AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

IMPORTANT:
Please complete this form and bring it with you to your scheduled visit.

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:
Part I: Contact information
Part II: Your medical history
Part III: Your male partner’s medical history (if applicable)

PART I: CONTACT INFORMATION

First Name __________________________  Middle Initial ___  Last Name __________________________  Age ______

Date of Birth (MM/DD/YY) _____/_____/___________  Occupation ___________________________

Home Street Address __________________________________________________________________

City ___________________  State_____  Zip/Postal Code_____________ Country _______________

Indicate which number to call or leave messages.
☐ Home Telephone ( )_______________  ☐ Work Telephone ( )_______________  ☐ Cell Phone ( )______________

Do you have a male partner?  ☐ Yes  ☐ No

Male Partner’s First Name ___________________  Middle Initial ___  Last Name __________________________  Age ______
☐ Not Applicable

Date of Birth (MM/DD/YY) _____/_____/___________  Occupation ___________________________

Home Street Address __________________________________________________________________

City ___________________  State_____  Zip/Postal Code_____________ Country _______________

Indicate which number to call or leave messages.
☐ Home Telephone ( )_______________  ☐ Work Telephone ( )_______________  ☐ Cell Phone ( )______________

By whom were you referred?
☐ Physician
Name __________________________________  Phone ( ) _____________
Address _________________________________________________________

☐ Former Patient/Friend___________________________________________________
☐ Web Site _____________________________________________________________
☐ Insurance (Name of Insurance)____________________________________________

Who is your Ob/Gyn?
Name ________________________________  Phone ( ) _____________
Address _________________________________________________________

Who is your Primary Care Physician?
Name ________________________________  Phone ( ) _____________
Address _________________________________________________________

FOR OFFICE USE ONLY

Physician Notes (for office use only)

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Page 1
PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit:  
- Infertility Evaluation
- Sperm Insemination
- Other

How many months have you been trying to conceive (unprotected intercourse or inseminations)? ____

Pregnancy Summary
- Total Number of ALL Pregnancies: _____
- Number of Full Term Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? ____
- Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? ____
- Number of Miscarriages (less than 20 weeks): _____
- Number of Ectopic/Tubal Pregnancies: _____
- Number of Elective Terminations (Abortions): _____
- Any Pregnancies with Birth Defects?  
  - No
  - Yes - explain _______________________________________________________

Menstrual History
- Menstrual cycle pattern (check all that 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
- 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
- How many periods do you have per year? _____
- Do you need medication to bring on a period?  
  - Yes
  - No
- 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?  
  - Yes: Always
  - Yes: Sometimes
  - Yes: Recently
  - Yes: In the past
  - No

Contraceptive History
- None
- Condoms - dates of use
- Diaphragm - dates of use
- IUD - dates of use
- Birth control pills - dates of use - complications?
- Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use - complications?
- Skin patch - dates of use - complications?
- Foams or Jellies
- Tubal sterilization procedure (tubes tied) - date (month/year)
- Tubes untied - date (month/year)

Did your mother take DES when she was pregnant with you?  
- Yes
- No
- Don’t know

Sexual History
- How many times do you have intercourse per week? _____ times per week
- Have you used over-the-counter ovulation kits to time intercourse?  
  - Yes
  - No
- Do you have pain with intercourse?  
  - Yes
  - No
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse?  
  - Yes
  - what type?
  - No

Any prior exposure to sexually transmitted diseases or pelvic infections?
- Yes (check all that apply)  
  - Chlamydia - date
  - Gonorrhea - date
  - Herpes - date
  - Genital warts/HPV - date
  - Syphilis - date
  - HIV/AIDS - date
  - Hepatitis - date

Physician Notes (for office use only)  
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
**Pap Smear History**
- When was your last pap smear (month and year)? /  
  - Normal  
  - Abnormal  
- When was your last abnormal pap smear?  
  - Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?  
- 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 self breast exams?  
  - Yes  
  - No

**Medical History**
- Are you allergic to any medications?  
  - Yes  
  - No  
  - Please list and describe reactions

- Are you allergic to any foods (peanuts, eggs, etc.)?  
  - Yes  
  - No  
  - 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?  
  - Yes  
  - No  
  - Please list

- Do you have any medical problem(s)?  
  - Yes  
  - No  
  - Please list type, dates, and treatments.

- Did you have either of these childhood illnesses?  
  - Chickenpox (Varicella)  
  - German Measles (Rubella)  
  - Don’t know

**Vaccinations**
- Chickenpox (Varicella):  
  - No  
  - Yes (dates)  
  - Don’t know
- MMR - Measles, Mumps, and Rubella (German Measles):
  - No  
  - Yes (dates)  
  - Don’t know
- BCG (Tuberculosis):
  - No  
  - Yes (dates)  
  - Don’t know
- Hepatitis B:
  - No  
  - Yes (dates)  
  - Don’t know
- Polio:
  - No  
  - Yes (dates)  
  - Don’t know
- Hepatitis A:
  - No  
  - Yes (dates)  
  - Don’t know
- Tetanus:
  - No  
  - Yes (dates)  
  - Don’t know
- Influenza:
  - No  
  - Yes (dates)  
  - 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 any marijuana, cocaine, or any other similar drug?  
  - No  
  - Yes (describe)
- Do you exercise?  
  - No  
  - Yes (describe)
- Are you aware of any radiation exposures other than X-rays?  
  - No  
  - Yes (describe)

**Physician Notes (for office use only)**

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**Surgical History**

- Have you had any surgeries? □ No   □ Yes (List all surgeries in chronologic order.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason and Type of Surgery</th>
</tr>
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<tbody>
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</tbody>
</table>

- Did you have any anesthesia problems? □ No   □ Yes (describe __________________________)  

**Physical Symptoms**

**General:**
- □ Recent weight gain or loss
- □ Anorexia/Bulimia
- □ Lack of energy
- □ Fever/Chills
- □ Other __________________________
- □ None

**Endocrine/Hormonal:**
- □ Diabetes  □ Hair loss
- □ Thyroid gland problems
- □ Rapid weight gain or loss
- □ Excessive hunger/thirst
- □ Temperature intolerance—hot flashes or feeling cold
- □ Other __________________________
- □ None

**Gastrointestinal:**
- □ Nausea/Vomiting  □ Ulcers
- □ Hepatitis  □ Diarrhea
- □ Blood in your stools  □ Constipation
- □ Irritable Bowel Syndrome
- □ Change in bowel habits
- □ Colitis (ulcerative or Crohn’s)
- □ Other __________________________
- □ None

**Musculoskeletal:**
- □ Unusual muscle weakness
- □ Decreased energy/stamina
- □ Rheumatoid arthritis
- □ Lupus Erythematosus
- □ Myasthenia gravis
- □ Other __________________________
- □ None

**Mental Health Problems:**
- □ Depression  □ Anxiety disorder
- □ Schizophrenia
- □ Other __________________________
- □ None

**Head, Eyes, Ears, Nose and Throat:**
- □ Dizziness  □ Loss of sense of smell
- □ Headaches  □ Chronic nasal congestion
- □ Blurred vision  □ Ringing ears
- □ Hearing loss/deafness
- □ Other __________________________
- □ None

**Breasts:**
- □ Discharge (clear?___ bloody?___ milky?___)
- □ Lumps  □ Pain  □ Cancer
- □ Abnormal mammogram
- □ Reduction
- □ Augmentation/Breast implants (saline?___ silicone?___)
- □ Other __________________________
- □ None

**Genito-Urinary:**
- □ Bladder infections
- □ Kidney infections
- □ Vaginal infections
- □ Frequent urination  □ Leaking urine
- □ Herpes
- □ Blood in the urine
- □ Other __________________________
- □ None

**Hematologic:**
- □ Blood clotting disorder/Blood clot
- □ Sickle cell Anemia  □ Thrombophlebitis
- □ Easy bruising
- □ Swollen glands/lymph nodes
- □ Blood transfusions (dates/reasons____________________)
- □ Other __________________________
- □ None

**Respiratory:**
- □ Shortness of breath
- □ Asthma  □ Bronchitis
- □ Pneumonia  □ Tuberculosis
- □ Bloody cough
- □ Other __________________________
- □ None

**Neurological Problems:**
- □ Weakness/Loss of balance
- □ Seizures/Epilepsy
- □ Headaches
- □ Migraine headaches
- □ Numbness
- □ Memory loss
- □ Other __________________________
- □ None

**Skin/Extremities:**
- □ Unexplained rash/inflammation
- □ Acne
- □ Skin cancer
- □ Burn injury
- □ Moles changing in appearance
- □ Excess hair growth
- □ Other __________________________
- □ None

**Cardiovascular:**
- □ Pulitations/Skipped beats
- □ Chest pain  □ Heart attack
- □ Stroke  □ Murmurs
- □ High blood pressure
- □ Rheumatic fever
- □ Mitral valve prolapse (Need antibiotics before dental procedures? Yes___ No___)
- □ Other __________________________
- □ None

**Physician Notes (for office use only) ________________________________________________
________________________________________________________________________________
________________________________________________________________________________
## Family History

<table>
<thead>
<tr>
<th>Relationship to You</th>
<th>Cause of Death/Age at Death</th>
<th>Living</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
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<tr>
<td>Paternal Grandmother</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td>Yes - age___</td>
<td>No</td>
</tr>
</tbody>
</table>

## Disorders in Your Family

<table>
<thead>
<tr>
<th>Relationship to You</th>
<th>Cause of Death/Age at Death</th>
<th>Living</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Colon cancer</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other cancer</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Thyroid problems</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood clots</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Obesity</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Psychiatric problems</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Endometriosis</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Infertility</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Menopause before age 40</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Birth defects</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Cystic Fibrosis</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Tay-Sachs disease</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Canavan disease</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Bloom syndrome</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Gaucher disease</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Niemann-Pick disease</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fanconi Anemia</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Familial Dysautonia</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Muscular Dystrophy</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Neurologic (brain/spine)</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Neural Tube Defects</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Bone/Skeletal Defects</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Dwarfism</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Developmental delay</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Learning problems</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Polycystic kidney disease</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Heart defect from birth</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Down syndrome</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other chromosome defects</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Marfan syndrome</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Hemophilia</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Sickle Cell Anemia</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Thalasemia</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Galactosemia</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Deafness/Blindness</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Color Blindness</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Hemochromatosis</td>
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<td>Yes</td>
<td>No</td>
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</tbody>
</table>

☐ None of the above  ☐ Other (Specify ___________________________)

## 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________________)
**PRIOR INFERTILITY TESTING AND TREATMENT**

- Have you had prior infertility testing or treatment elsewhere?  □ Yes  □ No

**Prior Tests** (check all that apply):
- □ Basal body temperature chart (date__/results______________________)
- □ 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______________________)

**Prior Treatment** (check all that apply):

<table>
<thead>
<tr>
<th>Procedure</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>Pregnant</th>
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</thead>
<tbody>
<tr>
<td>Intrauterine insemination:</td>
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<tr>
<td>Clomiphene citrate with timed intercourse:</td>
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<tr>
<td>Clomiphene citrate with insemination:</td>
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<tr>
<td>Daily fertility drug injections with insemination:</td>
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<tr>
<td>Completed in vitro fertilization cycle(s):</td>
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<td>Frozen embryo transfers:</td>
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<tr>
<td>Canceled in vitro fertilization attempt(s)</td>
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**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?  □ Yes  □ No
- Describe any emotional, marital, or sexual problems caused by your infertility. _________________________________________

__________________________
PATIENT’S SIGNATURE

__________________________
PHYSICIAN’S SIGNATURE

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I confirm that I have reviewed the information above.

__________________________
PHYSICIAN’S SIGNATURE

__________________________
PATIENT’S SIGNATURE
PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- 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
- Any prior exposure to sexually transmitted diseases or infections?
  □ Yes (check all that apply)  □ No
  □ Chlamydia - date_____ □ Gonorrhea - date_____ □ Herpes - date_____ □ Genital warts/HPV - date_____ □ Syphilis - date_____ □ HIV/AIDS - date_____ □ Hepatitis - 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___ □ Cancer - Yes___ No___ □ Multiple Sclerosis - Yes___ No___ □ Other neurologic problems - Yes___ No___ □ Prostatic infections - Yes___ No___ □ Urinary infections - Yes___ No___ □ High Blood Pressure - Yes___ No___ If yes, any medications?__________________________
- 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 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 problem(s):________________________________

- 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_____  □ Yes (describe__________________________)
- Do you use any marijuana, cocaine, or any other similar drug? □ No  □ Yes (describe__________________________)
- Do you use herbal medicines/vitamins or health food store supplements? □ No  □ Yes (describe__________________________)
- Are you aware of any radiation/toxic materials exposure? □ No  □ Yes
- Do you use hot tubs 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 Notes (for office use only)________________________________
  ____________________________________________________________
  ____________________________________________________________

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Disorders in Your Family

- Cystic Fibrosis
- Tay-Sachs disease
- Canavan disease
- Bloom syndrome
- Gaucher disease
- Niemann-Pick disease
- Fanconi Anemia
- Familial Dysautonia
- Muscular Dystrophy
- Neurologic (brain/spine)
- Neural Tube Defects
- Bone/Skeletal Defects
- Dwarfism
- Developmental delay
- Learning problems
- Polycystic kidney disease
- Heart defect from birth
- Down syndrome
- Other chromosome defects
- Marfan syndrome
- Hemophilia
- Sickle Cell Anemia
- Thalassemia
- Galactosemia
- Deafness/Blindness
- Color Blindness
- Hemochromatosis

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___________)

- None of the above
- Other (Specify _______________________________

**MALE PARTNER’S SIGNATURE_________________________ DATE________________________**

I confirm that I have reviewed the information above.

**PHYSICIAN’S SIGNATURE_________________________ DATE________________________**

**Physician Notes (for office use only) ___________________________________________**