Genetics & Metabolism Program
Pediatric Clinic Family History Questionnaire

****Please MAIL this form back in the enclosed envelope or FAX it back to (204) 787-1419 BEFORE the appointment****
If you have questions about completing the questionnaire, please contact our office at (204) 787-2494.

File Number: K _____ **Date Form Completed: _____**

Referred patient (child's) Name: _____ Date of Birth: _____**

****Please note:** Whenever you see the term "referred patient" in this form, we are asking about this child.

Name of person completing this form: _____ Relationship to referred patient:_____

Daytime Phone #: _____Address:_____

What questions would you like answered at the appointment?

_____

_____

Referred patient's Ethnic Background: Mother's Side:_____ Father's Side:_____
(For example: Aboriginal, Jewish, Icelandic, English, French Canadian, East Indian, Mennonite, etc)

Has a family member already been seen by Medical Genetics? (Yes/No) If yes, for what reason?_____

If yes, who? (Name/Relationship to referred patient)_____

Where were they seen?_____

Referred Patient's Prenatal History & Development:

During which month of pregnancy did the referred patient's mother start prenatal care? _____ Where? _____

Please list drugs, medications and supplements taken during pregnancy. Include vitamins, supplements, prescription medication, over-the-counter medication, and "street drugs." Please list the dose if known, and when in pregnancy it was taken.

_____ Any alcohol use during the pregnancy? (Y/N)

_____ Any cigarette use during the pregnancy? (Y/N)

_____ Any street drug use during the pregnancy? (Y/N) Type?_____
(ex. cocaine, marijuana, heroin, crack cocaine, etc)

Any ultrasounds during the pregnancy? (Y/N) If so, at what stage(s) of the pregnancy? _____

Did the referred patient's mother have any serious illnesses during pregnancy, such as: fever, rashes, infections, vaginal bleeding, high blood pressure, excessive vomiting, accidents, operations, or any other concerning condition in the pregnancy? If so, please list:

Referred Patient's Birth History:

Was baby full term? (Yes/No) Delivered at how many weeks? _____ Hospital/place of delivery: _____

Presentation: Head first? (Y/N) Breech (feet first)? (Y/N) Other: _____

Was anesthetic used? (Y/N) What kind? _____

Vaginal delivery or Caesarian section? (circle one) Forceps? (Y/N) Suction? (Y/N)

Single birth? (Y/N) Twins? (Y/N) If twins, 1st or 2nd born? _____ Other:_____

Please list any complications during the delivery: _____

Did the baby breathe immediately? (Y/N) Cry immediately? (Y/N) Need oxygen treatment? (Y/N)

Birth weight:_____ Birth length: _____ Head circumference: _____

Apgars score 1 min:_____ 5 min: _____ (Apgars are a score out of 10 given by doctors to describe how the baby is doing)

Any problems during the 1st week of life? (jaundice, respiratory distress, seizures, feeding problems, birth defects, etc)?

Length of mother's hospital stay: _____ Length of baby's hospital stay: _____

Did the referred patient have a different first or last name at birth? (Y/N) If so, what was it? _____

Who is the referred patient's pediatrician? _____

Please list the full names and locations of any medical specialists that the referred patient has seen (please list the type of doctor or medical specialty):

Has the referred patient been diagnosed with a medical condition, or had any major illnesses, hospital stays, or surgeries? If yes, please describe them:

_____

_____

_____

Developmental Milestones & Education: When did the referred patient first:

Hold head up? _____ months Smile responsively? _____ months Sit without support? _____ months

Walk without support? _____ months Say first words? _____ months

Is the referred patient going to school? (Y/N) If so, what grade? _____ Regular or special classes? _____

Does the referred patient have an educational assistant (EA) or an individualized education plan (IEP)? (Y/N) If yes, please describe:

_____

Were his or her most recent school grades average, below average, or above average? _____

Are there concerns about the referred patient's performance in school? (Y/N)

Does the referred patient have a social worker or Children's Special Services? (Y/N)

Referred Patient's Family History:

Instructions:

1) Please list all blood relatives, and state whether they have a diagnosed medical condition. **All information is kept confidential.** This form will help us understand your family history and prepare for the genetics visit.
2) You may need to speak with other relatives to get help filling out this questionnaire. We understand that sometimes this information is just not available to you. Please fill this questionnaire out to the best of your ability; it is alright if you don't have or cannot get all the information.
3) If the referred patient is **adopted**, please fill out the form for their biological relatives. Please include as much information as you know. We understand that you may not have a lot of information about these relatives; if so, please just write "no information known."
4) If you have questions about completing the questionnaire, please contact our office at (204) 787-2494.

The Referred Patient's Parents and Grandparents

Name (First, Last)	**Date of Birth** (or age if unknown)	**Living or deceased?** (give age and cause of death if deceased)	**Please list any <u>diagnosed medical or genetic conditions</u>, birth defects, learning disabilities, serious health conditions from birth or a young age, and whether this person has had multiple (more than 3) miscarriages or stillbirths.**	**<u>IF</u> this person has a genetic condition, at the time of diagnosis, where did this person live?** (e.g. City, Province, Country)
Mother				
Father				
Mother's Mother				
Mother's Father				
Father's Mother				
Father's Father				

The Referred Patient's Brothers and Sisters

Name (First, Last)	**Date of Birth** (or age if unknown)	**Living or deceased?** (give age and cause of death if deceased)	**Please list any <u>diagnosed medical or genetic conditions</u>, birth defects, learning disabilities, serious health conditions from birth or a young age, and whether this person has had multiple (more than 3) miscarriages or stillbirths.**	**IF this person has a genetic condition, at the time of diagnosis, where did this person live?** (e.g. City/ Province)
Sister 1				
Sister 2				
Sister 3				
Brother 1				
Brother 2				
Brother 3				

If any of the above are half-siblings, please list their names below and name the parent that they share with the referred patient:

_____

_____

The Referred Patient's Aunts and Uncles (Mother's side)

Name First, Last	**Date of Birth** (or age if unknown)	**Living or deceased?** (give age and cause of death if deceased)	**Please list any <u>diagnosed medical or genetic conditions</u>, birth defects, learning disabilities, serious health conditions from birth or a young age, and whether this person has had multiple (more than 3) miscarriages or stillbirths.**	**IF this person has a genetic condition, at the time of diagnosis, where did this person live?** (e.g. City/ Province)
Mother's sister 1				
Mother's sister 2				
Mother's sister 3				
Mother's brother 1				
Mother's brother 2				
Mother's brother 3				

If any of the above are half-siblings, please list their names below and name the parent they share with the referred patient's mother:

_____

_____

The Referred Patient's First Cousins
(Children of the patient's Mother's brothers and sisters)

Name First, Last and **Name of Parent**	**Gender** (boy/ girl)	**Date of Birth** (or age if unknown)	**Living or deceased?** (give age and cause of death if deceased)	**Please list any diagnosed medical or genetic conditions, birth defects, learning disabilities, serious health conditions from birth or a young age, and whether this person has had multiple (more than 3) miscarriages or stillbirths.**	**IF this person has a genetic condition, at the time of diagnosis, where did this person live?** (e.g. City/ Province)
Cousin 1 Parent:					
Cousin 2 Parent:					
Cousin 3 Parent:					
Cousin 4 Parent:					
Cousin 5 Parent:					
Cousin 6 Parent:					

Please include additional cousins on a separate piece of paper if required.

The Referred Patient's Aunts and Uncles (Father's side)

Name First, Last	**Date of Birth** (or age if unknown)	**Living or deceased?** (give age and cause of death if deceased)	**Please list any <u>diagnosed medical or genetic conditions</u>, birth defects, learning disabilities, serious health conditions from birth or a young age, and whether this person has had multiple (more than 3) miscarriages or stillbirths.**	**IF this person has a genetic condition, at the time of diagnosis, where did this person live?** (e.g. City/ Province)
Father's sister 1				
Father's sister 2				
Father's sister 3				
Father's brother 1				
Father's brother 2				
Father's brother 3				

If any of the above are half-siblings, please list their names below and name the parent they share with the referred patient's father:

_____

_____

The Referred Patient's Cousins
(Children of the patient's Father's brothers and sisters)

Name First, Last and **Name of Parent**	**Gender** (boy/ girl)	**Date of Birth** (or age if unknown)	**Living or deceased?** (give age and cause of death if deceased)	**Please list any diagnosed medical or genetic conditions, birth defects, learning disabilities, serious health conditions from birth or a young age, and whether this person has had multiple (more than 3) miscarriages or stillbirths.**	**IF this person has a genetic condition, at the time of diagnosis, where did this person live?** (e.g. City/ Province)
Cousin 1 Parent:					
Cousin 2 Parent:					
Cousin 3 Parent:					
Cousin 4 Parent:					
Cousin 5 Parent:					
Cousin 6 Parent:					

Please include additional cousins on a separate piece of paper if required.

Additional Relatives <u>with known inherited or genetic conditions</u>

Name First, Last and **<u>Relationship to the Referred patient</u>**	**Gender** (boy/ girl)	**Date of Birth** (or age if unknown)	**Living or deceased?** (give age and cause of death if deceased)	**Please list any <u>diagnosed medical or genetic conditions</u>, birth defects, learning disabilities, serious health conditions from birth or a young age, and whether this person has had multiple (more than 3) miscarriages or stillbirths.**	**IF this person has a genetic condition, at the time of diagnosis, where did this person live?** (e.g. City/ Province)
Relative 1 How related:					
Relative 2 How related:					
Relative 3 How related:					
Relative 4 How related:					
Relative 5 How related:					
Relative 6 How related:					

Please remember to send this form to us by mail or fax at least <u>two weeks prior</u> to your appointment. Having this information in advance will help us prepare for your Genetics appointment.

****Thank you for your time. We look forward to meeting with you and your child.****