Centre universitaire de santé McGill | McGill University Health Centre

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* F M U – 1 7 2 6 *

Department of Medical Genetics
Medical and Family History Questionnaire

Patient Information

Last name: _____ First name: _____
Date of birth: _____ Medicare card _____
Family physician: _____ Referring physician: _____

Please describe the patient's present condition/problem (ie. reason for this appointment):
_____
_____
_____

What are your main questions/concerns?
_____
_____
_____

A. PREGNANCY HISTORY

1. What were the parents' ages at the time of conception? Mother ____ Father ____

2. The parents' health at the time of conception (Give details in space provided):

Mother □ Healthy
□ Other (please explain)
_____
_____

Father: □ Healthy
□ Other (please explain)
_____
_____

3. Did the parents have any trouble getting pregnant? □ No □ Yes (please explain)
_____

4. Did the mother have prenatal care? □ No □ Yes
If yes, when was the first prenatal visit? _____ weeks.
Name of the doctor/hospital: _____ City: _____

5. Did the mother take prenatal vitamins □ No □ Yes
If yes, please state when and what was taken: _____

6. Was any of the following prenatal testing done. If you have copies of any of these results, please send them to us.

	No	Yes	When	Where	Results
a) Amniocentesis	□	□	_____	_____	_____
b) Chorionic villous sampling	□	□	_____	_____	_____
c) Maternal blood screening	□	□	_____	_____	_____
d) Ultrasound	□	□	_____	_____	_____
e) Other (please explain)	□	□	_____	_____	_____

Name :	MRN No.:

7. Was the mother exposed to any of the following during pregnancy?

		No	Yes	Details (**how much** and **when** in the pregnancy?)
a)	Birth control pills	□	□	_____
b)	Medications	□	□	_____
c)	Recreational/street drugs	■	□	_____
d)	X-rays	■	□	_____
e)	Tobacco	□	□	_____
f)	Alcohol	□	□	_____
g)	Other	□	□	_____

8. Did the mother have any of the following difficulties during the pregnancy?

		No	Yes	Details
a)	Infections	□	□	_____
b)	Spotting or bleeding	□	□	_____
c)	Loss of amniotic fluid	□	□	_____
d)	Rashes	□	□	_____
e)	Fever	□	□	_____
f)	High blood pressure	□	□	_____
g)	Edema (swelling)	□	□	_____
h)	Diabetes	□	□	_____
i)	Other	□	□	_____

9. What was the total weight gain during the pregnancy? _____ □ lbs □ kg

10. When did the baby first begin to move? _____ months

11. How active was the baby during pregnancy? (please check all that apply)

Details

□ Active until delivery _____
□ Not active (less than other pregnancies) _____
□ Same activity as other pregnancies _____
□ More active than other pregnancies _____
□ Other (please explain) _____

B. BIRTH HISTORY

1. How long was the pregnancy? _____ months _____ weeks

2. Labour: □ Spontaneous □ Induced (please explain) _____

3. Duration of labour: _____ hours

4. Delivery:

Doctor/Hospital: _____ City: _____

□ Vaginal □ Cesarean (please explain why): _____

If vaginal, how was the baby positioned? □ Head first □ Breech □ Other: _____

5. Birth weight:____ □ lbs □ kg **Length:**____ □ in □ cm **Head circumference:**____ □ in □ cm

6. Apgar scores: _____ at 1 minute _____ at 5 minutes _____ at 10 minutes

Name :	MRN No.:

	No	Yes	Details
7. Complications?	□	□	_____
8. Resuscitation/breathing assistance required?	□	□	_____
9. Unusual placenta or umbilical cord?	□	□	_____
10. Anything unusual or different about the baby?	□	□	_____

C. NEWBORN HISTORY

1. How long did the baby stay in the birthing hospital? _____

	No	Yes	Details
2. Ventilator or oxygen required?	□	□	_____
3. Sleeping problems (too much/little)	□	□	_____
4. Feeding problems	□	□	_____

If yes, how long did the feeding problems last? _____

Was the problem with □ Breast milk or □ Formula

What actions were taken? _____

D. MEDICAL HISTORY (after two months of age)

1. Does the patient have any of the following?

	No	Yes	Details
a) Childhood diseases	□	□	_____
b) Allergies	□	□	_____
c) Seizures	□	□	_____
d) Unexplained high fever	□	□	_____
e) Loss of consciousness with illness	□	□	_____
f) Unusual odor (body or urine)	□	□	_____
g) Unusual movements	□	□	_____
h) Feeding problems	□	□	_____
i) Hearing problems	□	□	_____
j) Behavioural problems	□	□	_____
k) Sleeping problems	□	□	_____
Are the child's vaccinations up to date?	□	□	_____

2. Is the patient taking any prescription medications now, or has he/she taken any for a long period in the past? If there is not enough space, please use a separate sheet of paper.

Medication	Reason	Age began	Age stopped

Name :	MRN No.:

3. Does the patient attend any outpatient clinics? If yes, please list below.

Doctor	Outpatient Clinic	Reason	Dates

4. Has the patient ever been admitted to the hospital wards? If yes, please list below.

Hospital and Doctor	Reason	Dates

5. Has the patient ever been seen by a health professional outside of the hospital (private office or clinic)?

Health Professional	Reason for Appointment	Dates

E. DEVELOPMENTAL HISTORY

1. Does the patient show any developmental delay? □ No □ Yes (please explain) _____

_____

2. Milestones (give approximate age when achieved):

a) Social smile _____ g) Crawl _____ m) Rode tricycle _____
b) Grasp/transfer objects _____ h) First steps _____ n) Rode bicycle _____
c) Roll over (front to back) _____ i) Walk alone _____ o) Button clothes _____
d) Roll over (back to front) _____ j) Say single words _____ p) Tie shoes _____
e) Pull up to sit _____ k) Talk in sentences (3-4 words) _____
f) Sit alone _____ l) Toilet trained _____ day _____ night

3. Has there been any loss of skills? If yes, which skills and when were they lost? _____

_____

_____

Name :	MRN No.:

G. SCHOOL ACHIEVEMENT (if applicable)

1. Does the patient have any learning disabilities? □ No □ Yes (please explain) _____

_____

_____

2. What school does the patient attend? _____

3. What grade is the patient in? _____

4. Does the patient receive any of the following?

	No	Yes	Details
a) Special education	□	□	_____
b) Additional educational support	□	□	_____

5. Has the patient ever had any of the following assessments?

	No	Yes	Ongoing Treatment?	Details
a) IQ testing	□	□	□	_____
b) Psychology	□	□	□	_____
c) Occupational therapy	□	□	□	_____
d) Physiotherapy	□	□	□	_____
e) Speech therapy	□	□	□	_____

F. FAMILY HISTORY

1. If anyone in the patient's immediate or extended family has had any of the following health problems, check the box and include more information about them in the following pages.

- ❑ Blindness
- ❑ Blood disorder (eg. anemia, clotting problem)
- ❑ Bone disorder (eg. curved spine, short bones)
- ❑ Cancer (under age 50)
- ❑ Chromosome abnormality (eg. Down syndrome)
- ❑ Deafness
- ❑ Genetic condition (eg. cystic fibrosis)
- ❑ Heart disease (under age 50)
- ❑ Infertility, stillbirth or more than 3 miscarriages
- ❑ Malformation at birth (eg. club foot, cleft lip)
- ❑ Mental retardation or learning disabilities
- ❑ Neurologic or muscular disorder (under age 65)
- ❑ Psychiatric disorder
- ❑ Other: _____

2. The following questions are about the patient's mother and her family.

Mother's Last Name: _____ First Name: _____

Date of Birth: _____ Medicare #: _____

Are the patient's mother and father related other than through marriage? □ Yes □ No

Does the mother have any medical concerns? If yes, please describe:

_____

_____

Name :	MRN No.:

Does the mother take any medications? If yes, please list:

_____

_____

If the mother has other children, please list them below, including those living and deceased. Fill in the current age and any current medical concerns or the age when deceased and the cause of death.

Full Name	Sex	Age	Medical Concern (if any)

Has the mother had any miscarriages, stillbirths or terminations of pregnancy? If yes, please list below, including the number of weeks and the cause if known:

_____

_____

Mother's brothers and sisters:
List the mother's brothers and sisters below, including those living and deceased. Fill in their current age and any current medical concerns or their age when deceased and the cause of death.

Full Name	Age	Sex	Full/Half	Medical Concern (if any)	Children	
					Boys	Girls

Are any of their children deceased or do any have a medical problem or birth defect? Please describe:

_____

_____

Mother's parents (patient's maternal grandparents):
Are the maternal grandparents related other than through marriage? □ Yes □ No

Grandmother's Full Name: _____ Date of Birth: _____
Country of Origin: _____ Ethnic Background: _____
Does the maternal grandmother have any medical concerns? If yes, please describe:
_____
Did the maternal grandmother have any miscarriages, stillbirths or terminations of pregnancy? If yes, please list, including the number of weeks and the cause, if known:

_____

Does the maternal grandmother have any relatives with medical concerns? If yes, please describe:

_____

_____

Grandfather's Full Name: _____ Date of Birth: _____
Country of Origin: _____ Ethnic Background: _____
Does the maternal grandfather have any medical concerns? If yes, please describe:

_____

Name :	MRN No.:

Does the maternal grandfather have any relatives with medical concerns? If yes, please describe:
_____
_____

3. The following questions are about the patient's father and his family.

Father's Last Name: _____ First Name: _____
Date of Birth: _____ Medicare #: _____

Does the father have any medical concerns? If yes, please describe:
_____
_____

Is the father taking any medications? If yes, please list:
_____
_____

If the father has children other than those listed on the previous page, please list them below. Include those living and deceased, their current age and any current medical concerns or their age when deceased and the cause of death.

Full Name	Sex	Age	Medical Concern (if any)

Has the father had any miscarriages, stillbirths or terminations of pregnancy with a previous partner? If yes, please list below, including the number of weeks and the cause if known:
_____
_____

Father's brothers and sisters:

List the father's brothers and sisters below, including those living and deceased. Fill in their current age and any current medical concerns or their age when deceased and the cause of death.

Full Name	Age	Sex	Full/Half	Medical Concern (if any)	Children	
					Boys	Girls

Are any of their children deceased or do any have a medical problem or birth defect? Please describe:
_____
_____

Father's parents (patient's paternal grandparents):
Are the paternal grandparents related other than through marriage? □Yes □ No

Name :	MRN No.:

Grandmother's Full Name: _____ Date of Birth: _____
Country of Origin: _____ Ethnic Background: _____

Does the paternal grandmother have any medical concerns? If yes, please describe:
_____

Did the paternal grandmother have any miscarriages, stillbirths or terminations of pregnancy? If yes, please list, including the number of weeks and the cause, if known:
_____

Does the paternal grandmother have any relatives with medical concerns? If yes, please describe:
_____
_____

Grandfather's Full Name: _____ Date of Birth: _____
Country of Origin: _____ Ethnic Background: _____

Does the paternal grandfather have any medical concerns? If yes, please describe:
_____

Does the paternal grandfather have any relatives with medical concerns? If yes, please describe:
_____
_____

4. Other:

Is there anyone else in the patient's family with medical concerns that have not been included above? Please list these below.
_____
_____
_____
_____
_____

5. Name of person completing this questionnaire: _____

Relationship to patient: _____

Date (AAAA/MM/JJ): _____