Shared health
Soins communs
Manitoba

Genetics & Metabolism Program
Family History Questionnaire

- Please complete this form to the best of your ability
- If the referred patient is a child there may be a prenatal and developmental history form attached
- All the information obtained from this form is to allow us to better prepare for the upcoming appointment
- Mail it back in the enclosed envelope or Fax it to (204)787-1419 **BEFORE** the appointment
- If you have questions about completing the questionnaire, please contact our office at (204) 787-2494.

Appointment with: _____ **Appointment date:** _____

Patient legal name: _____ **Patient preferred name:**_____

Date of birth: _____ **PHIN:** _____

Sex assigned at birth: Male / Female / Unassigned _____**Gender:** _____

Patient pronouns (she/her, he/him, they/them, etc):_____

Primary physician (location): _____

Person completing this form: _____ Relationship to patient: _____

Daytime Phone #: _____ Address: _____

What questions would you like answered at the appointment?

_____

_____

Briefly describe any diagnoses, major medical illnesses, hospital stays or surgeries that the patient has had:

_____

_____

Has a family member already been seen in Genetics? (Yes/No)

Name/Relationship to referred patient: _____

Why were they seen? _____

Where were they seen? _____

Ethnic Background of Patient's Biological Family (e.g. Aboriginal, Jewish, Icelandic, English, French Canadian, Mennonite, etc)

Maternal Grandmother _____ Maternal Grandfather _____

Paternal Grandmother _____ Paternal Grandfather _____

Family History

(if additional space required please attach additional sheets)

Patient's Partner's Name: _____ Date of Birth _____

Patient's Biological Parents (i.e mother/egg donor or father/sperm donor; if patient is adopted, provide adoptive parent's information on an additional sheet)

Are the parents of the patient related by blood? **(Y / N)** If so, how? _____

Name	Sex / gender	Date of birth (or age if unknown)	Medical diagnoses (include medical or genetic conditions, birth defects, mental or physical disabilities, cancer, infertility, seizures, etc…)	Age and cause of death (if applicable)

Patient's Siblings (please include half siblings, miscarriages, stillbirths, and deceased individuals)

Name	Sex / gender	Date of birth (or age if unknown)	Medical diagnoses (include medical or genetic conditions, birth defects, mental or physical disabilities, cancer, infertility, seizures, etc…)	Age and cause of death (if applicable)

Are any of the above siblings adopted? **(Y / N)** If so, please mark which ones.

Do all of the above siblings share the same two parents? **(Y / N)** If not, please list which ones do not and include which parent they share: _____

Patient's Biological Children (If applicable) Please include all miscarriages, stillbirths and deceased individuals

Name	Sex / gender	Date of birth (or age if unknown)	Medical diagnoses (include medical or genetic conditions, birth defects, mental or physical disabilities, cancer, infertility, seizures, etc…)	Age and cause of death (if applicable)

Please include other relatives with known inherited or genetic conditions

Name	Sex / gender	Relationship to patient (e.g., second cousin)	Date of birth (or age if unknown)	Genetic diagnosis	City (at the time the diagnosis was made)

Name: _____ PHIN: _____