Center for Reproductive Medicine • Advanced Reproductive Technologies

www.ivfminnesota.com

Recessive Disease Screening

Recessive conditions are conditions that result from two recessive genes being passed to a child - one from each asymptomatic parent – that cause a disease in that child. Current technological advances now make it possible to test for approximately **176** recessive conditions, each with its own severity, chance of inheritance, and sensitivity to screening. The total chance of having a child affected with one of these diseases is about 1/200, depending on the ethnicity of the parents.

The decision to screen for these diseases is a personal one and depends on each couple's philosophy and financial situation. In addition, there is a medical-legal dimension to this decision for CRM.

Because of the medical-legal issues involved we must ask you to declare your decision to screen or not to screen for these conditions prior to beginning your infertility treatment. The test involves a blood test on at least one of the partners. The blood test costs $350 and is not submitted to your insurance. There is about a **60%** chance that the test will show at least one recessive mutation in one of the partners.

If the test shows one partner to be a carrier of a recessive condition, the other partner would have the blood test for $350 to see if both partners are carriers of the same recessive condition.

If you are both carriers for the same condition (**about 2% Chance**), you would have the option of doing IVF with Preimplantation Genetic Diagnosis (PGD) where each embryo you make would be tested for the condition and only embryos without the condition transferred to your uterus. IVF with PGD costs approximately $25,000.

Or you could simply conceive and have the fetus tested early in the pregnancy. If the test was positive (1/4 chance), the pregnancy could be terminated or you could prepare for a baby with the inherited condition.

A third option would be to use donor sperm or donor eggs to avoid conceiving a child with the recessive condition.

Please make your recessive disease screening choice known below.

____I choose to be screened and to delay infertility treatment until my results are known.

____I choose to be screened but wish to begin infertility treatment before all results are known.

____I decline screening for recessive conditions.

___________________________________ ___________________________________ ____________

Patient Date

___________________________________ ___________________________________ ____________

Partner Date

2828 Chicago Avenue South #400
Minneapolis, MN 55407
p. 612.863.5390 f. 612.863.2697

991 Sibley Memorial Highway #100
Saint Paul, MN 55118
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New Patient Questionnaire

Name ________________________ DOB ____________ Age ________

Marital Status: ○ Single ○ Married ○ Partnered ○ Separated ○ Divorced ○ Remarried Occupation ______________

Home Address ____

Partner's name________________________ DOB__________ Age________Occupation______________

Partner Address ____

What is your travel time/distance to the Center for Reproductive Medicine?______________________

Phone # Home______________________ Work______________________ Cell______________________

Prior Physician History

Dates	MD	Clinic Address

Do you need a referral to come here? ○ Yes ○ No Referring Doctor:______________________

Do you want a letter sent to your referring physician? ○ Yes ○ No

Reason for today's visit? ○ Infertility ○ Recurrent Pregnancy Loss ○ Other______________

Are you interested in genetic screening? ○ Yes ○ No

When did you begin attempting pregnancy? Months: ______________________

Pregnancy History

Biochemical:______________ Ectopic:______________ Stillborn:______________

Term Pregnancy: ________ Preterm: ____________SAB: ____________ Living:____________

PAST PREGNANCIES (include miscarriages and abortions)

Date Mo/Yr	Weeks of Gestation At Delivery	Infertility Treatment	How Long to Conceive	Sex M/F	Type of Delivery	Current Partner	Live Birth	Comments/Complications
						Y / N	Y / N	
						Y / N	Y / N	
						Y / N	Y / N	
						Y / N	Y / N	
						Y / N	Y / N	

○ None

Surgical History (List all prior surgeries in chronological order)

Date	Procedure	Comments

PATIENT PAST MEDICAL HISTORY

	No	Yes		No	Yes
1. Hospitalizations	◯	◯	16. Genetic Abnormalities	◯	◯
2. Anesthesia Complications	◯	◯	17. Congenital Abnormalities	◯	◯
3. Diabetes	◯	◯	18. Bleeding disorder	◯	◯
4. Heart Disease (MVP) (Arrhythmias)	◯	◯	19. Clotting disorder	◯	◯
5. Autoimmune Disorder (Lupus)	◯	◯	20. Pulmonary Embolism	◯	◯
6. Kidney Disease	◯	◯	21. Hypertension	◯	◯
7. Neurological Disease	◯	◯	22. AIDS	◯	◯
8. Depression	◯	◯	23. Irritable Bowel Syndrome	◯	◯
9. Eating Disorder	◯	◯	24. Ulcerative Colitis	◯	◯
10. Hepatitis/Liver Disease	◯	◯	25. Crohns Disease	◯	◯
11. Thyroid Dysfunction	◯	◯	26. Chemotherapy	◯	◯
12. History of blood transfusions	◯	◯	27. Radiation Therapy	◯	◯
13. Pulmonary Disease (Asthma)	◯	◯	28. Seizures	◯	◯
14. Exposed to TB	◯	◯	29. Other	◯	◯
15. Cancer	◯	◯	30. Tubal /Pelvic Disease	◯	◯

Family History (include Parents, Siblings, Grandparents, Aunts, Uncles and Cousins)

	No	Yes	COMMENTS:
1. Infertility	◯	◯	
2. Recurrent Pregnancy Loss	◯	◯	
3. Genetic Abnormalities	◯	◯	
4. Birth Defects	◯	◯	
5. Bleeding or Clotting Disorders	◯	◯	
6. Mental Retardation	◯	◯	
7. Prior Genetic Testing	◯	◯	
8. Breast Cancer	◯	◯	
9. Ovarian Cancer	◯	◯	
10. Cystic Fibrosis	◯	◯	
11. Other	◯	◯	

Ancestry

◯ African-American	◯ Caucasian	◯ Pacific Islander
◯ American Indian/Native American	◯ Eastern European	◯ Unknown / Not Observed
◯ Ashkenazi Jewish	◯ Hispanic/Caribbean	◯ Refused
◯ Asian	◯ Northern European	
◯ Cajun/French Canadian	◯ Southern European	
◯ Other	◯ Native Hawaiian	

Social History

	No	Yes	COMMENTS:		
1. Exposure to chemicals	◯	◯	List:		
2. Smoking	◯	◯	How many packs per day?	For how many years?	Quit?
3. Alcohol	◯	◯	How much?		
4. Recreational Drugs	◯	◯			
5. Chemical Dependency	◯	◯	When Treatment?		
6. Caffeine	◯	◯	How much?		
7. Exercise Regularly	◯	◯	Type?	Frequency?	
8. Recent Piercing	◯	◯			
9. Recent Tattoo	◯	◯			

CURRENT MEDICATIONS

Name	Dose

ALLERGIES

- ◯ None
- ◯ Drug
- ◯ Food
- ◯ Environmental
- ◯ Latex
- ◯ Iodine
- ◯ Shell Fish
- ◯ Other________________

Menstrual History

Age at first period: __________ Interval between periods:__________Length of flow:__________ ◯ Regular ◯ Irregular

First day of last period:__________ Height:__________ Weight:__________ Lubricant Use: ◯ No ◯ Yes__________

Have you ever used any of the following birth control: ◯ Pill ◯ Depo Provera ◯ Implants ◯ IUD ◯ Tubal Ligation ◯ Vasectomy

GYN Review of Systems

	No	Yes	COMMENTS:
1. Bleeding between periods	◯	◯	
2. Bleeding after intercourse	◯	◯	
3. Unusually heavy periods	◯	◯	
4. Significant pain with periods	◯	◯	
5. Abnormal hair growth	◯	◯	
6. Breast Discharge	◯	◯	
7. Hot flashes	◯	◯	
8. Pelvic pain	◯	◯	
9. Significant weight change	◯	◯	

GYN History

	No	Yes	COMMENTS:
1. DES exposure	◯	◯	
2. Ovarian cyst	◯	◯	
3. Uterine Fibroid	◯	◯	
4. Uterine Polyp	◯	◯	
5. Uterine malformation	◯	◯	
6. Pelvic surgery	◯	◯	
7. Cervical surgery	◯	◯	
8. PID (Pelvic Inflammatory Disease)	◯	◯	
9. Condyloma (HPV)	◯	◯	
10. STD (GC, Chlamydia, Syphilis)	◯	◯	
11. Herpes virus	◯	◯	
12. Ectopic pregnancy	◯	◯	
13. Pelvic adhesions	◯	◯	
14. Endometriosis	◯	◯	
15. Tubal blockage	◯	◯	
16. Other	◯	◯	

MALE PARTNER INFORMATION

Name: ______________________________ Age: ______________

Do you need a separate referral to come here? ○ No ○ Yes

Have you seen an Urologist for evaluation? ○ No ○ Yes When: ______________

Physician name: ______________________________

Have you ever fathered any prior pregnancies? ○ No ○ Yes

Outcome: ______________________________

Are you interested in genetic screening? ○ No ○ Yes

Review of Systems

	No	Yes	COMMENTS:
Testicular swelling	○	○	
Testicular pain	○	○	
Difficulty with vaginal penetration	○	○	
Inability to obtain an erection	○	○	
Inability to maintain an erection	○	○	
Problems with ejaculation	○	○	

Urologic History

	No	Yes	COMMENTS:
1. Undescended testicle	○	○	
2. Prostate infection	○	○	
3. Varicocele	○	○	
4. Vasectomy	○	○	
5. Sperm Antibodies	○	○	
6. Congenital abnormalities	○	○	
7. Genetic abnormalities	○	○	
8. Sexually transmitted disease	○	○	
9. Testicular abnormalities	○	○	
10. Spinal injury	○	○	
11. Other medical problems	○	○	

Surgical History (List all prior surgeries in chronological order)

Date	Procedure None ○	Comments

Medications (List current medications)

Name of Medication None ○	Dose

MALE PARTNER INFORMATION

Allergies (List allergies to medication or environmental allergies)

Type of Allergy	None ○	Reaction

Past Medical History (List illnesses or hospitalizations)

○ None

1. ____________________
2. ____________________
3. ____________________

Social History

	No	Yes	COMMENTS:
1. Exposure to chemicals	○	○	List:
2. Smoking	○	○	How many packs per day? For how many years? Quit?
3. Alcohol	○	○	How Much?
4. Recreational drugs	○	○	
5. Chemical Dependency	○	○	When Treatment?
6. Excess heat exposure	○	○	
7. Recent Piercing	○	○	
8. Recent Tattoo	○	○	

Male Partner's Family History (Include parents, siblings, grandparents, aunts, uncles & cousins)

	No	Yes	COMMENTS:
1. Infertility	○	○	
2. Recurrent Pregnancy Loss	○	○	
3. Genetic Abnormalities	○	○	
4. Birth Defects	○	○	
5. Mental Retardation	○	○	
6. Prior Genetic Testing	○	○	
7. Cystic Fibrosis	○	○	
8. Bleeding or Clotting Disorder	○	○	
9. Other	○	○	

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PRIOR INFERTILITY TESTING AND TREATMENT ☐ Yes ☐ No

Test	Date	Result
AMH		
TSH		
PRL		
Estradiol		
FSH		
LH		
Hysterosalpingogram (HSG)		
Saline Infusion Sonogram (SIS)		
Hysteroscopy		
Laparoscopy		
Semen Analysis		

Treatment	✓	# of cycles	Please list dates of treatment	Dosage	Outcome
Only IUI					
Clomiphene (Clomid)					
Letrozole (Femara)					
Ovulation induction with injectable fertility medicine (Menopur, Repronex, Gonal - F, Follistim)					
In Vitro Fertilization (IVF)					
Frozen Embryo Transfer (FET)					

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