Patient's name: _____ Partner's name: _____

Patient's DOB: _____ Partner's DOB: _____

Do you (male partner) have a personal or family history of any of the following?

When considering family members, please include your children, brothers, sisters, parents, aunts, uncles, cousins, and grandparents.

***Please inform your genetic counselor/physician if you/your partner are adopted or if you are pregnant and a sperm/ovum donor was used to conceive the pregnancy**

Personal/Family History of:	No	Yes (please specify)
Down syndrome or other chromosomal abnormality		
Intellectual disability, severe developmental delay, or Autism		
Fragile X syndrome		
Congenital spine or brain defect		
Congenital heart defect		
Congenital kidney defect		
Blindness and/or deafness		
Cleft lip and/or cleft palate		
Other serious birth defect(s)		
Significant family history of common conditions such as cancer or heart disease [i.e., people who were diagnosed at a young (<40) age or multiple affected family members]		
Bleeding disorders (such as hemophilia)		
Inherited forms of anemia (such as sickle cell or Mediterranean/Cooley's anemia)		
Skeletal abnormalities/Dwarfism		
Neurological disorders such as Huntington disease		
Other genetic disease(s) such as cystic fibrosis or muscular dystrophy		
Multiple miscarriages		
Stillbirth or infant/child death		
Are you related to your partner/spouse other than through marriage?		

***What is your ethnicity/country(ies) of origin? _____

Signature: _____ **Date:** _____ **GC reviewed:** _____