Genetics and Genomics Institute
311 S L Street • Tacoma, WA, 98405
Phone: 253-403-3476 • Fax: 253-403-8674

GENETICS CLINIC INTAKE FORM – HYPERMOBILE ADULTS

Welcome

To help us prepare for your upcoming visit to the Genetics Clinic at MultiCare, please take a few minutes to fill out this health information survey prior to your visit.

General Information

Your Name: Today's date:

Age: Date of birth:

Primary care provider:
Specialists:
- Eye specialist (ophthalmologist, optometrist):
- Heart specialist (cardiologist):
- Physical therapist:
- Other specialists:

Have you or anyone else in the family seen a geneticist before, or had genetic testing?
☐ No ☐ Yes _____

Medical History

Please tell us why you are coming to genetics clinic. What are your main concerns?

Patient Identification - Write in or attach patient label

Name

MRN#

CSN #

Age /Sex and Gender

GENETICS CLINIC INTAKE FORM
HYPERMOBILE ADULTS

MultiCare

88-5651-6 (7/19)

Have you ever been hospitalized overnight?

☐ No ☐ Yes _____

Please list all overnight hospitalizations not at a MultiCare Hospital

Approximate date	Hospital/Location	Reason for hospital stay

Have you ever had surgery?

☐ No ☐ Yes _____

Do you take any medication regularly? (List all medications including prescription, over the counter medications, vitamins, herbal, homeopathic and other remedies.)

☐ No ☐ Yes _____

Do you have any allergies?

☐ No ☐ Yes _____

Do you have a history of any of the following? If you answer yes, please describe.

Joints that seem unusually flexible

☐ No ☐ Yes_____

Joints that feel like they pop out of place

☐ No ☐ Yes_____

Joints that dislocated and required medical treatment

☐ No ☐ Yes_____

Unusual scars

☐ No ☐ Yes_____

Vision problems

☐ No ☐ Yes_____

Heart problems

☐ No ☐ Yes_____

Family History

Is there a history of any of the following in the family? If you answer yes, please add details.

Very flexible joints

☐ No ☐ Yes_____

Aneurysm

☐ No ☐ Yes_____

Intestine rupture

☐ No ☐ Yes_____

Uterine rupture

☐ No ☐ Yes_____

Pneumothorax (collapsed lung)

☐ No ☐ Yes_____

Sudden or unexpected death (not related to an accident or homicide)

☐ No ☐ Yes_____

Your children:

Name (first and last)	Date of Birth or approx. age	Sex	Medical problems past or present	If deceased, age at death and cause	# of children
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			

Your brothers and sisters: (if half-siblings, please note maternal or paternal)

Name (first and last)	Date of Birth or approx. age	Sex	Medical problems past or present	If deceased, age at death and cause	# of children
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			

Mother's History

Date of birth _____ Height _____

# of Pregnancies _____ # of Live births _____

# of Miscarriages _____ # of Stillbirths _____

Medical Problems _____

Mother's brothers and sisters (if half-siblings, please note maternal or paternal):

Name (first and last)	Date of Birth or approx. age	Sex	Medical problems past or present	If deceased, age at death and cause	# of children

Mother's parents:

Name (first and last)	Date of Birth or approx. age	Medical problems past or present	If deceased, age at death and cause
Your grandmother:			
Your grandfather:			

Father's History

Date of birth _____ Height _____

Medical Problems _____

Father's brothers and sisters (if half-siblings, please note maternal or paternal):

Name (first and last)	Date of Birth or approx. age	Sex	Medical problems past or present	If deceased, age at death and cause	# of children
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			

Father's parents:

Name (first and last)	Date of Birth or approx. age	Medical problems past or present	If deceased, age at death and cause
Your grandmother:			
Your grandfather:			

Health Review

Do you have any of the following symptoms or health concerns? If yes, please add details.

Sleep problems? ☐ No ☐ Yes_____

Trouble falling asleep? ☐ No ☐ Yes Fatigue? ☐ No ☐ Yes

Trouble staying asleep? ☐ No ☐ Yes Needing to nap? ☐ No ☐ Yes

Poor sleep? ☐ No ☐ Yes

Appetite/eating problems? ☐ No ☐ Yes_____

Special diet? ☐ No ☐ Yes

Vision problems? ☐ No ☐ Yes _____

Prescribed glasses or contacts? ☐ No ☐ Yes

Hearing Problems? ☐ No ☐ Yes _____

Snoring? ☐ No ☐ Yes _____

Dental problems? ☐ No ☐ Yes _____

Breathing problems? ☐ No ☐ Yes _____

Frequent cough? ☐ No ☐ Yes Shortness of breath? ☐ No ☐ Yes

Frequent wheeze? ☐ No ☐ Yes

Heart problems? ☐ No ☐ Yes _____

Chest pain? ☐ No ☐ Yes

Fainting? ☐ No ☐ Yes

Ever had an echocardiogram? ☐ No ☐ Yes: Where/when: _____

Ever saw a heart doctor? ☐ No ☐ Yes: Where/when: _____

Abdominal problems? ☐ No ☐ Yes _____

Constipation? ☐ No ☐ Yes Vomiting? ☐ No ☐ Yes

Diarrhea? ☐ No ☐ Yes Heartburn? ☐ No ☐ Yes

Urinary problems? ☐ No ☐ Yes _____

Joint problems? ☐ No ☐ Yes _____

Back problems? ☐ No ☐ Yes _____

Broken bones? ☐ No ☐ Yes _____

Rashes? ☐ No ☐ Yes _____

Neurologic problems? ☐ No ☐ Yes_____

Frequent headache?	☐ No	☐ Yes	Numbness?	☐ No	☐ Yes
Seizures?	☐ No	☐ Yes	Attention problems?	☐ No	☐ Yes
Weakness?	☐ No	☐ Yes	Anxiety?	☐ No	☐ Yes
Balance problems?	☐ No	☐ Yes	Depression?	☐ No	☐ Yes

Blood problems? ☐ No ☐ Yes _____

Easy bruising?	☐ No	☐ Yes	Nosebleeds?	☐ No	☐ Yes
Easy bleeding?	☐ No	☐ Yes	Anemia?	☐ No	☐ Yes

Unexpected change in weight? ☐ No ☐ Yes_____

Hot or cold intolerance? ☐ No ☐ Yes_____

Frequent colds/infections? ☐ No ☐ Yes_____

For women:

Menstrual problems?	☐ No	☐ Yes	Heavy cramping?	☐ No	☐ Yes
Irregular periods?	☐ No	☐ Yes	Menopause?	☐ No	☐ Yes

Additional Information

Please share any additional information that you feel may be important.