MG#: _____

Kingston General Hospital

MEDICAL GENETICS PROGRAM
76 Stuart Street
Kingston, ON K7L 2V7
Telephone: 613-548-2467
Toll free: 1-800-567-5722 ext. 7950
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Medical & Family History Form

Please fill out this form as best you can and return it to us in the envelope provided. The information that you give on the form allows us to better prepare for your appointment. It may take about 15-20 minutes. If you are unable to fully complete this form, please return it to us with whatever information you are able to give.

Name of Person(s) Filling Out Form: _____

Today's Date: _____/_____/_____ (yyyy/mm/dd) Telephone:_____

How are you related to the patient?: _____

Patient Information

Name of Patient: _____ Sex: □ Male □ Female □ Unknown

Patient's Date of Birth: ____/___/___(yyyy/mm/dd)

Address:_____

_____

Phone No: Home: ( )_____ Work: ( )_____ Other: ( )_____

Best Place to Reach You (phone number and time of day):_____

What are some of the concerns/questions you would like addressed/answered at your visit to the genetics clinic?

_____
_____
_____
_____
_____
_____
_____
_____
_____

PATIENT'S MEDICAL HISTORY

PREGNANCY HISTORY:

- Age of patient's mother at birth: _____ years old
- During the pregnancy, did the patient's mother:
    - o Smoke cigarettes? □ Yes □ No
    - o Drink alcohol? □ Yes □ No
    - o Take medications and/or drugs? □ Yes □ No
    - o Have x-rays? □ Yes □ No
    - o Have diabetes? □ Yes □ No
    - o Have high blood pressure? □ Yes □ No
    - o Have seizures? □ Yes □ No
    - o Have a fever? □ Yes □ No
    - o Have an infection? □ Yes □ No
    - o Have any problems? □ Yes □ No

If you answered 'yes' to any of these questions, please explain:
_____
_____

- Did the patient's mother have an ultrasound during pregnancy? □ Yes □ No
    - o Was the ultrasound normal? □ Yes □ No If no, please explain:_____
      _____

- Did the patient's mother have any testing during pregnancy? □ Yes □ No If yes, please explain: _____
  _____

BIRTH HISTORY:

- Name of hospital where patient was born: _____

- Were there any problems during or after the birth? □ Yes □ No If yes, please describe: _____
  _____

FAMILY HISTORY INFORMATION

MOTHER'S FAMILY HISTORY:

Biological Mother's Name: _____ Age: _____
Health & Development Concerns? _____

Please list the MOTHER's brothers and sisters:

Name	Sex	Age	Health & Development Concerns?

Do all of the individuals listed above share the same two parents? □ Yes □ No - If 'No' please list the names of those with a different mother/father: _____

Mother's Parents' Information

Mother's Mother	**Mother's Father**
Name: _____	Name: _____
□ Living □ Deceased - Age: _____	□ Living □ Deceased - Age: _____
Cause of Death (If applicable) _____	Cause of Death (If applicable) _____
Race/Ethnic Origin:_____	Race/Ethnic Origin:_____

FATHER'S FAMILY HISTORY:

Biological Father's Name: _____ Age: _____
Health & Development Concerns? _____

Please list the FATHER's brothers and sisters:

Name	Sex	Age	Health & Development Concerns?

Do all of the individuals listed above share the same two parents? □ Yes □ No - If 'No' please list the names of those with a different mother/father:_____

Father's Parents' Information

Father's Mother	**Father's Father**
Name: _____	Name: _____
□ Living □ Deceased - Age: _____	□ Living □ Deceased - Age: _____
Cause of Death (If applicable) _____	Cause of Death (If applicable) _____
Race/Ethnic Origin:_____ ___	Race/Ethnic orgin:_____

- Are the patient's parents related by blood (example – cousins)? □ Yes □ No - If 'Yes' please explain how parents are related: _____

Does anyone related to the patient currently have or has had a history of the following medical conditions?

Condition	Yes	No	Unsure	Name of Family Member & How Related To Patient
Birth defects	□	□	□	
Mental retardation / learning disability / slow learner	□	□	□	
More than one miscarriage / stillbirth	□	□	□	
Medical problems similar to the patient	□	□	□	
Physical features similar to the patient	□	□	□	
Any health conditions you think might be passed down in your family	□	□	□	

Please list the patient's brothers and sisters:

Name	Sex	Age	Health & Development Concerns?

Are any of the individuals listed above adopted? □ Yes □ No - If 'Yes' please list their name(s): _____

Do all of the individuals listed above share the same two parents? □ Yes □ No - If 'No' please list the names of those with a different mother/father: _____
_____

- Is there anything else that you would like to share with us? _____
_____
_____
_____

Thank you for completing this form.

Please call us at (613) 548-2467 if you have any questions before the patient's appointment.