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
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?

_____
_____
_____
_____
_____
_____
_____
_____
_____

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: _____
□ 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 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: _____
□ 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	□	□	□	
Fainting with exercise	□	□	□	
Unexplained seizures	□	□	□	
Heart palpitations	□	□	□	
Sudden Infant Death Syndrome (SIDS)	□	□	□	
Sudden death (unexplained or heart related)	□	□	□	

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.