Genetics

Adult Genetics Clinic - New Patient History

Date:_____

Please complete the following questionnaire as well as you can. Don't be concerned if you don't know some of the answers.

Patient's name: _____ DOB:_____

Main reason for referral to Genetics: _____

Your main concerns: _____

Who is attending visit today: _____

Birth history: Please list any information in your birth history that you feel is pertinent to today's visit (i.e. were you exposed prenatally to harmful substances, was your mother diabetic when you were born, were you premature, your birth weight or length if you know it, etc.)

_____

What was your mother's age when you were born? _____ Father's age when you were born? _____

At what hospital were you born? (name, city, state): _____

Education information:

How many years of school have you completed? _____ GED? _____

Did you attend special classes or receive special help? □ Yes □ No

Describe_____

Has IQ testing been done in the past? _____Results?_____

Past medical history:

	Yes	No	When?	Results or Reason?
Had an eye examination?				
Had a hearing test?				
Been in the hospital overnight?				
Had surgery? (you may list at bottom of questionnaire if there are several)				
Been diagnosed with a major medical condition?				
Have you ever had genetic tests? (ex: chromosomes, DNA)				
Had other special tests or evaluations?				
Currently taking medicines?				
Been on any medicines in the past?				

Please list information about any specialists that have evaluated you

Doctor's name	Specialty (i.e. neurology, GI, ENT, eye doctor, etc)	Reason for evaluation:	Date of last visit:	Next Appointment:

Do you have any problems regarding:

	Yes	No	Describe
Eating, sleeping			
Eyes			
Ears, nose, mouth, throat			
Lungs			
Heart			
Stomach, intestines, bowels			
Kidneys, bladder, genitals			
Muscles, bones, spine, chest			
Skin			
Neurological system			
Psychological/behavior problems			
Hormones, diabetes			
Blood, sickle cell disease			
Allergies, immune system			

Family history:

Information about your Parents: Mother Father

Full Name	
DOB	
Ethnic background (i.e. German, Irish, Dutch etc.)	
Occupation	
Highest grade completed	
Repeated grades? Special Classes?	
How many pregnancies?	

Are your mother and father blood relatives? □ Yes □ No

Are you married/single/other? _____ Occupation? _____

Are you currently pregnant? _____ or planning to have more children? _____

Check all medical problems for family members of BOTH sides of your family, and tell how the family member is related to you (aunt, cousin, etc).

	Yes	**No**	**Who?**	**Problem**
Multiple miscarriages, stillbirths				
Early newborn/childhood deaths				
Birth defects				
Learning problems				
Mental retardation				
Spina bifida (open spine)				
Down syndrome or other chromosome problems				
Bone, joint problems				
Heart defects				
Anemia, sickle cell, hemophilia				
Cystic fibrosis				
Stomach, kidney, liver problems				
Diabetes				
Infertility				
Seizures, hydrocephalus (water on the brain), or cerebral palsy				

	Yes	No	Who?	Problem
Mental health problems				
Vision, cataracts, glaucoma				
Early hearing loss				
Birthmarks or skin problems				
Cancer				
Other health concerns: 1. 2.				

Please use the following space for additional information. Thank you for your time and effort.