PATIENT

DATE _____ **SPONSOR'S ID** _____

NAME _____ **DOB** _____ **CURRENT AGE** _____

ADDRESS _____ **CITY, STATE** _____ **ZIP** _____

PHONE HOME _____ CELL _____ WORK _____

EMAIL _____

PLEASE LIST ALL MEDICAL PROBLEMS YOU HAVE/HAD _____

ARE YOU CURRENTLY EMPLOYED OUTSIDE YOUR HOME No **IF YES, LIST OCCUPATION** _____

HAVE YOU HAD GENETIC COUNSELING PREVIOUSLY No **IF YES, WHERE AND WHEN** _____

PARTNER

NAME OF SPOUSE/ PARTNER _____ **DOB** _____ **AGE** _____

PHONE HOME _____ CELL _____ WORK _____

IS IT OK TO CONTACT HIM/HER WITH INFORMATION REGARDING YOUR CARE (i.e. TEST RESULTS) _ Yes _____

PLEASE LIST ALL MEDICAL PROBLEMS YOUR PARTNER HAS/HAD _____

IS HE/SHE CURRENTLY EMPLOYED OUTSIDE THE HOME Yes **IF YES, LIST OCCUPATION** _____

PREGNANCY

(CIRCLE ONE)
PRIMARY OB CARE AT Walter Reed Bethesda Other: _____

(INCLUDING CURRENT)
TOTAL PREGNANCIES _____ **MISCARRIAGES** _____ **STILLBIRTHS** _____ **ABORTIONS** _____ **LIVING CHILDREN** _____

(CIRCLE ALL THAT APPLY)
PREGNANT BY NATURAL CONCEPTION / IUI / IVF / ICSI / EGG DONOR **AGE AT DELIVERY** _____

IF IVF, EMBRYO TRANSFER DATE _____ **AGE OF EGG DONOR** (IF USED WITH IVF) _____

FIRST DAY OF LAST MENSTRUAL PERIOD _____ **DUE DATE** _____ **CURRENT WEIGHT** _____

TOBACCO AMOUNT & FREQUENCY _____ **ALCOHOL AMOUNT & FREQUENCY** _____

PLEASE LIST ALL MEDICATIONS USED WHILE PREGNANT _____

CONCERNS ABOUT EXPOSURES YOU HAVE HAD IN PREGNANCY _____

FAMILY HISTORY

PATIENT ANCESTRY / ETHNIC BACKGROUND _____

PATIENT FAMILY
FULL BROTHERS _____ #FULL SISTERS _____ ½ BROTHERS SAME DAD _____ ½ SISTERS SAME DAD _____ ½ BROTHERS SAME MOM _____ ½ SISTERS SAME MOM _____

PARTNER ANCESTRY / ETHNIC BACKGROUND _____

PARTNER FAMILY
FULL BROTHERS _____ #FULL SISTERS _____ ½ BROTHERS SAME DAD _____ ½ SISTERS SAME DAD _____ ½ BROTHERS SAME MOM _____ ½ SISTERS SAME MOM _____

HAVE YOU, YOUR PARTNER, OR ANYONE IN EITHER OF YOUR FAMILIES HAD ANY OF THE FOLLOWING; IF YES, PLEASE EXPLAIN:

CONGENITAL HEART DEFECT (REQUIRING SURGERY AT YOUNG AGE)	**NO**	**YES**	
CLEFT LIP AND / OR PALATE	**NO**	**YES**	
SPINA BIFIDA, ANENCEPHALY OR SIGNIFICANT SPINAL DEFECT	**NO**	**YES**	
OTHER BIRTH DEFECT (ABNORMAL DEVELOPMENT OF LIMB / BODY)	**NO**	**YES**	
MENTAL RETARDATION OR LEARNING PROBLEMS	**NO**	**YES**	
CHROMOSOME ABNORMALITY (DOWN SYNDROME, TRANSLOCATION)	**NO**	**YES**	
BLEEDING OR BLOOD CLOTTING DISORDER (HEMOPHILIA OR CLOT)	**NO**	**YES**	
CYSTIC FIBROSIS (CF) (LUNG DISEASE +/- DIGESTIVE PROBLEMS)	**NO**	**YES**	
NEUROLOGIC PROBLEMS (MUSCULAR DYSTROPHY / TREMOR)	**NO**	**YES**	
JEWISH, FRENCH CANADIAN OR FRENCH CAJUN ANCESTRY	**NO**	**YES**	
SICKLE CELL TRAIT / DISEASE OR THALASSEMIA (SEVERE ANEMIA)	**NO**	**YES**	
SEVERAL PREGNANCY LOSSES FOR SAME PERSON OR STILLBIRTH	**NO**	**YES**	
BABY THAT DIED AT BIRTH OR WITHIN A FEW DAYS OR MONTHS	**NO**	**YES**	
INFERTILITY / PROBLEMS BECOMING PREGNANT	**NO**	**YES**	
DEPRESSION, ANXIETY, OTHER PSYCHIATRIC CONDITION	**NO**	**YES**	
OTHER GENETIC CONDITION / DISEASE OR CONCERN	**NO**	**YES**	