MEDICAL GENETICS PROGRAM
Medical Genetics Clinic
Telephone 250-727-4461
Fax 250-727-4295
Email medicalgenetics@viha.ca

Victoria General Hospital
1 Hospital Way
Victoria, BC V8Z 6R5

Reason for referral: _____

Referred by: _____

The information on this form will help us gather more information about your referral. It is important that we receive this form before your appointment in order to accurately assess your referral in the context of your family information. **Please complete as much information as you can and return this form in the envelope provided, by fax or email as soon as possible.** The more details you provide, the more accurate our assessment will be.

Tips for completing this form:

- Please print clearly.
- If you need more space for any section, please attach an extra page.
- Provide the name(s) that your relatives commonly use if different from their given name(s).
- Approximate information is okay. If you do not have exact information, please provide your "best guess".
- This information will be kept on file as part of your Medical Genetics medical record. We will not share this information with others unless we have consent either from you.

If you have any questions or concerns about this form, please contact the Medical Genetics reception at 250-727-4461, located at the Victoria General Hospital.

QUESTIONNAIRE - ADULT

Patient's Name:	_____	_____	_____	VI# _____
	Last Name	First Name	Date of Birth	Our Reference No.
Address:	_____		_____	_____
	Street		City	Postal Code
Telephone:	_____	_____	_____	_____
	Home	Work	Cell	Other
Partner's Name:	_____	_____	_____	_____
(if applicable)	Last Name	First Name	Date of Birth	PHN/Care Card #

Please use this space to list any question or concerns that you would like addressed at the appointment.

_____

_____

_____

_____

Has another person in your family been seen in a Medical Genetics Clinic or had genetic testing? Please list these other care providers:

☐No ☐Yes ☐Unsure If yes, Name of family member: _____

For what condition: _____

Where and when: _____

FOR OFFICE USE ONLY

Referral Date: _____

Date Received: _____

YOUR HEALTH & EDUCATION

Have you had any surgeries, major illnesses or prolonged hospitalizations?
☐No ☐Yes, please list _____

Are you currently taking any medications?
☐ No ☐Yes, please list _____

What education level have you completed?
Grade Level _____ Years of post-secondary school _____

Did you experience any learning or behavioural difficulties during school?
☐ No ☐Yes, details: _____

Please indicate your occupation:
☐Homemaker ☐Student ☐ Not currently employed ☐Employed, details: _____

YOUR HEALTH

Are there any concerns about your:

SKIN e.g. light or dark birth marks; unusual hair or nails; bumps; rashes; absent sweating
☐No ☐Yes _____

EYES e.g. near-sighted; far-sighted; colour blindness; night blindness; cataracts; lazy eye; double vision
☐No ☐Yes _____

EARS e.g. hearing loss; many infections in childhood; ringing
☐ No ☐Yes _____

NOSE e.g. poor sense of smell; frequent colds; nosebleeds
☐No ☐Yes _____

MOUTH / TEETH e.g. cleft lip or palate; early or late eruption of teeth; unusually formed teeth; problems with teeth, gums, or tongue
☐No ☐Yes _____

THROAT / NECK e.g. difficulty swallowing; hoarse voice
☐No ☐ Yes _____

HEAD / BRAIN e.g. headaches; dizziness; seizures; numbness or tingling; balance problems; mood problems; psychiatric condition
☐No ☐Yes _____

HEART e.g. structural defect; murmur; irregular heartbeat; chest pain; high blood pressure
☐No ☐Yes _____

BLOOD e.g. easy bruising; easy bleeding; blood clots; stroke; low blood count
☐No ☐ Yes _____

LUNGS e.g. asthma; chronic wheezing or cough; pneumonia
☐No ☐Yes _____

STOMACH / INTESTINES e.g. frequent vomiting; heartburn; constipation; diarrhea; avoiding specific foods
☐No ☐ Yes _____

URINARY TRACT / GENITALIA e.g. kidney problems; bladder infections; blood in urine; abnormal genitalia
☐No ☐ Yes _____

MUSCLES e.g. weakness; coordination difficulties; paralysis; tight muscles
☐No ☐ Yes _____

Continued…

ENDOCRINE SYSTEM e.g. diabetes; thyroid problems; concerns with weight or growth
☐No ☐Yes _____

BONES / EXTREMITIES e.g. fractures; osteoporosis; abnormal number or shape of fingers or toes; swollen joints
☐No ☐Yes _____

Please list any investigations you have had that might be useful for our assessment: e.g. MRIs, muscle biopsies, blood tests

Type of investigation	Date	Location	Type of investigation	Date	Location

Please list any other specialists/health care providers you have seen or who are following you:

Name	Speciality	Location	Name	Speciality	Location

YOUR PARTNER'S HEALTH & FAMILY HISTORY (if applicable)

Please list any health concerns that your partner or his/her family has:

_____

_____

_____

_____

YOUR CHILDREN

Please list all of your children, as well as any pregnancy losses experienced by you or your partner(s).
If any of your children have a different mother/father, respectively, please indicate.

☐Neither myself nor my partner(s) have had any pregnancies/children.

	Child's name *or* pregnancy outcome (miscarriage, stillbirth, etc.)	Age *or* Date of Birth	Sex (M/F)	Medical or learning problems (if yes, please provide details)
1				☐No ☐Yes
2				☐No ☐Yes
3				☐No ☐Yes
4				☐No ☐Yes
5				☐No ☐Yes

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

_____

YOUR SIBLINGS

Please list all of your brothers/sisters, as well as any pregnancy losses experienced by your biological parents.
If you have any half-brothers or half-sisters, please indicate if they have same mother or father as you.

	Full Name	Sex (M/F)	Still living?	Medical or learning problems (if yes, please provide details)	Their children
1			☐Yes, Current age:	☐Yes ☐No:	# of Male:
			☐No, Age at death:		# of Female:
2			☐Yes, Current age:	☐Yes ☐No:	# of Male:
			☐No, Age at death:		# of Female:
3			☐Yes, Current age:	☐Yes ☐No:	# of Male:
			☐No, Age at death:		# of Female:
4			☐Yes, Current age:	☐Yes ☐No:	# of Male:
			☐No, Age at death:		# of Female:
5			☐Yes, Current age:	☐Yes ☐No:	# of Male:
			☐No, Age at death:		# of Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

YOUR BIOLOGICAL PARENTS

Are your biological parents related by blood? e.g. first cousins
☐No ☐Yes If yes, please explain relationship

YOUR BIOLOGICAL MOTHER

Please provide the following details about your mother and your mother's family:

Name: **Date of Birth (if known):**

Still living? ☐Yes ☐No If no, age and cause of death (if known):

Medical or learning problems? ☐Yes ☐No If yes, please provide details:

What is her race/ethnic ancestry? (Please list all that apply)
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

YOUR BIOLOGICAL MOTHER'S SIBLINGS: Please list your mother's brothers/sisters (your aunts and uncles).

	Full Name	Sex (M/F)	Still living?	Health problems and/or cause of death	Their children
1			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:
2			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:
3			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:
4			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of these aunts/uncles share the same 2 parents?
☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

YOUR BIOLOGICAL MOTHER'S MOTHER (maternal grandmother) Name:
Still living? ☐Yes ☐No If no, age and cause of death (if known):

YOUR BIOLOGICAL MOTHER'S FATHER (maternal grandfather) Name:
Still living? ☐Yes ☐No If no, age and cause of death (if known):

YOUR BIOLOGICAL FATHER

Please provide the following details about your father and your father's family:

Name:_____ **Date of Birth (if known):** _____

Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

Medical or learning problems? ☐Yes ☐No If yes, please provide details: _____

What is his race/ethnic ancestry? (Please list all that apply)_____
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

YOUR BIOLOGICAL FATHER'S SIBLINGS: Please list your father's brothers/sisters (your aunts and uncles).

	Full Name	Sex (M/F)	Still living?	Health problems and/or cause of death	Their children
1			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:
2			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:
3			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:
4			☐Yes: Current Age:		# of Male:
			☐No: Age at Death:		# of Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of these aunts/uncles share the same 2 parents?
☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

YOUR BIOLOGICAL FATHER'S MOTHER (paternal grandmother) Name:_____
Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

YOUR BIOLOGICAL FATHER'S FATHER (paternal grandfather) Name:_____
Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

YOUR FAMILY

Does anyone in your biological family currently have or have a history of any of the following conditions?
Please consider your parents, siblings, nieces, nephews, aunts, uncles, first cousins, and grandparents.

Yes	No	Unsure	Condition	Name and relationship to patient	Details:
☐	☐	☐	Medical problems similar to the patient		
☐	☐	☐	Birth defects		
☐	☐	☐	Intellectual disability/special needs/learning disability		
☐	☐	☐	Chromosome condition (eg. Down syndrome)		
☐	☐	☐	Two or more miscarriages		
☐	☐	☐	Stillbirth or early childhood death		
☐	☐	☐	Cancer under the age of 50		
☐	☐	☐	Any health condition being passed down in the family		