PROVINCIAL MEDICAL GENETICS PROGRAM
Department of Medical Genetics
Telephone 604-875-2157
Fax 604-875-2376

Children's and Women's Health Centre
Room C234, 4500 Oak Street
Vancouver, BC V6H 3N1

QUESTIONNAIRE - ADULT

Patient's Name: _____ _____ _____ _____
Last Name | First Name | Date of Birth | Our Reference No.

Address: _____ _____ _____
Street | City | Postal Code

Telephone: _____ _____ _____ _____
Home | Work | Cell | Other

Partner's Name: _____ _____ _____ _____
(if applicable) Last Name | First Name | Date of Birth | PHN/Care Card #

What are you hoping will be accomplished at this appointment?

_____

_____

_____

_____

Following this appointment, a letter summarizing the consult will be sent to the referring physician and any other care providers of your choice. Please list these other care providers.

_____

_____

_____

YOUR HEALTH & EDUCATION

Have you had any surgeries, injuries or prolonged hospitalizations?
☐No ☐Yes, please list _____

_____

_____

_____

Are you taking any medications or have you taken any medications for extended periods in the past?
☐ No ☐Yes, please list _____

_____

_____

What education level have you completed?
Grade Level _____ Years of post-secondary school _____ Degree(s) earned _____

Did you experience any learning or behavioural difficulties during school?
☐ No ☐Yes, details: _____

_____

_____

Please indicate your occupation:
☐Homemaker ☐Student ☐ Not currently employed ☐Employed, details: _____

FOR OFFICE USE ONLY
Referral Date: _____
MG#: _____
Wait List Time: _____
Date Received: _____

Our Reference Number

YOUR HEALTH

Are there any concerns about your:

SKIN e.g. light or dark birth marks; unusual hair or nails; bumps; rashes; absent sweating
☐No ☐Yes _____

EYES e.g. near-sighted; far-sighted; colour blindness; night blindness; cataracts; lazy eye; double vision
☐No ☐Yes _____

EARS e.g. hearing loss; many infections in childhood; ringing
☐ No ☐Yes _____

NOSE e.g. poor sense of smell; frequent colds; nosebleeds
☐No ☐Yes _____

MOUTH / TEETH e.g. cleft lip or palate; early or late eruption of teeth; unusually formed teeth; problems with teeth, gums, or tongue
☐No ☐Yes _____

THROAT / NECK e.g. difficulty swallowing; hoarse voice
☐No ☐ Yes _____

HEAD / BRAIN e.g. headaches; dizziness; seizures; numbness or tingling; balance problems; mood problems; psychiatric condition
☐No ☐Yes _____

HEART e.g. structural defect; murmur; irregular heartbeat; chest pain; high blood pressure
☐No ☐Yes _____

BLOOD e.g. easy bruising; easy bleeding; blood clots; stroke; low blood count
☐No ☐ Yes _____

LUNGS e.g. asthma; chronic wheezing or cough; pneumonia
☐No ☐Yes _____

STOMACH / INTESTINES e.g. frequent vomiting; heartburn; constipation; diarrhea; avoiding specific foods
☐No ☐ Yes _____

URINARY TRACT / GENITALIA e.g. kidney problems; bladder infections; blood in urine; abnormal genitalia
☐No ☐ Yes _____

MUSCLES e.g. weakness; coordination difficulties; paralysis; tight muscles
☐No ☐ Yes _____

ENDOCRINE SYSTEM e.g. diabetes; thyroid problems; concerns with weight or growth
☐No ☐Yes _____

BONES / EXTREMITIES e.g. fractures; osteoporosis; abnormal number or shape of fingers or toes; swollen joints
☐No ☐Yes _____

Please list any investigations you have had that might be useful for our assessment: e.g. MRIs, muscle biopsies, blood tests

_____

_____

_____

Are there any special considerations about you that we should be aware of?
☐No ☐Yes please describe _____

_____

_____

_____

YOUR PARTNER'S HEALTH & FAMILY HISTORY (if applicable)

Please list any health concerns that your partner or his/her family has:

_____

_____

_____

_____

Our Reference Number

YOUR CHILDREN

Please list all of your children, as well as any pregnancy losses experienced by you or your partner(s).

☐Neither myself nor my partner(s) have had any pregnancies/children.

	Child's name *or* pregnancy outcome (miscarriage, stillbirth, etc.)	Age *or* Date of Birth	Sex (M/F)	Medical or learning problems (if yes, please provide details)
1				☐No ☐Yes
2				☐No ☐Yes
3				☐No ☐Yes
4				☐No ☐Yes
5				☐No ☐Yes

Were any of these children adopted?

☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of these children share the same 2 parents?

☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

Were any assisted reproductive techniques used to help with any conceptions? e.g. egg donation, sperm donation, IVF, ICSI

☐No ☐Yes ☐Unsure If yes, please explain

YOUR SIBLINGS

Please list all of your brothers/sisters, as well as any pregnancy losses experienced by your biological parents.

	Name *or* pregnancy outcome (miscarriage, stillbirth, etc.)	Age *or* Date of Birth	Sex (M/F)	Medical or learning problems (if yes, please provide details)
1				☐No ☐Yes
2				☐No ☐Yes
3				☐No ☐ Yes
4				☐No ☐Yes
5				☐No ☐Yes

Were any of these children adopted?

☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of your brothers/sisters share the same 2 parents?

☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

YOUR BIOLOGICAL PARENTS

Are your biological parents related by blood? e.g. first cousins

☐No ☐Yes If yes, please explain relationship

Were any assisted reproductive techniques used to help with your conception? e.g. egg donation, sperm donation, IVF, ICSI

☐No ☐Yes ☐Unsure If yes, please explain

Our Reference Number

YOUR BIOLOGICAL MOTHER

Please provide the following details about your mother and your mother's family:

Name:_____ **Date of Birth (if known):**_____

Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

Medical or learning problems? ☐Yes ☐No If yes, please provide details: _____

What is her race/ethnic ancestry? (Please list all that apply)_____
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

YOUR BIOLOGICAL MOTHER'S SIBLINGS: Please list your mother's brothers/sisters (your aunts and uncles).

	Name	Sex (M/F)	Still living?	Age or Age at death	Does he/she have children?	If yes, how many?
1			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
2			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
3			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
4			☐No ☐Yes		☐No ☐Yes	Male:
						Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of these aunts/uncles share the same 2 parents?
☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

YOUR BIOLOGICAL FATHER

Please provide the following details about your father and your father's family:

Name:_____ **Date of Birth (if known):** _____

Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

Medical or learning problems? ☐Yes ☐No If yes, please provide details: _____

What is her race/ethnic ancestry? (Please list all that apply)_____
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

YOUR BIOLOGICAL FATHER'S SIBLINGS: Please list your father's brothers/sisters (your aunts and uncles).

	Name	Sex (M/F)	Still living?	Age or Age at death	Does he/she have children?	If yes, how many?
1			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
2			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
3			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
4			☐No ☐Yes		☐No ☐Yes	Male:
						Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of these aunts/uncles share the same 2 parents?
☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

Our Reference Number

YOUR EXTENDED FAMILY

Does anyone in your biological family currently have or have a history of any of the following conditions? Please consider your nieces, nephews, aunts, uncles, first cousins, and grandparents.

Yes	No	Unsure	Condition	Name and relationship to patient	Details:
☐	☐	☐	Medical problems similar to the patient		
☐	☐	☐	Birth defects		
☐	☐	☐	Intellectual disability/special needs/learning disability		
☐	☐	☐	Chromosome condition (eg. Down syndrome)		
☐	☐	☐	Two or more miscarriages		
☐	☐	☐	Stillbirth or early childhood death		
☐	☐	☐	Cancer under the age of 50		
☐	☐	☐	Any health condition being passed down in the family		

Are there any other family history concerns that you would like us to address?

Any questions about this form? Please contact us at 604-875-2157.