The Children's Hospital of San Antonio™
CHRISTUS Health

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Baylor College of Medicine

Genetics Clinic Adult Patient Questionnaire

To help us understand your medical situation, please answer the questions below. Select yes or no for each question as indicated and use the space provided to add an explanation in your own words.

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

What kind of work do you do? _____

Name of the person filling out this form: _____

Relationship to patient: _____

Who will accompany you to your appointment? _____

Primary Care Physician (PCP) Name: _____

Name of Practice: _____

PCP Address: _____

PCP Phone Number: _____ PCP Fax Number: _____

Did another health care provider refer you to our clinic? ☐ Yes ☐ No

If yes, referring health care provider: _____

Specialty: _____

Why do you or your doctor want a genetics evaluation? How did this question come up? Why is it important to get an answer?

Background: From Birth to Adulthood

Where were you born? City: _____ State: _____ Country: _____

How old was your mother when you were born? _____ years old

How many children did she have before you? _____ How many pregnancies before you? _____

Did she have any difficulties with your pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

Was there prenatal genetic testing? ☐ Yes ☐ No

If yes, what? _____

Were you born early? ☐ Yes ☐ No If yes, how many weeks gestation: _____

How much did you weigh? _____ pounds _____ ounces/_____ kg

Did you require care in the NICU or intensive care nursery? ☐ Yes ☐ No

Did you have any birth defects? ☐ Yes ☐ No If so, what were they?

Where did you grow up? City: _____ State: _____ Country: _____

Yes	No	Birth to 18 Years	If you answered YES, please explain here:
☐	☐	As an infant (from birth to 12 months of age) were you unwell?	
☐	☐	Did you have any problems with growth or development?	
		How old were you when you walked?	_____ Years _____ Months
☐	☐	Were you slow to speak?	
☐	☐	Did you receive speech therapy?	
☐	☐	Did you receive occupational or physical therapy?	
☐	☐	Did you repeat a grade in elementary school?	
☐	☐	Did you repeat a grade in middle school/junior high or high school?	
☐	☐	Did you receive special education?	
☐	☐	Did you have learning disabilities?	
☐	☐	Were you diagnosed with autism?	
☐	☐	Early or delayed puberty?	
☐	☐	Did you have any serious illnesses before turning 18?	
☐	☐	Did you have any surgeries before you were 18?	
☐	☐	Were you hospitalized before you were 18?	

Yes	No	Since you turned 18 years old, have you had:	If you answered YES, please explain here:
☐	☐	Any serious illnesses?	
☐	☐	Any prior surgeries?	
☐	☐	Overnight hospitalizations?	
☐	☐	Any chronic illnesses?	

General

How is your general health?

What do you consider your biggest health problem?

When was the last time you were completely well?

Have you ever seen a clinical geneticist or a genetic counselor?

Whom did you see? _____

Where was the office? _____

Was it one visit or many? _____ When did you see them? _____

Do you have a copy of the evaluation? ☐ Yes ☐ No Have you ever had any genetic tests? ☐ Yes ☐ No If yes, please describe:

Prior Testing and Imaging:

Yes	No		Results	Approximate Date
☐	☐	MRI		
☐	☐	CT		
☐	☐	X-rays		
☐	☐	Ultrasound		
☐	☐	Abnormal Lab Tests		
☐	☐	Other		

Past Medical History:

Have you ever seen a doctor in these specialties:

Yes	No		Physician's Name/Reason/Date of Last Visit
☐	☐	Allery/Immunology	
☐	☐	Audiology (Hearing)	
☐	☐	Cardiology (Heart)	
☐	☐	Dermatology (Skin)	
☐	☐	Ear, Nose, and Throat	
☐	☐	Endocrinology (Hormones)	
☐	☐	Gastroenterology (Stomach/Intestines)	
☐	☐	Hematology/Oncology (Blood/Cancer)	

Yes	No		Physician's Name/Reason/Date of Last Visit
☐	☐	Infertility Specialist	
☐	☐	Nephrology (Kidneys)	
☐	☐	Neurology (Brain)	
☐	☐	Neurosurgery	
☐	☐	Ophthalmology (Eyes)	
☐	☐	Orthopedics (Bones)	
☐	☐	Plastic Surgery	
☐	☐	Psychology/Psychiatry	
☐	☐	Pulmonology (Lungs)	
☐	☐	Rheumatology (Joints)	
☐	☐	Urology	
☐	☐	Other:	

Review of Your Systems:

Yes	No	Cardiovascular	Comments
☐	☐	Heart problems	
☐	☐	Chest pain, tightness, or squeezing	
☐	☐	Shortness of breath lying down	
☐	☐	Need to sleep sitting up	
☐	☐	Heart racing	
☐	☐	Irregular heart beat (palpitations)	
☐	☐	Heart murmur	
☐	☐	Swelling of the legs	
☐	☐	Leg pain when walking	
☐	☐	Abnormal EKG	
☐	☐	Prior echocardiogram	
☐	☐	Other concerns about your heart or blood vessels	

Yes	No	Eyes, Ears, Nose, Throat	Comments
☐	☐	Decreased ability to see or blindness	
☐	☐	Blurred vision	
☐	☐	Cataracts	
☐	☐	Difficulty in hearing or deafness	
☐	☐	Ringing in your ears	
☐	☐	Trouble smelling things	
☐	☐	Nosebleeds	
☐	☐	Dental problems	
☐	☐	Hoarseness	
☐	☐	Other problems with eyes, ears, nose, or throat	

Yes	No	Allergy/Immunology	Comments
☐	☐	Seasonal allergies	
☐	☐	Weak immune system or recurrent infections	
☐	☐	Recent or recurrent fever	
☐	☐	Food allergies	
☐	☐	Other	

Yes	No	Respiratory	Comments
☐	☐	Cough	
☐	☐	Wheezing	
☐	☐	Shortness of breath	
☐	☐	Breathing fast	
☐	☐	Tobacco use or smoking	
☐	☐	Other breathing or lung problems	

Yes	No	Gastrointestinal	Comments
☐	☐	Weight gain or obesity	
☐	☐	Weight loss or underweight	
☐	☐	Nausea	
☐	☐	Vomiting	
☐	☐	Trouble swallowing	
☐	☐	Diarrhea	
☐	☐	Constipation	
☐	☐	Poor Appetite	
☐	☐	Heartburn	
☐	☐	Abdominal pain	
☐	☐	Blood in stools	
☐	☐	Black stools	
☐	☐	Special diet	
☐	☐	Do some foods make you sick?	
☐	☐	Do you use antacids? How often?	
☐	☐	Hemorrhoids	
☐	☐	Other concerns about your stomach, digestion, liver, or abdomen	

Yes	No	Endocrine	Comments
☐	☐	Diabetes	
☐	☐	Thyroid problem	
☐	☐	Goiter	
☐	☐	Heat intolerance	
☐	☐	Cold Intolerance	
☐	☐	Change in pitch of the voice	
☐	☐	Increased body hair	
☐	☐	Decreased body hair	
☐	☐	Darkening of skin color	
☐	☐	Other	

Yes	No	Genito-Reproductive (Male)	Comments
☐	☐	Concerns about the shape or size of your penis	
☐	☐	Concerns about the shape or size of your testicles	
☐	☐	Performance problems	
☐	☐	Infertility	
☐	☐	Low sperm count	

Yes	No	Breast	Comments
☐	☐	Lumps	
☐	☐	Pain	
☐	☐	Discharge from your nipple	
☐	☐	Abnormal mammograms	
☐	☐	Abnormal breast MRI	
☐	☐	Other	

Yes	No	Genito-Reproductive (Female)	Comments
☐	☐	Age of onset of menstrual periods	
☐	☐	Age which periods stopped (menopause)	
☐	☐	Pregnancies, specify number	
☐	☐	Live births, specify number	
☐	☐	Miscarriages or pregnancy losses, specify number	
☐	☐	Infertility	
☐	☐	Prenatal genetic carrier testing for cystic fibrosis	
☐	☐	Prenatal genetic carrier testing for any other genetic disease	
☐	☐	Abnormal uterine findings (shape, size, fibroids)	
☐	☐	Other	

Yes	No	Hematology/Oncology	Comments
☐	☐	Easy bleeding	
☐	☐	Easy bruising	
☐	☐	Anemia	
☐	☐	Clotting problem	
☐	☐	Cancer diagnosis	
☐	☐	Other	

Yes	No	Skin, Nails, Hair	Comments
☐	☐	Birthmarks	
☐	☐	Dark spots	
☐	☐	Moles	
☐	☐	Café-au-lait spots	
☐	☐	Stretch marks	
☐	☐	Hemangiomas	
☐	☐	Small or unusual fingernails or toenails	
☐	☐	Thin hair	
☐	☐	Patch of hair in the middle of the back	
☐	☐	Different colors of hair	
☐	☐	Do you pluck the hair between your eyebrows?	
☐	☐	Other	

Yes	No	Musculoskeletal	Comments
☐	☐	Short Stature	
☐	☐	Tall Stature	
☐	☐	Short arms or legs	
☐	☐	Long arms, legs, fingers, or feet	
☐	☐	Flat feet	
☐	☐	High arch of feet	
☐	☐	Foot drop	
☐	☐	Scoliosis	
☐	☐	Can't straighten elbows or knees completely	
☐	☐	Stiffness of any joints	
☐	☐	Deformities of the joints or extremities	
☐	☐	Muscle pain	
☐	☐	Neck pain	
☐	☐	Back pain or joint pain	
☐	☐	Flexible joints	
☐	☐	Joint dislocation	
☐	☐	Multiple broken bones	
☐	☐	Other	

Yes	No	Rheumatology	Comments
☐	☐	Joint pain	
☐	☐	Joint swelling	
☐	☐	Red or warm joints	
☐	☐	Stiff joints	

Yes	No	Urinary	Comments
☐	☐	Unusual odor of urine	
☐	☐	Pain or burning on urination	
☐	☐	Frequent urination	
☐	☐	Large volumes of urine	
☐	☐	Extreme urge to urinate	
☐	☐	Difficulty starting urinary stream	
☐	☐	Kidney stones	

Yes	No	Mental Health	Comments
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Insomnia	
☐	☐	Stress	
☐	☐	Bipolar disorder	
☐	☐	Schizophrenia	
☐	☐	Hallucinations	
☐	☐	Excess alcohol use	
☐	☐	History of substance abuse	

Yes	No	Neurologic	Comments
☐	☐	Weak grip	
☐	☐	Difficulty loosening grip or letting go	
☐	☐	Can you run?	
☐	☐	Can you ride a bike?	
☐	☐	Difficulty with memory	
☐	☐	Is your head bigger or smaller than usual?	
☐	☐	Difficulty with thinking or problem solving	
☐	☐	Seizures	
☐	☐	Headaches	
☐	☐	Blackouts	
☐	☐	Dizziness	
☐	☐	Double vision	
☐	☐	Weakness of an arm or leg	
☐	☐	Stroke	
☐	☐	Numbness	
☐	☐	Poor balance	
☐	☐	Loss of coordination	
☐	☐	Difficulty in speaking	
☐	☐	Tremor of the hands	
☐	☐	Other	