GENETIC FAMILY HISTORY

Are you or your partner from any of these ethnic backgrounds? **(check all that apply)**

Chinese,Taiwanese, Asian, Indian, Pakistani, Filipino Southeast Asian	□ Patient	□ Partner
Italian,Greek, Middle Eastern, Spanish or Portuguese	□ Patient	□ Partner
Jewish, French Canadian or Cajun	□ Patient	□ Partner
African American, African descent, Black, Puerto Rican, Caribbean or Central America	□ Patient	□ Partner
Hispanic or Mexican	□ Patient	□ Partner
Caucasian	□ Patient	□ Partner
Other (specify)	□ Patient	□ Partner

Have you, your partner or anyone in your families ever had the following conditions:
(check all that apply)

Down Syndrome	□ Yes	□ No	Polycystic kidney disease	□ Yes	□ No
Other Chromosome problem	□ Yes	□ No	Huntington disease	□ Yes	□ No
Mental retardation or autism	□ Yes	□ No	Heart defect at birth	□ Yes	□ No
Spina Bifida (open spine)	□ Yes	□ No	Cleft lip/cleft palate	□ Yes	□ No
Anencephaly (opening in head/brain)	□ Yes	□ No	Blindness/deafness	□ Yes	□ No
Blood disorder,hemophilia,sickle cell	□ Yes	□ No	Baby died after birth Or 1st Year	□ Yes	□ No
Stillborn or 2 more pregnancy losses	□ Yes	□ No	Any birth defect not listed	□ Yes	□ No
Cystic Fibrosis	□ Yes	□ No	Neurofibromatosis	□ Yes	□ No
Muscular Dystrophy or neuromuscular disease	□ Yes	□ No			
Any other inherited (genetic) condition	□ Yes	□ No			
Skeletal disorder, like dwarfism	□ Yes	□ No			
Any other serious medical condition /surgery	□ Yes	□No			

Are you or your partner adopted?	□ Yes	□ No
Are you and your partner related to each other – other than by marriage?	□ Yes	□ No

Please specify the cause of infertility, if known____

Have you and/or your partner had carrier testing for cystic fibrosis?	□ Yes	□ No
Have you and/or your partner had carrier testing for any other genetic disorder?	□ Yes	□ No
Have you and/or your partner had blood chromosome testing?	□ Yes	□ No

Print Name:_______________________ Signature:__________________________

Date:_______________