Children's Hospital
London Health Sciences Centre

Medical Genetics Program of Southwestern Ontario
Tel: 519-685-8140 Fax: 519-685-8214

DEMOGRAPHIC INFORMATION

Please complete the following information on the individual being referred to our clinic. The information provided by you on this form will be kept on file in the Genetics clinic only.

Name of individual referred: _____

Date of birth: _____ Sex: ☐ Male ☐ Female
☐ Other: _____

Address: _____

_____

Email Address:_____
If you consent to being contacted via email for appointment arrangements, please complete the other page of this form

Phone number: (home) _____ (work) _____

(cell) _____

Reason for referral: _____

_____

Name of Referring Physician: _____ Phone number: _____

Name of Family Physician: _____ Phone number: _____

Please list the name and phone number of any additional physicians who require a copy of the results and consult letters regarding your visit to genetics: _____

_____

_____

Name of Parent or Legal Guardian, if applicable: _____

Phone number: _____ Relationship: _____

Name of Person Completing this form: _____

Relationship to individual referred: _____ Date: _____

EMAIL COMMUNICATION WITH PATIENT AGREEMENT

Name of Patient: _____

Name of Substitute Decision Maker (if applicable): _____

Relationship of Substitute Decision Maker to Patient (if applicable): _____

Patient/Substitute Decision Maker Email Address: _____

Date: _____

Patient/Substitute Decision Maker Email Address: _____

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PREGNANCY AND CHILD DEVELOPMENT QUESTIONNAIRE

Name of Child: _____ **Date of Birth:** _____

Name of person completing this form: _____

Relationship to child: _____

Please complete the following information regarding the child being referred to the genetics clinic. This information will aid us in the assessment of your child and allow us to provide the best possible service to you and your family.

If you do not know an answer, please write "don't know" or "DK" in the space provided. If necessary, please add a page with additional information.

Thank you.

Pregnancy History

Age of biological mother at the time of the pregnancy: _____
During the pregnancy, did the child's biological mother have any exposure to:

Recreational Drugs	☐ No	☐ Yes, please specify _____
Alcohol	☐ No	☐ Yes, please specify _____
Medications	☐ No	☐ Yes, please specify _____
Cigarettes	☐ No	☐ Yes, please specify _____
X-rays	☐ No	☐ Yes, please specify _____
Chemicals	☐ No	☐ Yes, please specify _____

During the pregnancy, did the child's biological mother have any:

Infections/Rashes	☐ No	☐ Yes, please specify _____
High Fever	☐ No	☐ Yes, please specify _____
Bleeding	☐ No	☐ Yes, please specify _____

Duration of Pregnancy: _____ weeks

Were there any complications during the pregnancy? ☐ No ☐ Yes, please specify: _____

Was the pregnancy the result of infertility treatment? ☐ No ☐ Yes, please specify: _____

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Birth/Neonatal History

Type of Delivery: ☐ Vaginal ☐ C-section
Was the delivery induced? ☐ No ☐ Yes
Was vacuum or forceps required? ☐ No ☐ Yes, please specify: _____

Birth weight of child: _____

Apgar Scores: 1 minute _____ 5 minutes _____ 10 minutes _____

Did the child require any oxygen or special treatment following the birth? ☐ No ☐ Yes

If yes, please specify: _____

Were there any complications following the birth? ☐ No ☐ Yes

If yes, please specify: _____

Development History

Please fill in the age at which the child reached the following developmental milestones:

Sitting _____ Drank from a cup_____

Crawling _____ Spoke 1st words _____

Walking _____ Toilet trained _____

What is the child's present school grade or highest grade completed if no longer in school? _____
Is the child in a modified program? ☐ No ☐ Yes

Please indicate in the space provided if the child has had any hospitalizations or surgeries:

_____

_____

Please indicate in the space provided if the child is taking any medications:

_____

_____

Do you have any additional concerns regarding your child's development?

_____

_____

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Your child may be offered genetic testing following their assessment by the geneticist. To aid in interpretation of your child's results, we may need to arrange for parents to provide a blood sample for follow-up genetic testing. It would be helpful to have the following information available.

Name of patient: _____

Name of person completing this form: _____ **Phone:** _____

Biological Mother:

Last Name: _____ First Name: _____

Date of Birth: _____

Health Card Number: _____ Version Code: _____

Doctor's name and phone number: _____

Mailing address (if different than child's):

_____

_____

_____

Biological Father:

Last Name: _____ First Name: _____

Date of Birth: _____

Health Card Number: _____ Version Code: _____

Doctor's name and phone number: _____

Mailing address (if different than child's):

_____

_____

_____

Is the child under the care of the Children's Aid Society? Yes ☐ No ☐
If yes, are the biological parents available for genetic testing? Yes ☐ No ☐

Please include the name and contact information of the CAS Case Worker:

Name: Phone number:

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http://www.lhsc.on.ca/About_Us/Genetics/

Please note the following:

- Please complete the information requested as completely as possible. All questions are in relation to the person referred to our clinic (patient).
- Information contained in this questionnaire is confidential and will be used to draw a family tree that will be reviewed prior to the genetics appointment. The information provided will form part of the patient's health record.
- If you do not know an answer, please write "don't know" or "DK" in the space provided. If needed, please add a page with additional information.
- Please do not include information on adopted family members.
- Please make a copy for yourself.
- **Please contact our office at (519) 685-8140 if you are having difficulty completing this form or have questions about the information being gathered.**

FAMILY HISTORY QUESTIONNAIRE

Full name of person referred to the genetic clinic (patient):_____
(first name) (last name)

Date of birth: _____ / _____ / _____
Day Month Year

Why has the patient been referred to the Genetics Clinic? _____

_____

Does anyone else in the family have similar problems/concerns? ☐ No ☐ Yes
If *"yes"* please list their name(s): _____

Has this patient or any family members been seen in this or another genetics clinic? ☐ No ☐ Yes
If "*yes*" please indicate who and where: _____

What are some of the concerns/questions you would like to talk about at your visit to the genetics clinic:

Family History of Patient

Brothers and sisters of the patient:

Please list the names of the patient's brothers and sisters (include stillbirths, miscarriages and deceased individuals)	**Sex M/F**	**Date of Birth (D/M/Y)**	**Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age**	**Please list the number of sons and daughters, if applicable**
Example: John Doe (brother to patient)	M	03/Nov/80	Spina bifida Died heart attack Age 30	1 son 2 daughters
Example: miscarriage	F	1982	Cause unknown	

Do all the individuals listed above share the same two parents? ☐ No ☐ Yes

If "*No"*, please list the names of those with a different mother/father and indicate which parent they have in common with the patient (for example John Doe, same mom)

Parents of the patient:

	Name	Date of Birth	Please list any significant health problems, birth defects or medical diagnoses	If deceased, please list cause of death and age
Mother				
Father				

Are the parents of the patient related by blood? (for example – cousins) ☐ No ☐ Yes

If "*yes"*, please explain how they are related: _____

Children of the patient – if the patient has children, please identify this information below:

Please list the names of the patient's children (include stillbirths, miscarriages and deceased individuals)	Sex M/F	Date of Birth (D/M/Y)	Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age	Please list the number of sons and daughters, if applicable
Example: John Doe (son of patient)	M	5/Nov/85	Developmental delay	

Family History of Patient's Mother

Brothers and sisters of patient's mother (maternal aunts/uncles of patient):

Please list the names of the patient's maternal aunts/uncles (include stillbirths, miscarriages and deceased individuals)	**Sex M/F**	**Date of Birth (D/M/Y)**	**Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age**	**Please list the number of sons and daughters, if applicable**
Example: Jack Jones	M	DK	Cystic fibrosis	1 son 4 daughters

Patient's mother's parents (maternal grandparents of patient):

	Name	**Please list any significant health problems, birth defects or medical diagnoses**	**If deceased, please list cause of death and age**
Mother			
Father			

What is the race/ethnic origin of the Patient's Grandmother (Mother's Mother)? _____

What is the race/ethnic origin of the Patient's Grandfather (Mother's Father)? _____

Family History of Patient's Father

Brothers and sisters of patient's father (paternal aunts/uncles of patient):

Please list the names of the patient's paternal aunts/uncles (include stillbirths, miscarriages and deceased individuals)	**Sex M/F**	**Date of Birth (D/M/Y)**	**Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age**	**Please list the number of sons and daughters, if applicable**

Patient's father's parents (paternal grandparents of patient):

	Name	**Please list any significant health problems, birth defects or medical diagnoses**	**If deceased, please list cause of death and age**
Mother			
Father			

What is the race/ethnic origin of the Patient's Grandmother (Father's Mother)? _____

What is the race/ethnic origin of the Patient's Grandfather (Father's Father)? _____

General Family Health Information

Please complete the following for information not already mentioned in the questionnaire. Please only complete boxes that are applicable to your family history.

Condition	**Name of family member**	**Relation to patient (example: maternal cousin)**	**Name of their parent(s)**
Birth defects **(please specify)**			
Intellectual delay/ developmental delay (Ex. Fine/gross motor delay, speech delay)			
Learning difficulties (Ex. ADHD, ADD, ODD, dyslexia)			
Three or more miscarriages			
One or more stillbirths or neonatal deaths **(please specify)**			
Cardiac/sudden death of family member under the age of 50			
Deafness or blindness from birth or as an infant **(please specify)**			
Neurologic conditions (Ex. Seizures, difficulties walking, dementia) **(please specify)**			

Please use the space below to provide information on any other health concerns or other relevant family information, which has not already been provided.

Please feel free to attach additional pages if we have not provided you with enough space.