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

RECALL QUESTIONNAIRE - ADULT

Date last seen in Medical Genetics: _____ **Our Reference No.:** _____

Please fill out this questionnaire in order that we may determine if a follow-up Medical Genetics appointment is indicated.

Patient's Name: _____ _____ _____ _____
Last Name | Previous Last Name(s) | First Name | Date of Birth

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 #

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

YOUR HEALTH

Are there any <u>new</u> 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 _____

FOR OFFICE USE ONLY
Date Received: _____

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 <u>new</u> investigations you have had that might be useful for our assessment: e.g. MRIs, muscle biopsies, blood tests

_____

_____

_____

Have you had any surgeries, injuries or prolonged hospitalizations since your last visit to Medical Genetics?
☐No ☐Yes, please list _____

_____

_____

_____

Are you taking any medications or have you taken any medications for extended periods since your last visit to Medical Genetics?
☐ No ☐Yes, please list _____

_____

_____

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 <u>new</u> health concerns that your partner or his/her family has:

_____

_____

_____

Our Reference Number _____

YOUR CHILDREN (if applicable)

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

	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 (if applicable)

Please list your siblings and their health status

	Name	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

Our Reference Number _____

YOUR BIOLOGICAL MOTHER

Please provide the following details about your mother:

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: _____

_____

_____

YOUR BIOLOGICAL FATHER

Please provide the following details about your father:

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: _____

_____

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		

Has anyone in your family been seen in Medical Genetics (in BC or elsewhere)? ☐ No ☐ Yes
If yes, please provide details (Name, clinic location, year seen): _____

_____

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

_____

_____

_____

Do you wish to be seen again in Medical Genetics? ☐ No ☐ Yes

If yes, what are you hoping will be accomplished at a follow-up appointment?

_____

_____

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