

**GENETICS PRE-VISIT HEALTH RISK ASSESSMENT**

**PATIENT NAME:**

**CURRENT AGE:**

**BIOLOGICAL SEX:** MALE FEMALE

**DATE OF BIRTH:**

**GENDER IDENTITY:** MALE FEMALE NON-BINARY

(IF A MINOR) PATIENT'S MOTHER'S NAME :  
PATIENT'S FATHER'S NAME:

**REFERRED BY:**

NAME:  
ADDRESS:  
TELEPHONE NUMBER:  
FAX NUMBER:

**PRIMARY CARE PHYSICIAN:**

NAME:  
ADDRESS:  
TELEPHONE NUMBER:  
FAX NUMBER:

**WHY ARE YOU SEEKING A GENETIC EVALUATION?**

**WHEN DID THIS PROBLEM PRESENT?**

**WHICH OF THESE GENETIC TESTS HAVE BEEN PERFORMED ON YOU IN THE PAST?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CHROMOSOME ANALYSIS (KARYOTYPE) | <input type="checkbox"/> WHOLE EXOME SEQUENCING   | <input type="checkbox"/> MUTATION ANALYSIS               |
| <input type="checkbox"/> CHROMOSOMAL MICROARRAY          | <input type="checkbox"/> WHOLE GENOME SEQUENCING  | <input type="checkbox"/> CARRIER SCREENING               |
| <input type="checkbox"/> FISH TEST                       | <input type="checkbox"/> DNA METHYLATION ANALYSIS | <input type="checkbox"/> OTHER SPECIALIZED GENETIC STUDY |
|  |   | <input type="checkbox"/> NONE OF THE ABOVE               |

**HAVE ANY OF THESE GENETIC TESTS BEEN PERFORMED ON A BLOOD RELATIVE? IF SO, PLEASE LIST THEIR FAMILIAL RELATIONSHIP TO YOU (E.G., MOTHER, FATHER, SISTER, COUSIN, ETC), NAME OF TEST, AND RESULT:**

**\*\*\*PLEASE FORWARD US RESULTS OF ALL PERTINENT GENETIC TESTS YOU OR YOUR RELATIVES HAVE HAD\*\*\***

**WHICH OF THESE OTHER TESTS AND STUDIES HAVE YOU HAD?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> CT SCAN                  | <input type="checkbox"/> EKG (HEART)        | <input type="checkbox"/> OTHER BLOODWORK            |
| <input type="checkbox"/> DEVELOPMENTAL ASSESSMENT | <input type="checkbox"/> EYE/VISION EXAM    | <input type="checkbox"/> OTHER STUDIES (LIST HERE): |
| <input type="checkbox"/> ECHOCARDIOGRAM           | <input type="checkbox"/> HEARING EVALUATION | <input type="checkbox"/> SKIN BIOPSY                |
| <input type="checkbox"/> EEG (BRAIN)              | <input type="checkbox"/> MRI                | <input type="checkbox"/> ULTRASOUND                 |
|   | <input type="checkbox"/> ORGAN BIOPSY       | <input type="checkbox"/> X-RAYS                     |

**LIST RESULTS HERE (IF YOU NEED MORE SPACE PLEASE USE THE OTHER/COMMENTS SECTION AT THE END OF THIS FORM):**

**PRENATAL HISTORY**

**WHICH OF THE FOLLOWING APPLIED TO THE PATIENT'S MOTHER'S HEALTH DURING HER PREGNANCY WITH THE PATIENT? (CHECK OFF ALL THAT ARE APPLICABLE).**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ABNORMAL FETAL MOVEMENTS | <input type="checkbox"/> EXPOSURE TO CHEMICALS        | <input type="checkbox"/> OTHER PREGNANCY COMPLICATIONS |
| <input type="checkbox"/> ALCOHOL USE              | <input type="checkbox"/> EXPOSURE TO X-RAYS           | <input type="checkbox"/> PRENATAL VITAMIN USE          |
| <input type="checkbox"/> BLEEDING                 | <input type="checkbox"/> FEVER                        | <input type="checkbox"/> TOBACCO USE                   |
| <input type="checkbox"/> CAFFEINE USE             | <input type="checkbox"/> FOLATE USE BEFORE CONCEPTION | <input type="checkbox"/> NONE OF THE ABOVE             |
| <input type="checkbox"/> CHRONIC ILLNESS          | <input type="checkbox"/> INFECTION                    |  |
| <input type="checkbox"/> DRUG USE                 | <input type="checkbox"/> MEDICATION USE               |  |

**PLEASE EXPLAIN IN MORE DETAIL THE ITEMS YOU HAVE CHECKED OFF:**

**GENETICS PRE-VISIT HEALTH RISK ASSESSMENT**

**WHAT PRENATAL TESTING WAS PERFORMED DURING THE PREGNANCY?**

- AFP (OR TRIPLE SCREEN)
- AMNIOCENTESIS
- CHORIONIC VILLUS SAMPLING (CVS)
- GLUCOSE (SUGAR) TEST
- ULTRASOUND
- OTHER:

**PLEASE DESCRIBE ANY ABNORMAL RESULTS:**

**BIRTH HISTORY**

**WAS THE PATIENT BORN:**

- FULL-TERM
- PREMATURELY (NUMBER OF WEEKS:\_\_\_\_\_)

**MODE OF DELIVERY:**

- VAGINAL
- C-SECTION (WHY:\_\_\_\_\_)

**PRESENTATION:**

- HEAD FIRST
- BOTTOM FIRST
- OTHER:

**BIRTH WEIGHT:**

**BIRTH LENGTH:**

**HEAD CIRCUMFERENCE:**

**AT WHICH HOSPITAL (NAME, LOCATION, COUNTRY)?**

**APGAR SCORES, IF KNOWN:**

**BIRTH COMPLICATIONS, IF ANY:**

**LENGTH OF STAY IN NURSERY:**

**REASON FOR PROLONGED STAY, IF APPLICABLE:**

**MEDICAL HISTORY: *Has the patient had any of the following? If so, when?***

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ALLERGIES:_____                   | <input type="checkbox"/> GONORRHEA             | <input type="checkbox"/> MISCARRIAGES         |
| <input type="checkbox"/> ANEMIA                            | <input type="checkbox"/> GOUT                  | <input type="checkbox"/> MONONUCLEOSIS        |
| <input type="checkbox"/> ANOREXIA                          | <input type="checkbox"/> GROWTH PROBLEMS       | <input type="checkbox"/> MOTOR DELAYS         |
| <input type="checkbox"/> ANXIETY DISORDER                  | <input type="checkbox"/> HEARING PROBLEMS      | <input type="checkbox"/> MULTIPLE SCLEROSIS   |
| <input type="checkbox"/> ASTHMA                            | <input type="checkbox"/> HEART DISEASE         | <input type="checkbox"/> MUSCULAR DYSTROPHY   |
| <input type="checkbox"/> ATTENTION DEFICIT/ADHD            | <input type="checkbox"/> HEPATITIS             | <input type="checkbox"/> PACEMAKER            |
| <input type="checkbox"/> BEDWETTING/SOILING                | <input type="checkbox"/> HERNIA (TYPE:_____)   | <input type="checkbox"/> PNEUMONIA            |
| <input type="checkbox"/> BEHAVIOR PROBLEMS                 | <input type="checkbox"/> HERPES (GENITAL)      | <input type="checkbox"/> PSYCHIATRIC DISORDER |
| <input type="checkbox"/> BIPOLAR DISORDER                  | <input type="checkbox"/> HIGH BLOOD PRESSURE   | <input type="checkbox"/> SCHIZOPHRENIA        |
| <input type="checkbox"/> BLEEDING DISORDERS                | <input type="checkbox"/> HIGH CHOLESTEROL      | <input type="checkbox"/> STD                  |
| <input type="checkbox"/> BLOOD TRANSFUSION<br>(WHEN:_____) | <input type="checkbox"/> HIV POSITIVE          | <input type="checkbox"/> STROKE               |
| <input type="checkbox"/> CANCER                            | <input type="checkbox"/> HYPOTHYROIDISM        | <input type="checkbox"/> SUICIDE ATTEMPT      |
| <input type="checkbox"/> CATARACTS                         | <input type="checkbox"/> HYPERTHYROIDISM       | <input type="checkbox"/> SLEEPING PROBLEMS    |
| <input type="checkbox"/> CHLAMYDIA                         | <input type="checkbox"/> INFECTIOUS DISEASE    | <input type="checkbox"/> SPEECH DELAYS        |
| <input type="checkbox"/> DEPRESSION                        | <input type="checkbox"/> IMMUNOLOGICAL DISEASE | <input type="checkbox"/> SYPHILIS             |
| <input type="checkbox"/> DIABETES                          | <input type="checkbox"/> KIDNEY DISEASE        | <input type="checkbox"/> THYROID DISEASE      |
| <input type="checkbox"/> EMPHYSEMA                         | <input type="checkbox"/> LEARNING DISABILITY   | <input type="checkbox"/> TUBERCULOSIS         |
| <input type="checkbox"/> EPILEPSY/SEIZURES                 | <input type="checkbox"/> LIVER DISEASE         | <input type="checkbox"/> UNUSUAL HABITS       |
| <input type="checkbox"/> FEEDING DIFFICULTIES              | <input type="checkbox"/> LOW BLOOD PRESSURE    | <input type="checkbox"/> ULCERS               |
| <input type="checkbox"/> GLAUCOMA                          | <input type="checkbox"/> LOW CHOLESTEROL       | <input type="checkbox"/> VISION PROBLEMS      |
| <input type="checkbox"/> GOITER                            | <input type="checkbox"/> MANIC DISORDER        | <input type="checkbox"/> OTHER:               |
|  | <input type="checkbox"/> MIGRAINES             | <input type="checkbox"/> NONE OF THE ABOVE    |

**PLEASE EXPLAIN ANY ITEMS CHECKED OFF ABOVE:**

**DESCRIBE ANY CHRONIC MEDICAL ISSUES OR SIGNIFICANT ILLNESSES NOT LISTED ABOVE (IF NONE, WRITE "NONE"):**

**LIST PRIOR HOSPITALIZATIONS (HOSPITAL, DATE, DIAGNOSIS, TREATMENT) (IF NONE, WRITE "NONE"):**

**LIST PRIOR SURGERIES (HOSPITAL, DATE, DIAGNOSIS) (IF NONE, WRITE "NONE"):**

**GENETICS PRE-VISIT HEALTH RISK ASSESSMENT**

**CURRENT PRESCRIBED OR OVER-THE-COUNTER MEDICATIONS THE PATIENT IS TAKING, INCLUDING DOSES:**

**LIST ALLERGIES TO MEDICATIONS AND TYPE OF REACTION:**

**LIST ANY DIETARY RESTRICTIONS:**

**HOURS OF SLEEP PER NIGHT:**

**IMMUNIZATIONS UP TO DATE?    YES                    NO**

**HOW MANY COVID VACCINES HAS THE PATIENT HAD (INCLUDE DATES)?    DOSE 1:                    DOSE 2:                    DOSE 3:                    DOSE 4:**

**PHYSICIANS INVOLVED IN THE PATIENT’S MEDICAL CARE (NAME/SPECIALITY/LAST VISIT/NEXT VISIT):**

**SOCIAL HISTORY:\***

- WITH WHOM DOES THE PATIENT LIVE?
- HOW MANY DAYS A WEEK DOES THE PATIENT HAVE AN ALCOHOLIC DRINK?
- HOW MANY ON A TYPICAL DAY?
- HOW OFTEN MORE THAN 6 PER DAY?    DAILY    WEEKLY    MONTHLY    LESS THAN MONTHLY    NEVER
- HOW MANY CIGARETTES DOES THE PATIENT SMOKE PER DAY?                    FOR HOW MANY YEARS?
- HOW MANY CAFFEINATED DRINKS DOES THE PATIENT HAVE PER DAY?
- ARE ANY OTHER SUBSTANCES USED?

**DEVELOPMENTAL SCREENING (FOR CHILDREN)**

**AT WHAT AGE WAS THE PATIENT FIRST ABLE TO DO THE FOLLOWING TASKS?**

*(IF YOU CANNOT REMEMBER WHEN, BUT YOUR CHILD CAN PERFORM THE TASK, JUST CHECK THE BOX. IF YOU KNOW THAT THE SKILL WAS REACHED LATER THAN NORMAL, WRITE "LATE"):*

ASK FOR FOOD	SAY FIRST WORD
BABBLE	SAY MAMA/DADA
CRAWL	SIT UNSUPPORTED
CRAWL UP STAIRS	SMILE
ENJOY LOOKING AROUND	TELL HIS/HER NAME AND AGE
FINGERFEED	TELL STORIES
JUMP SKIP	TURN HEAD TO SOUND
LAUGH	USE A SPOON
LIFT CHEST WHILE ON STOMACH	USE A CUP
MANAGE STEPS WITHOUT HELP	USE TWO-WORD COMBINATIONS
NAME COLORS	WALK ALONE
PEDAL A TRICYCLE	WALK ALONG FURNITURE/ WALL
PLAY WITH OTHERS	WALK WITH HANDS HELD
POINT TO BODY PARTS	WAVE BYE-BYE
RAISE HEAD WHILE ON STOMACH	RECOGNIZE PARENTS
RECONGIZE STRANGERS	ROLL OVER
RUN	

**LIST THE PATIENT’S GRADE LEVEL IN SCHOOL:**

**THE PATIENT IS ENROLLED IN:**

- REGULAR CLASSES
- SPECIAL EDUCATION

**THE PATIENT RECEIVES:**

- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- SPEECH THERAPY
- INFANT STIMULATION
- ADAPTIVE PE
- OTHER THERAPY

**GENETICS PRE-VISIT HEALTH RISK ASSESSMENT**

HAS THE PATIENT BEEN REFERRED TO A REGIONAL CENTER:

YES (WHICH ONE? \_\_\_\_\_)  NO

DO YOU HAVE ANY CONCERNS ABOUT THE PATIENT'S DEVELOPMENT OR SCHOOL PERFORMANCE? YES NO  
IF YES, PLEASE DESCRIBE HERE:

**EDUCATIONAL/DEVELOPMENTAL/OCCUPATIONAL SCREENING (FOR ADULTS)**

WHAT LEVEL OF EDUCATION HAS THE PATIENT ATTAINED?

DOES THE PATIENT HAVE DEVELOPMENTAL DELAY, LEARNING OR INTELLECTUAL DISABILITY, OTHER COGNITIVE IMPAIRMENT, OR BEHAVIORAL DISORDER? IF SO, PLEASE DESCRIBE.

IS THE PATIENT EMPLOYED? YES NO

IF SO, WHAT IS THE OCCUPATION?

**THREE GENERATION FAMILY HISTORY SCREENING FOR PEDIGREE ANALYSIS**

ARE THERE ANY BLOOD RELATIVES WITH A SIMILAR PROBLEM AS THE PATIENT? YES NO

IF YES, WHO?

**PATIENT'S MOTHER'S MEDICAL HISTORY**

CURRENT AGE:  
DATE OF BIRTH:  
HEIGHT:  
NUMBER OF TOTAL PREGNANCIES:  
NUMBER OF LIVE BIRTHS:

NUMBER OF MISCARRIAGES:  
NUMBER OF STILLBIRTHS:  
MEDICAL PROBLEMS:  
MEDICATIONS USED:

**PATIENT'S FATHER'S MEDICAL HISTORY**

CURRENT AGE:  
DATE OF BIRTH:  
HEIGHT:

MEDICAL PROBLEMS:  
MEDICATIONS USED:

ARE THE PATIENT'S MOTHER AND FATHER BLOOD-RELATED (E.G., COUSINS?) YES NO

**LIST THE PATIENT'S CHILDREN (IF ANY):**

NAME	AGE	SEX	HEALTH

**BROTHERS AND SISTERS OF PATIENT**

(IF HALF-SIBLINGS, PLEASE NOTE MATERNAL OR PATERNAL) (ADD LINES IF NEEDED):

NAME	AGE	SEX	HEALTH	FULL OR HALF SIBLING

**GENETICS PRE-VISIT HEALTH RISK ASSESSMENT**

DO THE PATIENT'S BROTHERS AND SISTERS HAVE KIDS?

ARE THEY HEALTHY?

**GRANDPARENTS OF PATIENT**

RELATIONSHIP	NAME	AGE	ETHNICITY *	HEALTH
MATERNAL GRANDMOTHER				
MATERNAL GRANDFATHER				
PATERNAL GRANDMOTHER				
PATERNAL GRANDFATHER				

\*ETHNICITY: Mark if your grandparents or other ancestors are from any of these geographic regions or ethnic groups (relates to the epidemiology of some genetic diseases):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> African           | <input type="checkbox"/> Filipino                       | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Ashkenazic Jewish | <input type="checkbox"/> French Canadian                | <input type="checkbox"/> Persian Jewish   |
| <input type="checkbox"/> Asian             | <input type="checkbox"/> Hispanic                       | <input type="checkbox"/> Sephardic Jewish |
| <input type="checkbox"/> Caribbean         | <input type="checkbox"/> Middle Eastern                 | <input type="checkbox"/> South American   |
| <input type="checkbox"/> Central American  | <input type="checkbox"/> Middle Eastern Jewish          | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> European          | <input type="checkbox"/> Native American/Alaskan Native |   |

**AUNTS AND UNCLES OF PATIENT**

*LIST THE PATIENT'S MOTHER'S BROTHERS AND SISTERS (IF HALF SIBLINGS, PLEASE NOTE MATERNAL OR PATERNAL) (ADD ADDITIONAL LINES IF NECESSARY)*

NAME	AGE	SEX	HEALTH	FULL OR HALF SIBLING

*LIST THE PATIENT'S FATHER'S BROTHERS AND SISTERS (IF HALF SIBLINGS, PLEASE NOTE MATERNAL OR PATERNAL) (ADD ADDITIONAL LINES IF NECESSARY)*

NAME	AGE	SEX	HEALTH	FULL OR HALF SIBLING

**IS THERE HISTORY IN THE PATIENT'S FAMILY OF:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> ATTENTION DEFICIT/HYPERACTIVITY | <input type="checkbox"/> INFERTILITY              | <input type="checkbox"/> STILLBIRTHS       |
| <input type="checkbox"/> AUTISM                          | <input type="checkbox"/> INTELLECTUAL DISABILITY  | <input type="checkbox"/> UNUSUAL FEATURES  |
| <input type="checkbox"/> BIRTH DEFECTS                   | <input type="checkbox"/> MISCARRIAGES             | <input type="checkbox"/> OTHER DISEASES:   |
| <input type="checkbox"/> CANCER                          | <input type="checkbox"/> NEWBORN/CHILDHOOD DEATHS | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> DEVELOPMENTAL DELAY             | <input type="checkbox"/> PSYCHIATRIC DISORDERS    |  |

**IF YES, PLEASE EXPLAIN IN MORE DETAIL:**

**SCREENING BY SYSTEMS**

**PATIENT HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**DOES THE PATIENT HAVE ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS? (IF SO, CHECK THEM OFF BELOW).**

**GENERAL**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> FEVER            | <input type="checkbox"/> FATIGUE                 | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> CHILLS           | <input type="checkbox"/> TEMPERATURE SENSITIVITY |  |
| <input type="checkbox"/> SWEATS           | <input type="checkbox"/> OTHER:                  |  |
| <input type="checkbox"/> CHANGE IN WEIGHT |  |  |

**SKIN**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> RASHES        | <input type="checkbox"/> LUMPS            | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> EASY BRUISING | <input type="checkbox"/> SKIN CHANGES     | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> ECZEMA        | <input type="checkbox"/> NAIL CHANGES     |  |
| <input type="checkbox"/> BIRTHMARKS    | <input type="checkbox"/> CHANGES IN MOLES |  |

**EYES**

- |   |                                     |   |
|---|-------------------------------------|---|
| <input type="checkbox"/> REDNESS          | <input type="checkbox"/> GLAUCOMA   | <input type="checkbox"/> SENSITIVITY TO LIGHT |
| <input type="checkbox"/> DISCHARGE        | <input type="checkbox"/> CATARACTS  | <input type="checkbox"/> OTHER:               |
| <input type="checkbox"/> CHANGE IN VISION | <input type="checkbox"/> EYEGLASSES | <input type="checkbox"/> NONE OF THE ABOVE    |

**EARS**

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> INFECTIONS | <input type="checkbox"/> HEARING IMPAIRMENT | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> RINGING    | <input type="checkbox"/> OTHER:             |  |

**NOSE**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> BLEEDING       | <input type="checkbox"/> NASAL POLYPS | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> OTHER:       |  |

**MOUTH/THROAT**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> PROBLEMS WITH TEETH | <input type="checkbox"/> FREQUENT SORE THROATS | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> PROBLEMS WITH GUMS  | <input type="checkbox"/> UNUSUAL VOICE         | <input type="checkbox"/> NONE OF THE ABOVE |

**NECK**

- |                                 |   |  |
|---------------------------------|---|--|
| <input type="checkbox"/> GOITER | <input type="checkbox"/> PAIN             | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> LUMPS  | <input type="checkbox"/> THYROID PROBLEMS | <input type="checkbox"/> NONE OF THE ABOVE |

**CHEST**

- |                                   |   |  |
|-----------------------------------|---|--|
| <input type="checkbox"/> COUGH    | <input type="checkbox"/> SHORTNESS OF BREATH                | <input type="checkbox"/> PNEUMONIA         |
| <input type="checkbox"/> ASTHMA   | <input type="checkbox"/> SHORTNESS OF BREATH WHILE SLEEPING | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> SNORING  | <input type="checkbox"/> RESPIRATORY PROBLEMS               | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> PAIN     |   |  |
| <input type="checkbox"/> WHEEZING |   |  |

**HEART**

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> SHORTNESS OF BREATH WITH EXERTION | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> HEART MURMUR |  | <input type="checkbox"/> NONE OF THE ABOVE |

**DIGESTIVE**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> BLOOD IN STOOLS  | <input type="checkbox"/> NAUSEA                | <input type="checkbox"/> VOMITING          |
| <input type="checkbox"/> CONSTIPATION     | <input type="checkbox"/> POOR APPETITE         | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> DIARRHEA         | <input type="checkbox"/> STOMACH ACHES         | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> EXCESSIVE HUNGER | <input type="checkbox"/> SWALLOWING DIFFICULTY |  |
| <input type="checkbox"/> FOOD INTOLERANCE | <input type="checkbox"/> THIRST                |  |
| <input type="checkbox"/> LIVER DISEASE    |  |  |

**URINARY**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> PAIN ON URINATION    | <input type="checkbox"/> FREQUENT URINATION  | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> BLOOD IN URINE       | <input type="checkbox"/> BEDWETTING          | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> STRONG ODOR OF URINE | <input type="checkbox"/> UNUSUAL URINE COLOR |  |

**MUSCLE/BONE**

- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> WEAKNESS               | <input type="checkbox"/> CRAMPS     | <input type="checkbox"/> OTHER:            |
| <input type="checkbox"/> LIMITATION OF MOVEMENT | <input type="checkbox"/> STIFFNESS  | <input type="checkbox"/> NONE OF THE ABOVE |
|   | <input type="checkbox"/> JOINT PAIN |  |

**GENETICS PRE-VISIT HEALTH RISK ASSESSMENT**

**NEUROLOGIC**

- HEADACHE
- FAINTING
- TINGLING
- MOOD CHANGES
- SEIZURES
- SLEEP DISORDERS
- DIZZINESS
- TREMORS
- UNSTEADY GAIT
- TICS
- NUMBNESS
- SPEECH DISORDER
- OTHER:
- NONE OF THE ABOVE

**PSYCHIATRIC\*\***

- LOSS OF INTEREST IN ACTIVITIES
- DIFFICULTY CONCENTRATING
- FEELING DEPRESSED/HOPELESS
- MOVING/SPEAKING MORE SLOWLY
- FEELING RESTLESS/FIDGETY
- WANTING TO HURT YOURSELF OR OTHERS
- OTHER:
- NONE OF THE ABOVE

**GYN (FOR FEMALES)**

- CURRENTLY PREGNANT? YES NO UNSURE
- IF YES, HOW MANY WEEKS?
- NUMBER OF PREGNANCIES:
- NUMBER OF LIVE BIRTHS:
- NUMBER OF MISCARRIAGES:
- NUMBER OF STILLBIRTHS:
- AGE AT FIRST PERIOD (MENARCHE):
- DATE OF LAST MENSTRUAL PERIOD:
- PROBLEMS WITH PERIODS (DESCRIBE):
- OTHER GYNECOLOGICAL PROBLEMS (DESCRIBE):
- PLAN ON BECOMING EGG DONOR
- OTHER:
- NONE OF THE ABOVE

**UROLOGICAL (FOR MALES)**

- LOW SPERM COUNT
- OTHER UROLOGICAL PROBLEMS
- MULTIPLE MISCARRIAGES IN FEMALE PARTNER
- PLAN ON BECOMING SPERM DONOR
- OTHER:
- NONE OF THE ABOVE

**OTHER/ADDITIONAL COMMENTS**

THIS FORM WAS COMPLETED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

\*Based on AUDIT-C Screening Tool

\*\*Based on PHQ-9 Screening Tool