Human Genetics Division

Reproductive Genetics Intake Form

Weill Cornell Medical College

NewYork-Presbyterian
Phyllis and David Komansky
Center for Children's Health

Department of Pediatrics
Division of Human Genetics

505 East 70th Street, 3rd Floor, Box 128
New York, NY 10065
Telephone: 646-962-2205
Fax: 646-962-0273

Patient Demographic Information:

Patient Name:_____ DOB:_____

Contact Number:_____ home phone/ mobile

Partner's name (if applicable)_____ DOB:_____

Referring Physician Information:

Name:_____ Phone:_____

Address:_____ Fax:_____

_____

Pregnancy Related Information (if applicable):

Pregnancy conceived (circle one): naturally by IUI by IVF/ICSI

Pregnancy due date (EDD):_____ by LMP / Ultrasound (circle one)

Date of CVS/amniocentesis procedure (if applicable):_____

Medications Prescribed/ in use:_____

Exposures (circle if applicable): infection / cigarette / alcohol / illicit drug(s) / other:_____

Reproductive History:

Total number of previous pregnancies:_____

Please complete if applicable:

No. of miscarriages:_____ No. of terminations:____ No. of stillbirths/infant deaths: ____

If genetic testing/autopsy completed in previous pregnancy, what were the results:_____

Please use this space to specify any specific concerns you may have or additional relevant information (i.e. known carrier status for a condition, etc):_____

_____