AND GENTIC DISEASES THAT MIGHT BE IN YOUR FAMILY

(Please check any of the following that might be in your family)

- | | |
|---|---|
| <input type="checkbox"/> Anencephaly (open skull) | <input type="checkbox"/> Malformations or birth defects |
| <input type="checkbox"/> Blindness or eye problem | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Bone disorder | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Chromosome abnormality | <input type="checkbox"/> Neurologic or degenerative disorder |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Short stature (under 5 ft.) |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Down syndrome (mongolism) | <input type="checkbox"/> Skeletal problems (like easily broken bones or curvature of the spine) |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Skin disease (including dark or light patches of skin) |
| <input type="checkbox"/> Heart defect | <input type="checkbox"/> Spina bifida (open spine) |
| <input type="checkbox"/> Hemophilia (bleeding tendency) | <input type="checkbox"/> Tay-Sachs disease |
| <input type="checkbox"/> Hydrocephalus (water on the brain) | <input type="checkbox"/> Urinary tract abnormality |
| <input type="checkbox"/> Limb defects | |
| <input type="checkbox"/> Other _____ | |

MEDICATION / DRUG EXPOSURES

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. Do you take any prescription drugs or over-the-counter medications?
If you are pregnant, have you taken any medications since your last period? |

Examples: Please check those you have taken during this pregnancy.

- | | |
|---|--|
| <input type="checkbox"/> Accutane or other dermatologic or acne medications | <input type="checkbox"/> Male hormones |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Medications for epilepsy (seizures) |
| <input type="checkbox"/> Anticoagulants (blood thinners to prevent blood clots) | <input type="checkbox"/> Multi-vitamins |
| <input type="checkbox"/> Antithyroid drugs | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Chemotherapeutic drugs (anti-cancer drugs) | <input type="checkbox"/> Vitamin A supplements |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Other high dose vitamins |
| <input type="checkbox"/> Female hormones | <input type="checkbox"/> Other _____ |

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you had any illness or infection recently or do you have any chronic disease not covered on the other side? |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you had frequent or high fevers or do you take saunas or hot whirlpool baths? |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. Have you recently had x-rays or surgery or are you planning to do so soon? |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. Are you exposed to pesticides or potentially toxic chemicals at home or elsewhere? |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you been exposed to pesticides or potentially toxic chemicals at home or elsewhere? |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. Do you drink more than one glass of alcohol per week (including beer)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have a household cat or clean a cat litter box? |
| <input type="checkbox"/> | <input type="checkbox"/> | 30. Do you eat raw or very rare meat? |
| <input type="checkbox"/> | <input type="checkbox"/> | 31. Do you smoke? How many packs of cigarettes per day? |
| <input type="checkbox"/> | <input type="checkbox"/> | 32. Do you use any other drugs or medications not previously listed? |