Pre-Appointment Questionnaire

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INSTRUCTIONS:

1) If you type directly into this form, you will need to use Adobe software. **If you have an Apple computer, DO NOT use the default Apple PDF reader software.** You will need to use Adobe Reader to complete this form, otherwise the form comes back blank to us.

2) Please complete the entire questionnaire to the best of your ability. **PLEASE DO NOT INCLUDE ADDITIONAL PAGES WITH MEDICAL HISTORY INFORMATION.** Once you have completed the questionnaire, please send it back for review. **Completed questionnaires can be returned by:**

1. E-mail to **clinicalgenetics@gbmc.org**
2. Fax to: 443-849-2919 (Attn: Dr. Clair Francomano). Please note, we will only accept typed questionnaires via fax. Handwritten questionnaires must be mailed as they are difficult to read when faxed.
3. Mail to: Dr. Clair Francomano; 6701 N. Charles St, Ste 2326, Baltimore, MD 21204. **PLEASE DO NOT DOUBLE SIDE QUESTIONNAIRE WHEN RETURNING.**

3) Once we receive your questionnaire, we will review it prior to scheduling your appointment. After doing so, we will contact you to schedule an appointment. **PLEASE DO NOT SEND MEDICAL RECORDS OR ADDITIONAL MEDICAL INFORMATION SHEETS UNLESS REQUESTED.**

*Please note: Dr. Francomano does not see patients every day. In addition, certain days and times are allotted for specific appointment types.

If you have any questions or concerns, please feel free to contact us at 443-849-3131.

FREQUENTLY ASKED QUESTIONS:

How long will I have to wait for an appointment?

Our wait time for a new patient appointment is about 30 months; however this can vary . We also maintain a cancellation list. If you would like to be added to the cancellation list, please ask when making your appointment.

What medical records should I send prior to my appointment?

After reviewing your questionnaire, we will let you know what specific medical records will likely be helpful for your upcoming appointment. In general, we would like copies of any genetic testing, previous genetic evaluations, or abnormal test results/studies that relate to why we are seeing you.

Should I bring medical records to my appointment?

Due to time limitations, generally, we are unable to review medical records at the time of your appointment. We prefer to receive records at least one week prior to your appointment so that we have time to adequately review your records. If you bring records to your appointment, **we ask that you make copies for us ahead of time**. Please note: if you bring records at the time of your appointment, we may not have time to review these records.

Patient's Name: _____

Patient's Date of Birth (mm/dd/yy): _____ **Date Completed (mm/dd/yy):** _____

1) How did you hear about us? If you were referred by a specific physician, please provide his/her name and speciality.

2) Have you already been diagnosed with a genetic condition? ☐ No ☐ Yes

If yes, what specific condition? _____

Who diagnosed you?
and type of physician? _____

When were you diagnosed? _____

3) What is the reason for the visit with us? Is there a specific diagnosis in question?

4) If you have any, what are your top 3 current complaints/concerns?

PATIENT REGISTRATION

Patient's First Name: _____ Patient's Middle Initial: _____

Patient's Last Name: _____ Patient's Gender: _____

Patient's Date of Birth (mm/dd/yyyy): _____ Patient's SSN: _____

Patient's Race: _____ Patient's Religion: _____

Street Address: _____

City _____ State _____ Zip Code _____ Country _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

If you are not present to receive a telephone call, may we leave a voice mail message? ☐ Yes ☐ No

May we leave a detailed message with someone else? ☐ Yes ☐ No

If yes, with whom and what is his/her relationship to you?

_____

E-mail: _____

Primary Care Physician: _____

Emergency Contact:

Name: _____ Relation to Patient: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____

If Patient is a Minor (<18y) Please Provide Parent's/Legal Guardian's Information:

Parent/Legal Guardian #1's Name: _____ Date of Birth: _____

Same contact information as patient? ☐ Yes ☐ No: please provide below

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Legal Guardian #2's Name: _____ Date of Birth: _____

Same contact information as patient? ☐ Yes ☐ No: please provide below

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S EMPLOYMENT INFORMATION

☐ Not Employed ☐ Employed ☐ Full-time ☐ Part-time

Employer: _____ Occupation: _____

Employer's Address: _____

PATIENT'S INSURANCE

Primary Insurance:

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

Secondary Insurance:

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S MEDICAL HISTORY

Date Completed: _____

Your Birth History:

Complications while your mother was pregnant with you: _____

☐ Vaginal delivery ☐ C-section delivery

Reason for C-section? _____

☐ Full-term ☐ Pre-term

If pre-term, your gestational age and reason for pre-term labor? _____

Your Birth Weight: _____ Your Birth Length: _____

Any neonatal problems for you (for example: required oxygen, required intubation, feeding problems, breathing problems)?

Early Childhood & Development:

Any delays or issues with development or learning (for example: motor delay, speech delay, delay/issues in reaching developmental milestones, learning disabilities)?

Reproductive History (Females Only):

☐ Pre-puberty (has not experienced first menses) ☐ Pre-menopausal ☐ Post-menopausal

Age at first period: _____ Age at menopause: _____

Total # of Pregnancies: _____ Total # of Miscarriages: _____ Total # of Terminations: _____

Are you currently pregnant? ☐ No ☐ Yes

If pregnant, what was the date of the first day of your last period? _____

Patient's Name: _____ Patient's Date of Birth: _____

Medical Diagnoses/Conditions:

Please ONLY list medical diagnoses/conditions, along with the date of diagnosis. Please also include a history of any birth defects. **Please DO NOT list symptoms/issues that you experiencing; there will be another section within this questionnaire to list any ongoing symptoms/issues.** Please list as legibly as possible.

Surgical History:

Please list type, date of surgery, and where the surgery was done. Please list as legibly as possible.

Patient's Name: _____ Patient's Date of Birth: _____

Hospitalizations:

Please list dates and reason for hospitalization.

Trauma History:

Please list significant accidents and the approximate dates (for example: car accidents, falls, etc). Please describe any injuries received from these accidents.

Known Allergies:

Please list allergen and corresponding reaction.

Patient's Name: _____ Patient's Date of Birth: _____

CURRENT MEDICATIONS

Date Completed: _____

Please list all prescription and non-prescription medications and supplements. Please provide dosage and frequency of use (for example: 10mg once a day OR 10mg three times a day)

MEDICATION	DOSE	FREQUENCY	REASON FOR MEDICATION	ROUTE (mouth, injections, eye drops, etc)

☐ Check this box if list of medications is continued on the next page.

Patient's Name: _____ Patient's Date of Birth: _____

CURRENT MEDICATIONS (CONTINUED)

Date Completed: _____

Please list all prescription and non-prescription medications and supplements. Please provide dosage and frequency of use (for example: 10mg once a day OR 10mg three times a day)

MEDICATION	DOSE	FREQUENCY	REASON FOR MEDICATION	ROUTE (mouth, injections, eye drops, etc)

Patient's Name: _____ Patient's Date of Birth: _____

SOCIAL HISTORY

What is your marital status?

☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐ Lives with domestic partner

Who lives with you at home?

_____

What is your employment status?

☐ Unemployed ☐ Student, not employed ☐ Employed, full-time ☐ Employed, part-time ☐ On disability

If employed, what is your occupation and place of work? _____

What is your highest level of education?

_____

Have you ever used tobacco? ☐ No ☐ Yes

What type of tobacco (cigarettes, chewing tobacco, pipe, etc)? _____

During what ages? If you currently smoke, please indicate this and specify starting age.

_____

Amount of tobacco use per day (for example: 1 pack/day)? _____

Do you currently consume alcohol? ☐ No ☐ Yes

How many drinks per week? _____

How many days per week? _____

Other comments? _____

Have you ever used illicit/recreational drugs? ☐ No ☐ Yes

If yes, please explain type(s) of drugs, frequency of use, and if you currently use illicit/recreational drugs.

Patient's Name: _____ Patient's Date of Birth: _____

REVIEW OF SYSTEMS

Please check the corresponding box if any of the following problems are are CURRENT and ONGOING issues for you. If these were problems in the past that have resolved, please do not check the corresponding box. **Please use only the amount of text available to explain any affirmative responses.**

General Health: ☐ **NO PROBLEMS**

- ☐ Unexplained weight gain — How much & over what time? _____
- ☐ Unexplained weight loss — How much & over what time? _____
- ☐ Difficulty falling asleep — Comments: _____
- ☐ Difficulty staying asleep — Comments: _____
- ☐ Chronic fatigue — Comments: _____

Skin/Hair: ☐ **NO PROBLEMS**

- ☐ Unexplained rashes — Describe: _____
- ☐ Poor wound healing — Comments: _____
- ☐ Stretch marks (unrelated to weight gain) — Where & since what age? _____
- ☐ Other skin/hair problems — Specify: _____

Head/Ears/Eyes/Nose/Teeth: ☐ **NO PROBLEMS**

- ☐ Ringing in the ears — Comments: _____
- ☐ Hearing loss — Explain: _____
- ☐ Nearsightedness (myopia) — Comments: _____
- ☐ Farsightedness (hyperopia) — Comments: _____
- ☐ Seeing floaters/spots — Comments: _____
- ☐ Gum disease — Specify: _____
- ☐ Tooth abnormalities — Specify: _____
- ☐ Swallowing difficulties — Specify: _____
- ☐ Other ear/eye/nose/dental problems: — Explain: _____

Patient's Name: _____ Patient's Date of Birth: _____

Respiratory: ☐ **NO PROBLEMS**

- ☐ Shortness of breath — Explain: _____
- ☐ Difficulty breathing — Explain: _____
- ☐ Wheezing — Explain: _____
- ☐ Chronic cough — Explain: _____

Cardiovascular: ☐ **NO PROBLEMS**

- ☐ Chest pain — Explain: _____
- ☐ Racing heart beat — Comments: _____
- ☐ Light-headedness — Comments: _____
- ☐ Fainting — How often? _____

Gastrointestinal: ☐ NO PROBLEMS

- ☐ Nausea — How often? _____
- ☐ Vomiting — How often? _____
- ☐ Diarrhea — How often? _____
- ☐ Constipation — How often? _____
- ☐ Bowel incontinence — How often? _____
- ☐ Abdominal pain — How often? _____

Genitourinary: ☐ **NO PROBLEMS**

- ☐ Urinary incontinence — How often? _____
- ☐ Urinary urgency — Comments: _____
- ☐ Urinary frequency — How often? _____
- ☐ Frequent urinary tract infections — How often? _____
- ☐ Sexual dysfunction — Explain: _____

Patient's Name: _____ Patient's Date of Birth: _____

Blood/Lymphatic: ☐ **NO PROBLEMS**

- ☐ Easy, unexplained bruising — Comments: _____
- ☐ Prolonged/easy bleeding — Comments: _____
- ☐ Frequent nose bleeds — How often? _____
- ☐ Unexplained swollen lymph nodes — Explain: _____

Muscles/Bones: ☐ **NO PROBLEMS**

- ☐ Loose joints — Comments: _____
- ☐ Joint pain — Which joints? _____
- ☐ Joint dislocations — Which joints? _____
- ☐ Joint subluxations (i.e. popping) — Which joints? _____
- ☐ Muscle pain — Where? _____
- ☐ Muscle weakness — Which muscles? _____
- ☐ Frequent sprains — Where? _____
- ☐ Frequent fractures — Where? _____
- ☐ Scoliosis — Comments: _____

Neurological: ☐ **NO PROBLEMS**

- ☐ Migraine headaches — How often? _____
- ☐ Non-migraine headaches — How often? _____
- ☐ Seizures — How often? _____
- ☐ Tremors — Where? _____
- ☐ Numbness — Where? _____
- ☐ Frequent falls — Explain: _____
- ☐ Memory loss — Explain: _____
- ☐ Confusion — Explain: _____

Patient's Name: _____ Patient's Date of Birth: _____

Endocrine: ☐ **NO PROBLEMS**

☐ Temperature instability Explain: _____

☐ Irregular menstrual cycle Explain: _____

☐ Heavy menstruation Explain: _____

☐ Decreased interest in sexual relations Explain: _____

Immunologic: ☐ **NO PROBLEMS**

☐ Frequent & severe infections Explain: _____

Psychiatric: ☐ **NO PROBLEMS**

☐ Depression Comments: _____

☐ Anxiety Comments: _____

☐ Bipolar disorder Comments: _____

☐ Obsessive compulsive disorder Comments: _____

☐ ADD or ADHD Specify: _____

☐ Unexplained changes in mood or personality Explain: _____

Additional Problems/Concerns:

Karnofsky Score: Please check ONE statement that best describes your current level of functioning.

☐ I feel normal: no complaints, no evidence of disease **(100)**

☐ I am able to carry on normal activity with minor symptoms **(90)**

☐ I carry on normal activity with effort and some symptoms **(80)**

☐ I am able to care for myself, but unable to carry on normal activities **(70)**

☐ I require occasional assistance, but can care for most of my needs **(60)**

☐ I require considerable assistance and frequent care by others **(50)**

☐ I am disabled. I require considerable assistance and frequent care by others **(40)**

☐ I am severely disabled. I am hospitalized, but death is not imminent **(30)**

☐ I am very sick. I require active supportive care by others **(20)**

☐ I have fatal processes that are rapidly progressing. I am near death **(10)**

Patient's Name: _____ Patient's Date of Birth: _____

DIAGNOSTIC STUDIES/TESTS

Genetic Testing

Please list any genetic testing that you have had done along with the result.

Have you ever had an echocardiogram (ultrasound of heart)? ☐ No ☐ Yes

Any abnormalities or differences? _____

Date of last echocardiogram? _____

Have you ever had a formal eye exam by an ophthalmologist (not an optometrist)? ☐ No ☐ Yes

Any abnormalities or differences? _____

Date of last eye exam? _____

Have you ever had an MRI of your BRAIN or SPINE? ☐ No ☐ Yes

Any abnormalities or differences? _____

Date of MRI? _____

Have you ever had a sleep study? ☐ No ☐ Yes

Any abnormalities or differences? _____

Date of sleep study? _____

Other Diagnostic Studies/Tests

Please provide information regarding any other diagnostic studies/tests that showed any abnormalities or differences. Please include 1) study, 2) date of study, and 3) type of abnormality.

Patient's Name: _____ Patient's Date of Birth: _____

PAIN INVENTORY

Do you experience chronic pain? ☐ Yes, please answer the questions below. ☐ No, please proceed to page 18.

Where do you feel pain?

What do you believe is the cause of your pain?

How would you describe your pain? Please check the boxes that for the adjectives that best describe your pain.

☐ Aching ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Gnawing ☐ Sharp ☐ Tender ☐ Burning
☐ Exhausting ☐ Tiring ☐ Penetrating ☐ Nagging ☐ Numb ☐ Miserable ☐ Unbearable

Please rate your pain by checking the ONE box that best describes your pain at its WORST.

☐ 0 No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

Please rate your pain by checking the ONE box that best describes your pain at its LEAST.

☐ 0 No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

Please rate your pain by checking the ONE box that best describes your pain on AVERAGE.

☐ 0 No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

Please rate your pain by checking the ONE box that best describes your pain you have RIGHT NOW.

☐ 0 No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

During the past week, how has pain interfered with your:

A. General activity?

☐ 0, Does not interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10, Completely interferes

B. Mood?

☐ 0, Does not interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10, Completely interferes

C. Walking ability?

☐ 0, Does not interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10, Completely interferes

D. Normal work (includes both work outside the home and housework)?

☐ 0, Does not interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10, Completely interferes

E. Relations with other people?

☐ 0, Does not interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10, Completely interferes

F. Sleep?

☐ 0, Does not interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10, Completely interferes

G. Enjoyment of Life?

☐ 0, Does not interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10, Completely interferes

Patient's Name: _____ Patient's Date of Birth: _____

PAIN INVENTORY CONTINUED

What kinds of things make your pain feel better (for example: heat, medicine, rest)?

What kinds of things make your pain worse (for example: walking, standing, lifting)?

What medications do you take for pain management? (Include prescription and non-prescription medications)

If you take pain medication, within the last week, how much relief have your pain medications provided?

☐ 0%, no relief ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50%
☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%, complete relief

If you take pain medication, how many hours does it take before the pain returns or worsens?

☐ Pain medication does not help at all ☐ One hour ☐ Two hours ☐ Three hours ☐ Four hours
☐ Five to eight hours ☐ Nine to 12 hours ☐ More than 12 hours

What non-medication therapies/interventions do you utilize for pain management?

How much pain relief do these other therapies/interventions provide?

☐ 0%, no relief ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50%
☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%, complete relief

How many hours does it take before the pain returns after these other therapies/interventions?

☐ Less than one hour ☐ One hour ☐ Two hours ☐ Three hours ☐ Four hours
☐ Five to eight hours ☐ Nine to 12 hours ☐ More than 12 hours

Patient's Name: _____ Patient's Date of Birth: _____

FAMILY HISTORY

☐ I am adopted and know nothing about my biological family history (you are finished with the questionnaire)

☐ I am adopted but have some information about my biological family history (please answer questions below)

Has anyone in your family been diagnosed with a genetic condition? ☐ No ☐ Yes

If yes, who (what is their relation to you?) and what was the exact diagnosis?

Has anyone in your family had genetic testing? ☐ No ☐ Yes

If yes, who (what is their relation to you?), what was the test, and what was the result?

Has anyone in your family had the following? If yes, who (what is their relation to you? Ex: maternal first cousin)

Aortic Aneurysm? ☐ Yes _____

Early, unexplained death? ☐ Yes _____

Retinal Detachment? ☐ Yes _____

Lens dislocation (of the eye)? ☐ Yes _____

Cleft palate? ☐ Yes _____

Early hearing loss (<40y)? ☐ Yes _____

Ancestry

What countries are your paternal ancestors originally from? _____

What countries are your maternal ancestors originally from? _____

PATIENT'S BIOLOGICAL PARENTS

Mother: ☐ Alive ☐ Deceased

If living, current age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

Father: ☐ Alive ☐ Deceased

If living, current age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

PATIENT'S BIOLOGICAL GRANDPARENTS

Maternal Grandfather: ☐ Alive ☐ Deceased

If alive, current age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Maternal Grandmother: ☐ Alive ☐ Deceased

If alive, current age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Paternal Grandfather: ☐ Alive ☐ Deceased

If alive, current age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Paternal Grandmother: ☐ Alive ☐ Deceased

If alive, current age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL CHILDREN ☐ Patient has no children, proceed to page 22.

Child #1's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Child #2's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Child #3's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Child #4's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL CHILDREN CONTINUED

Child #5's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Child #6's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Child #7's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Child #8's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Pleast LIST medical diagnoses, health problems, or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL SIBLINGS

☐ Patient has no siblings, proceed to page 25

Sibling #1's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased ☐ Maternal half-sibling ☐ Paternal half-sibling

If alive, age? _____

If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this sibling has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Sibling #2's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased ☐ Maternal half-sibling ☐ Paternal half-sibling

If alive, age? _____

If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this sibling has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL SIBLINGS CONTINUED

Sibling #3's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased ☐ Maternal half-sibling ☐ Paternal half-sibling

If alive, age? _____

If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this sibling has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Sibling #4's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased ☐ Maternal half-sibling ☐ Paternal half-sibling

If alive, age? _____

If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this sibling has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL SIBLINGS CONTINUED

Sibling #5's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased ☐ Maternal half-sibling ☐ Paternal half-sibling

If alive, age? _____

If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this sibling has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Sibling #6's Name? _____ ☐ Male ☐ Female ☐ Alive ☐ Deceased ☐ Maternal half-sibling ☐ Paternal half-sibling

If alive, age? _____

If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this sibling has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL AUNTS & UNCLES

☐ Patient has no aunts or uncles, proceed to page 31.

Aunt/Uncle #1's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Aunt/Uncle #2's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL AUNTS & UNCLES

Aunt/Uncle #3's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Aunt/Uncle #4's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL AUNTS & UNCLES

Aunt/Uncle #5's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Aunt/Uncle #6's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL AUNTS & UNCLES

Aunt/Uncle #7's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Aunt/Uncle #8's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL AUNTS & UNCLES

Aunt/Uncle #9's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Aunt/Uncle #10's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

PATIENT'S BIOLOGICAL AUNTS & UNCLES

Aunt/Uncle #11's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Aunt/Uncle #12's Name? _____ ☐ Maternal aunt ☐ Maternal uncle ☐ Paternal aunt ☐ Paternal uncle

☐ Alive ☐ Deceased

If alive, age? _____ If deceased, age at death? _____ Cause of death? _____

Please LIST medical diagnoses, health problems, or symptoms/features similar to patient.

If this aunt/uncle has children, please provide: 1) Names, 2) Gender, 3) Ages, and 4) Medical diagnoses, health problems or symptoms/features similar to patient.

Patient's Name: _____ Patient's Date of Birth: _____

OTHER NOTABLE FAMILY HISTORY

Are there any other notable diagnoses or health problems in other family members (not already listed)? If yes, please provide further details below. Be sure to include 1) name of individual, 2) exact relationship to patient (for example: mother's mother's sister), 3) gender, 4) age or age at death, 5) and medical history. **PLEASE MAKE THIS LEGIBLE.**

OTHER COMMENTS

Do you have any other comments, concerns, or issues (not previously mentioned)?

YOU ARE FINISHED!
Thank you for taking the time to complete this pre-appointment questionnaire. This information will help us to be prepared for your upcoming visit.

If you are mailing or faxing this form to us, PLEASE DO NOT SEND DOUBLE-SIDED DOCUMENTS. PLEASE DO NOT SEND MEDICAL RECORDS UNLESS REQUESTED.

ALL MEDICAL AND FAMILY HISTORY INFORMATION MUST BE INCLUDED IN THIS QUESTIONNAIRE. WE CANNOT ACCEPT ADDITIONAL MEDICAL HISTORY SHEETS.