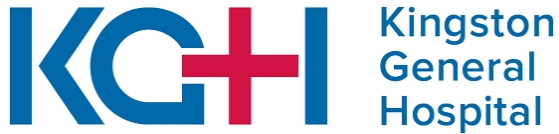


MG#: \_\_\_\_\_



## MEDICAL GENETICS PROGRAM

76 Stuart Street  
Kingston, ON K7L 2V7  
Telephone: 613-548-2467  
Toll free: 1-800-567-5722 ext. 7950  
Fax: 613-548-1348

### Medical & Family History Form – Cardiogenetics

**Please fill out this form as best you can and return it to us in the envelope provided, within 10 days of receiving this package.** 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.

#### Patient Information

Name of Patient: \_\_\_\_\_ Sex: ☐ Male ☐ Female ☐ Other

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?

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**PATIENT'S MEDICAL HISTORY****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 concerns or diagnoses? \_\_\_\_\_

**Please list the MOTHER's brothers and sisters:**

Name	Sex	Age	Health concerns or diagnoses?

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: _____
<input type="checkbox"/> Living <input type="checkbox"/> Deceased - Age: _____	<input type="checkbox"/> Living <input type="checkbox"/> 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 concerns or diagnoses? \_\_\_\_\_

**Please list the FATHER's brothers and sisters:**

Name	Sex	Age	Health concerns or diagnoses?

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: _____
<input type="checkbox"/> Living <input type="checkbox"/> Deceased - Age: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased - Age: _____
Cause of Death (If applicable) _____	Cause of Death (If applicable) _____
Race/Ethnic Origin: _____	Race/Ethnic origin: _____

- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental retardation / learning disability / slow learner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting with exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unexplained seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sudden Infant Death Syndrome (SIDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sudden death (unexplained or heart related)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please list the patient's brothers and sisters:

Name	Sex	Age	Health concerns or diagnoses?

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: \_\_\_\_\_

Please list the patient's children:

Name	Sex	Age	Health concerns or diagnoses?

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: \_\_\_\_\_

Do you know if anyone else in your family has been referred for genetic counselling?  
☐ Yes ☐ No - If 'Yes' please list their name(s) and their relationship to you: \_\_\_\_\_

Where were they seen (Name of Genetics Clinic; City)? \_\_\_\_\_

Is there anything else that you would like to share with us? \_\_\_\_\_

**Thank you for completing this form.**  
Please call us at (613) 533-6310 if you have any questions before the patient's appointment.