Genetics and Genomics Institute
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GENETICS CLINIC INTAKE FORM - ADULT

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.

Patient Information

Name: Date of birth:

Primary care provider:

Specialists you have seen:

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

Reason for Referral

Why were you referred to Genetics Clinic?

____

____

____

How and when did this problem present?

____

____

____

____

Patient Identification - Write in or attach patient label

Name

MRN#

CSN #

Age /Sex and Gender

88-5649-4 (7/19)

Birth and prenatal history

Prenatal History ☐ Prenatal Information not known (check box and proceed to birth history)

Location of prenatal care: ____

What prenatal testing did patient's mother have? *(Check all that apply)*

☐ Blood test for Down syndrome and other conditions (for example, AFP, Triple / Quad / Sequential / Integrated screen / NIPT)
☐ Glucose (sugar) Test
☐ Chorionic Villus Sampling (CVS)
☐ Amniocentesis
☐ Ultrasound
☐ Fetal echocardiogram
☐ Other: ___________________________________
☐ Uncertain/not sure

Describe any abnormal results: ____

Which of these applied to your mother's pregnancy? *(Check all that apply)*

☐ Chronic illness
☐ Diabetes
☐ Medicine use_____________________
☐ Infection
☐ Fever
☐ Bleeding
☐ Tobacco use
☐ Alcohol use
☐ Drug use
☐ Exposure to chemicals
☐ Exposure to x-rays
☐ Prenatal vitamin use
☐ Uncertain/not sure
☐ Other pregnancy complications: ____

____

Birth History ☐ Birth information not known (check box and proceed to medical history)

Mother's age at birth: ________________ Father's age at birth: ________________

Length of pregnancy: _________________ Delivery type: ☐ Vaginal ☐ C-section

Birth weight: ________________ Birth length: ________________ Head circumference: ___________

Hospital: ____________________ Apgar score: ________________ Length of hospital stay: ________

Birth complications, if any:

____

____

Medical History

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 ____

Which studies have you had done? *(Check all that apply)*

☐ Developmental assessment ☐ Eye/vision exam ☐ Hearing evaluation
☐ Neuropsychology assessment ☐ X-rays/MRI/US ☐ Genetic tests
☐ Other studies: ____
☐ None of the above

Developmental / Educational History

When did you first…? *(If you cannot remember when, but you can perform the task, check the box)*

Roll over		Smile	
Sit unsupported		Say first word	
Walk alone		Point to objects	
Use a spoon		Use two-word combinations	
Complete toilet training		Dress yourself	

Education

Did you: *(check all that apply)*

☐ Need extra help in school ☐ Attend Regular Classes ☐ Attend Special Education
☐ Have a learning disability ☐ Complete high school ☐ Attend college

Occupation/work: ____

Family History

Are there any relatives with a similar problem as you? If so, who? ____________________________________

Are your mother and father related? *(For example: cousins)* ☐ No ☐ Yes ☐ Possibly

Is there a history in your family of …? *(Check all that apply)*

☐ Miscarriages ☐ Stillbirths ☐ Newborn/childhood deaths
☐ Infertility ☐ Birth defects ☐ Unusual features
☐ Developmental problems ☐ Learning disorders ☐ Cancer
☐ Other disease (please list):

If yes, please explain: ____

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

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

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

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:
Have you had any pregnancies? ☐ No ☐ Yes: How many? ________________
Menstrual problems? ☐ No ☐ Yes
Irregular periods? ☐ No ☐ Yes
Heavy cramping? ☐ No ☐ Yes
Menopause? ☐ No ☐ Yes

Completed by: ____ Date: ______________

Relationship to patient: ____