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.

K# __________ **Appointment with:** _____________________ **Appointment date:** _________________

Patient Name: ____

Date of Birth: _________________ **Sex (circle one):** Male / Female / Unknown

Primary physician (location): ____

Person completing this form: ________________________ Relationship to patient: __________________

Daytime Phone #: ______________________ Address: ____

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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:

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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 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 Birth Parents (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	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 Brothers and Sisters (please include half siblings, miscarriages, stillbirths, and deceased individuals)

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

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

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

Name	Sex	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	Relationship to Patient (eg. second cousin)	Date of Birth (or age if unknown)	Genetic Diagnosis	City (at the time the diagnosis was made)