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):			