Genetics # :
Appointment:

REGIONAL GENETICS PROGRAM
PROGRAMME RÉGIONAL DE GÉNÉTIQUE

FAMILY HISTORY QUESTIONNAIRE: Vascular Genetics

Return Options		
In person	**By Mail**	**By Fax**
CHEO Genetics Clinic - WC2 3rd Floor Max Keeping Wing	Genetics Clinic - WC2 CHEO, 401 Smyth Road Ottawa, ON, K1H 8L1	613-738-4220

(**Please complete to the best of your ability; add additional sheets as needed)

Contact / Registration Information (please complete ALL areas) :

Full Name of referred Individual (First, Middle & Last):	Previous Name :	Date of Birth : (D/M/Y)

PATIENT'S PARENTS AND GRANDPARENTS

NAME	**DOB** (dd/mm/yyyy)	**Current age or Deceased at age**	**HEIGHT** if known or approx	**LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS**
Father:		☐ Alive age: ☐ Deceased at age:		
Paternal Grandfather:		☐ Alive age: ☐ Deceased at age:		
Paternal Grandmother:		☐ Alive age: ☐ Deceased at age:		
Mother:		☐ Alive age: ☐ Deceased at age:		
Maternal Grandfather:		☐ Alive age: ☐ Deceased at age:		
Maternal Grandmother:		☐ Alive age: ☐ Deceased at age:		

Paternal Ancestry:
- ☐ European
- ☐ Black
- ☐ Latino
- ☐ French Canadian
- ☐ Other (specify):
- ☐ Indigenous
- ☐ Middle Eastern
- ☐ Ashkenazi Jewish
- ☐ South Asian
- ☐ East Asian

Maternal Ancestry:
- ☐ European
- ☐ Black
- ☐ Latino
- ☐ French Canadian
- ☐ Other (specify):
- ☐ Indigenous
- ☐ Middle Eastern
- ☐ Ashkenazi Jewish
- ☐ South Asian
- ☐ East Asian

PATIENT'S SIBLINGS

NAME	**GENDER (M/F)**	**DOB** (dd/mm/yyyy) **or approx age**	**HEIGHT** if known or approx	**LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)**

Do all these brothers/sisters share both the same parents? ☐ Yes ☐ No

If some of these siblings are half-sibling, next to their names, please indicate which parent they have in common with the person referred

PATIENT'S CHILDREN

NAME	GENDER (M/F)	DOB (dd/mm/yyyy) **or approx age**	**HEIGHT** If known or approx	**LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)**

PATIENT'S AUNTS & UNCLES (Father's side)

NAME	GENDER (M/F)	DOB (dd/mm/yyyy) **or approx age**	**HEIGHT** If known or approx	**LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)**

PATIENT'S AUNTS & UNCLES (Mother's side)

NAME	GENDER (M/F)	DOB (dd/mm/yyyy) **or approx age**	**HEIGHT** If known or approx	**LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)**

Why were you/your child referred to Medical Genetics (if known)? What questions or concerns would you like to have answered during your appointment?
Please list any personal health problems (past or present) for the person being referred :
Did any of the parents of the person referred ever have an echocardiogram (ultrasound of the heart)? If so, at which hospital/clinic and when was this study done? Do you know the results?
Is someone in your family affected with the condition for which you/your child is/are being referred? How is this person related to you? (e.g.: sibling, parent, aunt, uncle, grandparent, etc.)
Has anyone in your family been seen by Genetics? If so, 1) do you know at which hospital they were seen and 2) please describe why they were seen:

Does anyone in your family (brothers, sisters, children, parent, aunts, uncles and cousins) have any of the following conditions?	No	Yes*	Mom's Family	Dad's Family	*If yes, please provide the following:	
					Relationship to Patient	At what age?
Example: hearing loss		√	√		***Cousin: Mother's sister's son***	***At birth***
Multiple tendon rupture(s)						
Collapsed lung (pneumothorax)						
Dislocated lens of the eye (ectopia lentis)						
Severe Myopia (near sighted)						
Chest bone malformation (pectus)						
Curve in spine (scoliosis) requiring surgery or bracing						
Cleft palate						
Born with dislocated hips						
Born with club feet						
Sudden death						
Dissection (rupture) of a large blood vessel (if so, please specify which blood vessel)						
Surgery to repair a blood vessel						
Aneurysm of the aorta in the chest						
Aneurysm of the aorta in the abdomen						
Aneurysm non-aortic (ex. brain, other)						
Stroke						
Heart attack before 50 years old						
Genetic condition (ex. Marfan syndrome or other)						
Kidney disease						
Other						

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MEDICAL HISTORY QUESTIONNAIRE – Vascular Genetics

(Please complete to the best of your ability)

Name: ______________________________ Date of birth (D/M/Y): _________________

Do you have any of the following conditions?	No	Yes
Born with club feet		
Born with dislocated hips		
Migraines		
Headaches		
Muscle weakness		
Myopia (near sighted)		
Had a dilated eye exam		
Cataracts (If yes, age of onset: _____)		
Glaucoma (If yes, age of onset: _____)		
Hearing loss (If yes, age of onset: _____)		
Snoring		
Sleep apnea and/or need a CPAP		
Heart palpitations		
Shortness of breath		
Chest pain		
Dizziness		
Acid reflux (GERD)		
Functional bowel disorder (IBS, bloating, constipation, diarrhea)		
Stretch marks (If yes, age of onset: _____)		
Easy bruising (even before taking aspirin/blood thinner)		
Bruising without knowing how it happened		
Abnormal scars / poor wound healing		
Hyperextensible skin		
Hypermobile joints/very flexible/double jointed		
Joint subluxation (partial dislocation) in the absence of trauma		
Joint dislocation (full dislocation) in the absence of trauma		
Joint pain (If yes, which joints and how often: daily, weekly, monthly)		
Musculoskeletal pain in two or more limbs daily for at least 3 months		
Chronic, widespread pain for over 3 months		
Bone fractures		
Braces for your teeth		
Expander for your palate		
Delayed exfoliation of primary teeth (delay in baby teeth falling out)		

Do you have any of the following conditions? (now or had in the past)	No	Yes	If yes, describe
Diabetes			Age of onset: _____ Well controlled? Y or N
High blood pressure (hypertension)			Age of onset: _____ Well controlled? Y or N
High cholesterol (hypercholesterolemia)			Age of onset: _____ Well controlled? Y or N
Collapsed lung (pneumothorax)			Age of onset: _____
Hernia			Age of onset: _____
Tendon rupture			Age of onset: _____
Prolapse (rectal and/or vaginal)			Age of onset: _____
Other: ______________________________			Age of onset: _____

Other medical history and lifestyle questions			
At what age did you start walking?			
How many pregnancies have you had? _______ or n/a			
Have you had any surgeries? (if yes, what type and at what age)			
What is your type of employment? (describe or indicate n/a)			
Lifestyle questions:	**No**	**Yes**	**If yes, describe**
Do you smoke?			
Do you drink alcohol?			
Do you use drugs?			
Do you play a wind instrument?			
Do you scuba-dive?			
Do you play contact sports (sports with a risk of impact)?			
Do you exercise?			

Please list all your current medications including vitamins and supplements:	
Name of medication:	Dose: