

# MicroSort

Division of the Genetics & IVF Institute

## Medical History Form

Date completed \_\_\_\_\_

*Please complete all sections of this questionnaire to the best of your ability. Your confidential answers will be reviewed by a clinician and will help to give you the best possible care. Mail or fax (703-995-4928) the completed form to MicroSort, 3015 Williams Dr., Suite 101, Fairfax, VA 22031.*

What is the primary reason for your consultation (circle)? **Family Balancing**, **Genetic Disease Prevention** or **Other** (list) \_\_\_\_\_

Desired Gender: Female [ ] Male [ ]

Please list other physicians or practices that you have consulted. \_\_\_\_\_

Comments: \_\_\_\_\_

(To be completed by **both** partners)

### Wife

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(date of birth) (age)

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Tel #: \_\_\_\_\_

Phone (day) \_\_\_\_\_

(eve) \_\_\_\_\_

(cellular) \_\_\_\_\_

(e-mail) \_\_\_\_\_

(voice mail) \_\_\_\_\_

(pager) \_\_\_\_\_

(FAX) \_\_\_\_\_

### Primary Care Physician or GYN

Print Name \_\_\_\_\_

(address) \_\_\_\_\_

(city) \_\_\_\_\_

(state, zip code) \_\_\_\_\_

(phone) \_\_\_\_\_

(FAX) \_\_\_\_\_

(medical specialty) \_\_\_\_\_

### Husband

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(date of birth) (age)

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Tel #: \_\_\_\_\_

(day) \_\_\_\_\_

(eve) \_\_\_\_\_

(cellular) \_\_\_\_\_

(e-mail) \_\_\_\_\_

(voice mail) \_\_\_\_\_

(pager) \_\_\_\_\_

(FAX) \_\_\_\_\_

### Primary Care Physician

Print Name \_\_\_\_\_

(address) \_\_\_\_\_

(city) \_\_\_\_\_

(state, zip code) \_\_\_\_\_

(phone) \_\_\_\_\_

(FAX) \_\_\_\_\_

(medical specialty) \_\_\_\_\_

Who should we send a summary letter to? [ ] Primary Care Physician [ ] OB/GYN

**Date of Marriage:** \_\_\_\_\_

|                                 |              |             |                |
|---------------------------------|--------------|-------------|----------------|
| <b>Contraceptive practices:</b> | <b>(yes)</b> | <b>(no)</b> | <b>(dates)</b> |
| Condoms/Diaphragm               | _____        | _____       | _____          |
| Depo-Provera                    | _____        | _____       | _____          |
| Norplant                        | _____        | _____       | _____          |
| Intrauterine device (IUD)       | _____        | _____       | _____          |
| Oral contraceptives             | _____        | _____       | _____          |
| Rhythm/withdrawal               | _____        | _____       | _____          |
| Other methods                   | _____        | _____       | _____          |

**Pregnancies (Wife):**

| Pregnancy (include all pregnancies) | When? (Year) | How long to conceive? | Gender | Is current husband the father? (Yes/No) | Health of Child | Outcome (miscarriage, termination, ectopic, vaginal delivery, Cesarean section, or stillbirth) | Complications (high blood pressure, eclampsia, preeclampsia, diabetes, small for dates, placenta previa, infection, excessive blood loss, preterm labor, premature membrane rupture, early or late delivery, transfusion, Rh sensitization, multiples, etc.) |
|-------------------------------------|--------------|-----------------------|--------|---|-----------------|--|--|
| First                               |              |                       |        |   |                 |  |  |
| Second                              |              |                       |        |   |                 |  |  |
| Third                               |              |                       |        |   |                 |  |  |
| Fourth                              |              |                       |        |   |                 |  |  |
| Fifth                               |              |                       |        |   |                 |  |  |

**Husband:** Pregnancies from previous marriage(s) or partner(s), if any

| Pregnancy (include all) | When? (Year) | How long to conceive? | Gender | Date of Birth | Health of Child | Outcome (miscarriage, termination, ectopic, vaginal delivery, Cesarean section, or stillbirth) and list complications, if any |
|-------------------------|--------------|-----------------------|--------|---------------|-----------------|---|
| First                   |              |                       |        |               |                 |   |
| Second                  |              |                       |        |               |                 |   |
| Third                   |              |                       |        |               |                 |   |

**Husband and Wife:** All Adopted Children

| Adopted Children | Gender of Child | Date of Birth of Child | Health of Child |
|------------------|-----------------|------------------------|-----------------|
| First            |                 |                        |                 |
| Second           |                 |                        |                 |

# Male History

## Erectile function difficulties:

(yes)

(no)

collecting semen for testing

\_\_\_\_\_

\_\_\_\_\_

## Growth and development:

undescended testicles

\_\_\_\_\_

\_\_\_\_\_

delayed puberty

\_\_\_\_\_

\_\_\_\_\_

breast enlargement

\_\_\_\_\_

\_\_\_\_\_

## Testicular injury:

(date)

torsion (twisted)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

painful swelling

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

severe trauma

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Toxicant exposure:

alcohol

\_\_\_\_\_ drinks/week

\_\_\_\_\_

\_\_\_\_\_

recreation drugs

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

smoking

\_\_\_\_\_ packs/day

\_\_\_\_\_

\_\_\_\_\_

pesticides

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

other chemicals

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

radiation

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Varicocele:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Sexually transmitted infections:

chlamydia

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

genital warts (HPV)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

gonorrhea

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

herpes

\_\_\_\_\_ episodes/year

\_\_\_\_\_

\_\_\_\_\_

HIV

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

syphilis

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Urinary tract infections:

bladder infection

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

kidney infection

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

prostatitis

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Recent high fever:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Hot tub use:

\_\_\_\_\_ times/week

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Male History (cont.)**

**List all medication you take now (prescription, vitamin and over the counter preparations):**

(drug)

(date)

(dose)

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**List all allergic reactions you have had:**

(drug or allergen)

(date)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**List all surgery you have had:**

(type of surgery)

(date)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**List all other serious illnesses for which you have been under the care of a physician:**

(illness)

(date)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**List all blood transfusions you have had:**

(number of units)

(date)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

# Male Family History

**Country of origin:** Mother \_\_\_\_\_ Father \_\_\_\_\_

**Ethnic background (circle):** African-American Asian Asian-Indian Caucasian Hispanic Jewish American-Indian  
Mediterranean Middle East Other \_\_\_\_\_

| <b>Ethnic group</b><br>(Check all that apply) | <b>Have you been tested for?</b> | <b>Yes</b> | <b>No</b> | <b>Date</b> | <b>Result</b> |
|---|----------------------------------|------------|-----------|-------------|---------------|
| African, African/American                     | sickle cell trait                |            |           |             |               |
| Asian, Mediterranean or Hispanic              | thalassemia                      |            |           |             |               |
| Caucasian, Jewish                             | cystic fibrosis                  |            |           |             |               |
| Jewish  | Tay Sachs                        |            |           |             |               |
| Jewish  | Canavan                          |            |           |             |               |
| Jewish  | Gaucher                          |            |           |             |               |

**Are you related to your current partner (consanguinity)?** \_\_\_\_\_

**Is there anyone in the family who has had any of the following illnesses?**

|                        | <b>Yes</b> | <b>Relationship</b> |                               | <b>Yes</b> | <b>Relationship</b> |
|------------------------|------------|---------------------|-------------------------------|------------|---------------------|
| abnormal breasts       |            |                     | learning problems             |            |                     |
| abnormal genitals      |            |                     | mental retardation            |            |                     |
| birth defects          |            |                     | metabolic disorder            |            |                     |
| chromosomal disorders  |            |                     | miscarriages (2 or more)      |            |                     |
| delayed development    |            |                     | short stature                 |            |                     |
| early puberty          |            |                     | testicular cancer             |            |                     |
| hormone disorders      |            |                     | undescended testicles         |            |                     |
| pituitary tumor        |            |                     | infertility                   |            |                     |
| lack of sense of smell |            |                     | genetic (inherited) disorders |            |                     |

Comments: \_\_\_\_\_

\_\_\_\_\_

# Female History

## Menstrual History

Age at first menstrual period \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_

# of days from the beginning of one period to the beginning of the next: average \_\_\_\_ shortest \_\_\_\_ longest \_\_\_\_

If your cycles are irregular, how many cycles do you usually have in a year? \_\_\_\_\_

Average duration of your menstrual flow (days)? \_\_\_\_\_

|                              |            |          |              |
|------------------------------|------------|----------|--------------|
|                              | Mild/Light | Moderate | Severe/Heavy |
| Severity of menstrual cramps | _____      | _____    | _____        |

|                          |       |       |       |
|--------------------------|-------|-------|-------|
| Amount of menstrual flow | _____ | _____ | _____ |
|--------------------------|-------|-------|-------|

|                              |            |              |                 |
|------------------------------|------------|--------------|-----------------|
| Medication taken for cramps: | drug _____ | amount _____ | frequency _____ |
|------------------------------|------------|--------------|-----------------|

|                       |       |       |
|-----------------------|-------|-------|
| Do you have midcycle: | (yes) | (no)  |
| spotting              | _____ | _____ |
| pain                  | _____ | _____ |
| cervical mucus        | _____ | _____ |

|   |       |       |
|---|-------|-------|
| Does the cramping or bleeding prevent you from: | (yes) | (no)  |
| going to work                                   | _____ | _____ |
| participating in fun activities                 | _____ | _____ |

When was your last Pap smear? \_\_\_\_\_ Result \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_ Result \_\_\_\_\_

### Do you have or have you ever had (check all that apply):

|                              |                             |                         |                              |
|------------------------------|-----------------------------|-------------------------|------------------------------|
| <b>Infectious Problems</b>   |                             | <b>Medical Problems</b> |                              |
| positive HIV test            | contact with cats or mice   | anemia                  | kidney disease               |
| chicken pox (varicella)      | chlamydia                   | bleeding disorders      | kidney infection             |
| chicken pox immunization     | gonorrhea                   | blood clots             | liver problems               |
| hepatitis A, B or C          | syphilis (RPR)              | blood transfusion       | lost 15 lbs last year        |
| hepatitis A vaccination      | pelvic infection (PID)      | diabetes                | gained 15 lbs last year      |
| hepatitis B vaccination      | nongonococcal urethritis    | cancer                  | lung disease                 |
| German measles (rubella)     | condyloma (venereal warts)  | appendicitis            | asthma                       |
| Rubella immunization         | herpes: genital             | heart disease           | recurrent urinary infections |
| rheumatic fever              | herpes: oral                | high blood pressure     | thyroid problems             |
| chronic bronchitis           | trichomoniasis              | mitral valve prolapse   | arthritis                    |
|                              |                             |                         |                              |
| <b>Neurological Problems</b> | <b>Gynecologic Problems</b> |                         |                              |
| severe headaches             | abnormal mammogram          | endometriosis           | breast discharge             |
| seizures (epilepsy)          | abnormal pap smear          | uterine anomalies       | excess hair growth           |
|                              | blocked fallopian tubes     | cervical stenosis       | hot flashes or night sweats  |
|                              | pelvic adhesions            | DES exposure            | Rh sensitized                |

Comments: \_\_\_\_\_

**Female History (cont.)**

Weight \_\_\_\_\_ Height \_\_\_\_\_

Particular food diet or any special dietary habits? \_\_\_\_\_

How much do you exercise? \_\_\_\_\_

| <b>Toxicant exposure:</b> | (yes)             | (no)  | (date last exposed) |
|---------------------------|-------------------|-------|---------------------|
| alcohol                   | _____ drinks/week | _____ | _____               |
| recreation drugs          | _____             | _____ | _____               |
| smoking                   | _____ packs/day   | _____ | _____               |
| pesticides                | _____             | _____ | _____               |
| other chemicals           | _____             | _____ | _____               |
| radiation                 | _____             | _____ | _____               |

**List all medication you take now (prescription, vitamins and over the counter preparations):**

| (drug) | (date) | (dose) |
|--------|--------|--------|
| _____  | _____  | _____  |
| _____  | _____  | _____  |
| _____  | _____  | _____  |
| _____  | _____  | _____  |

Are you taking prenatal vitamins? \_\_\_\_\_

**List all allergic reactions you have had:**

| (drug or allergen) | (date) |
|--------------------|--------|
| _____              | _____  |
| _____              | _____  |

Are you allergic to egg yolk? \_\_\_\_\_

Do you have a known allergy to Hoechst 33342 dye? Yes [ ] No [ ]

**List all surgery you have had (cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.):**

| (type of surgery) | (date) |
|-------------------|--------|
| _____             | _____  |
| _____             | _____  |
| _____             | _____  |
| _____             | _____  |

**List all other serious illnesses for which you have been under the care of a physician:**

| (illness) | (date) |
|-----------|--------|
| _____     | _____  |
| _____     | _____  |

# Family History of Female

Country of origin: Mother \_\_\_\_\_ Father \_\_\_\_\_

Ethnic background (circle): African/American Asian Asian Indian Caucasian Hispanic Jewish Indian Mediterranean Middle East Other \_\_\_\_\_

| Ethnic group<br>(Check all that apply) | Have you been tested for? | Yes | No | Date | Result |
|--|---------------------------|-----|----|------|--------|
| African, African/American              | sickle cell trait         |     |    |      |        |
| Asian, Mediterranean or Hispanic       | thalassemia               |     |    |      |        |
| Caucasian, Jewish                      | cystic fibrosis           |     |    |      |        |
| Jewish                                 | Tay Sachs                 |     |    |      |        |
| Jewish                                 | Canavan                   |     |    |      |        |
| Jewish                                 | Gaucher                   |     |    |      |        |

Are you related to your current partner (consanguinity)? \_\_\_\_\_

Is there anyone in the family who has had any of the following illnesses?

|                       | Yes | Relationship |                           | Yes | Relationship |
|-----------------------|-----|--------------|---------------------------|-----|--------------|
| abnormal genitals     |     |              | learning problems         |     |              |
| birth defects         |     |              | mental retardation        |     |              |
| bleeding disorders    |     |              | early menopause <age 40   |     |              |
| breast cancer         |     |              | metabolic disorder        |     |              |
| chromosomal disorders |     |              | ovarian cancer            |     |              |
| delayed development   |     |              | pituitary tumor           |     |              |
| early puberty         |     |              | hormone disorders         |     |              |
| endometriosis         |     |              | 2 or more miscarriages    |     |              |
| excess body hair      |     |              | other inherited disorders |     |              |
| infertility           |     |              |                           |     |              |

Comments: \_\_\_\_\_

To assist us in reviewing and interpreting any prior tests, please complete this section to the best of your ability. Pertinent records should also be obtained so the results can be confirmed.

| <b>Previous female fertility tests:</b> | (result) | (date) |
|---|----------|--------|
| basal body temperature                  | _____    | _____  |
| ovulation predictor kits                | _____    | _____  |
| endometrial biopsy                      | _____    | _____  |
| post-coital test                        | _____    | _____  |
| HSG                                     | _____    | _____  |
| hysterosonogram                         | _____    | _____  |
| hysteroscopy                            | _____    | _____  |
| laparoscopy                             | _____    | _____  |
| ultrasound, pelvic                      | _____    | _____  |
| other                                   | _____    | _____  |

| <b>Previous male fertility tests:</b> | (result)                                   | (date) |
|---------------------------------------|--|--------|
| semen analysis                        | conc _____ motility _____ morphology _____ | _____  |
|                                       | conc _____ motility _____ morphology _____ | _____  |
|                                       | conc _____ motility _____ morphology _____ | _____  |
| post-coital test                      | _____                                      | _____  |
| antisperm antibodies (semen)          | _____                                      | _____  |
| antisperm antibodies (serum)          | _____                                      | _____  |
| other                                 | _____                                      | _____  |

| <b>Previous hormonal tests:</b> | <u>Male</u> |       | <u>Female</u> |       |
|---------------------------------|-------------|-------|---------------|-------|
|                                 | Result      | Date  | Result        | Date  |
| testosterone                    | _____       | _____ | _____         | _____ |
| prolactin                       | _____       | _____ | _____         | _____ |
| TSH                             | _____       | _____ | _____         | _____ |
| FSH (random)                    | _____       | _____ | _____         | _____ |
| FSH (day 3)                     | _____       | _____ | _____         | _____ |
| FSH (day 10)                    | _____       | _____ | _____         | _____ |
| progesterone                    | _____       | _____ | _____         | _____ |
| DHEAS                           | _____       | _____ | _____         | _____ |

**Infectious disease**

**Male**

**Female**

|                             | Result | Date  | Result | Date  |
|-----------------------------|--------|-------|--------|-------|
| HIV-1                       | _____  | _____ | _____  | _____ |
| hepatitis B surface Antigen | _____  | _____ | _____  | _____ |
| rubella IgG                 | _____  | _____ | _____  | _____ |
| varicella IgG (Chicken Pox) | _____  | _____ | _____  | _____ |
| toxoplasmosis IgG           | _____  | _____ | _____  | _____ |

**Medical screening tests:**

|                             |       |       |       |       |
|-----------------------------|-------|-------|-------|-------|
| blood group and Rh          | _____ | _____ | _____ | _____ |
| CBC                         | _____ | _____ | _____ | _____ |
| chemistry panel             | _____ | _____ | _____ | _____ |
| chest x-ray (CXR)           | _____ | _____ | _____ | _____ |
| cholesterol (lipid profile) | _____ | _____ | _____ | _____ |
| EKG                         | _____ | _____ | _____ | _____ |
| fasting glucose             | _____ | _____ | _____ | _____ |
| PT/PTT                      | _____ | _____ | _____ | _____ |
| urinalysis                  | _____ | _____ | _____ | _____ |

**Previous fertility treatments:**

|                       | (yes) | (no)  | # cycles | Comments |
|-----------------------|-------|-------|----------|----------|
| clomiphene            | _____ | _____ | _____    | _____    |
| dopamine agonist*     | _____ | _____ | _____    | _____    |
| glucocorticoids (Dex) | _____ | _____ | _____    | _____    |
| insemination (IUI)    | _____ | _____ | _____    | _____    |
| clomiphene and IUI    | _____ | _____ | _____    | _____    |
| FSH and IUI           | _____ | _____ | _____    | _____    |
| IVF or ICSI           | _____ | _____ | _____    | _____    |
| other:                | _____ | _____ | _____    | _____    |
| Comments:             | _____ |       |          |          |

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\* dopamine agonist - bromocriptine (Parlodel), pergolide mesylate (Permax), cabergoline (Dostinex)

\*\* FSH - Pergonal, Humegon, Repronex, Metrodin, Fertinex, Gonal-F, and/or Follistim

# INFECTIOUS DISEASE RISK QUESTIONNAIRE

## ***HUSBAND:***

**PLEASE ANSWER THE FOLLOWING QUESTIONS (circle yes or no):**

Have you ever been refused as a blood donor? Yes      No  
If yes, why? \_\_\_\_\_

Have you ever been tested for AIDS? Yes      No  
If yes, why? \_\_\_\_\_

Have you ever received Pituitary-derived Human Growth Hormone? Yes      No  
If yes, what year? \_\_\_\_\_

Have you ever had Creutzfeldt-Jacob disease? Yes      No

### **In the last 12 months, have you**

Had a blood transfusion? Yes      No

Had a tattoo? Yes      No

Had your body pierced? Yes      No

Received non-viral inactivated Factor VIII or Factor IX concentrate? Yes      No

Been exposed to known or suspected HIV-infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane? Yes      No

Had Hepatitis B or C? Yes      No  
If yes, which one? \_\_\_\_\_ When? \_\_\_\_\_

### **Sexual History:**

#### **In the last 12 months, have you had sex with**

A person other than your current spouse? Yes      No  
If yes, vaginal, anal, and/or oral? \_\_\_\_\_

A person having non-medical intravenous, intramuscular, or subcutaneous injections of drugs? Yes      No

A person having engaged in sex in exchange for money or drugs? Yes      No

A person that has been diagnosed as positive for the HIV virus? Yes      No

A person who has had sex with another partner described in any of the above? Yes      No

**I certify that the information contained in this questionnaire, to the best of my knowledge, is true and complete.**

**Husband NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

---

### ***FOR CLINICAL USE ONLY:***

LR      HR

S      NS

12M      1M

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# INFECTIOUS DISEASE RISK QUESTIONNAIRE

## ***WIFE:***

**PLEASE ANSWER THE FOLLOWING QUESTIONS (circle yes or no):**

Have you ever been refused as a blood donor? Yes      No  
If yes, why? \_\_\_\_\_

Have you ever been tested for AIDS? Yes      No  
If yes, why? \_\_\_\_\_

Have you ever received Pituitary-derived Human Growth Hormone? Yes      No  
If yes, what year? \_\_\_\_\_

Have you ever had Creutzfeldt-Jacob disease? Yes      No

### **In the last 12 months, have you**

Had a blood transfusion? Yes      No

Had a tattoo? Yes      No

Had your body pierced? Yes      No

Received non-viral inactivated Factor VIII or Factor IX concentrate? Yes      No

Been exposed to known or suspected HIV-infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane? Yes      No

Had Hepatitis B or C? Yes      No  
If yes, which one? \_\_\_\_\_ When? \_\_\_\_\_

### **Sexual History:**

#### **In the last 12 months, have you had sex with**

A person other than your current spouse? Yes      No  
If yes, vaginal, anal, and/or oral? \_\_\_\_\_

A person having non-medical intravenous, intramuscular, or subcutaneous injections of drugs? Yes      No

A person having engaged in sex in exchange for money or drugs? Yes      No

A person that has been diagnosed as positive for the HIV virus? Yes      No

A person who has had sex with another partner described in any of the above? Yes      No

**I certify that the information contained in this questionnaire, to the best of my knowledge, is true and complete.**

**Wife** NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

---

#### FOR CLINICAL USE ONLY:

LR      HR

S      NS

12M    1M

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