SIU HealthCare

Exceptional Medicine. Partners in Care.

Patient name: _____

DOB: _____ DOV: _____

MRN: _____

Provider: _____

GENETICS CLINIC PATIENT QUESTIONNAIRE (ADULT)

Patient Name: _____ Date of Birth: _____

Person completing form: _____ Relationship to Patient: _____

Parents' Names (if parent has power of attorney or guardianship): _____

Contact Phone Number(s): _____

This form is confidential and will become part of the patient's medical record.

Referring physician: _____
Address: _____
_____
_____

Primary Care Physician: _____
Address: _____
_____
_____

Other Physician: _____
Address: _____
_____
_____

Other Physician: _____
Address: _____
_____
_____

By signing below, you give us permission to send a copy of the clinic note from the clinic visit to the healthcare providers you listed above.

_____ _____

Patient's Signature/Signature of Parent or Guardian Date

Your Questions for the Doctor

Please list the reason why your child was referred to Genetics and specific questions or concerns you would like to discuss during the clinic visit.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____

Past Medical History

List all physicians that you have seen (except general physician/primary and emergency room visits):

Doctor's Specialty	Physician Name & Hospital	Date Last Seen	Diagnosis or Surgery
Genetics (prior to today's appointment)			
Cardiology (Heart doctor)			
Dermatology (Skin Doctor)			
Endocrinology (Hormone doctor)			
ENT/otolaryngology (Ear, Nose & Throat)			
Gastroenterology (GI doctor)			
Neurology or Neurosurgery			
Urology			
Nephrology / Renal (Kidney doctor)			
Ophthalmology or Optometry (Eyes)			
Orthopedic surgery (Bone doctor)			
Pulmonology (Lung doctor)			
Psychology/Psychiatry			
Other specialist(s):			

Patient Name: _____

Please list any **surgeries or overnight admissions to the hospital**:

Date (Month/Year)	**Physician/Hospital**	***Briefly* Describe Admission or Surgery**

Medications ☐ No medications

Medication Name	**Reason** (example: allergies or heart disease)	**Dose** (examples: 25 mg tablet or 100 mg/5 ml suspension)	**Frequency Taken** (examples: 1 tablet twice daily or 2 teaspoons 3 times a day)

Do you have any **allergies to medications**: Yes / No
If yes, please list medication name(s) and describe allergic reaction(s): _____
_____

Diet History

Do you have any food aversions, food allergies, or require a special diet? Yes / No
If yes, please explain: _____
_____

Patient Name: _____

Previous Tests or Studies

Please list if your child has had any of the following tests:

Test/Study	Date Performed	Hospital / City	Results (if known)
Brain MRI or Head CT			
Other MRI or CT (indicate of what)			
Hearing test/Audiology			
Echocardiogram			
Radiographs/X-rays (Indicate of what and reasons)			
Ultrasound (liver, kidneys, etc. – not related to a pregnancy)			
Genetic Testing (indicate type)			
Metabolic Testing (indicate type)			
Biopsy (indicate what of)			
Bone density studies			
Other:			

Family History

Are you or your partner currently pregnant? Yes / No Due date: _____

Has a family member been diagnosed with a genetic condition or had a abnormal genetic testing? Yes / No

If yes, please obtain a copy of their report prior to your appointment.

Please be sure to indicate who is affected on the family history form included in the packet mailed to you.

What is the name of the diagnosis? _____

Do you feel that the similar symptoms? Yes / No

If yes, please describe: _____

_____

Patient Name: _____

Pregnancy and Birth History

Did your mother have any complications during her pregnancy with you? YES / NO

If yes, please describe: _____

Were there any complications with your birth or delivery? YES / NO

If yes, please describe: _____

Developmental History

Are you aware of any delays in your development as a child (like learning to walk or talk)? Yes / No

If known, at what age did you learn to:

Walk_____ Talk_____

What is the highest level of education that you completed? _____

If you did not complete high school:

What was the reason? _____

Do you have your GED? Yes / No

Did you have any learning concerns while in school? Yes / No Please circle all that apply below:

Special education Autism/Asperger syndrome

Resource Room ADD/ADHD

Learning disabilities Low IQ

Held back a grade Other: _____

Are you unable to perform any of the below tasks (circle all that apply):

Read Drive a car

Cook for yourself Manage your own money & finances

Make change (for example, how many quarters are in a dollar?)

Social and Family History

Who do you live with?_____

Do you smoke or use other tobacco products? Yes / No

Do you drink alcohol? Yes / No Amount_____

What is your occupation? _____

Are you currently on disability or applying to receive disability? Yes / No

What is the biological mother's ethnic background? _____

What is the biological father's ethnic background? _____