VMP, llc
Expanding Genetic Horizons

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HISTORY QUESTIONNAIRE - Adult

Patient's Name

Patient's Date of Birth

The attached questionnaire is important. It is designed to provide important information in a consistent manner and is needed even if you supply some other narrative of the history. Much of this information is regarding early childhood development, milestones, and family relationships & history. Many have found looking through your "baby book" or other records you may have will frequently generate answers. In addition, it is nice to have a recent photograph.

To take full advantage of the time you have with your physician in your appointment:

- please answer as many of the questions as possible,
- answer as fully as possible, and
- **return to us as soon as possible but at least 2 weeks prior** to your scheduled appointment.

We are honored that you have allowed us to participate in your care.

What do you hope to accomplish with this appointment?

What are the most important questions that need to be addressed during your appointment?

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PREGNANCY: Please answer to the best of your ability. If unknown, please indicate UKN.

1. How old was your mother when she became pregnant with you? _______________

2. What number pregnancy was this pregnancy for your mother? _________________

3. Was prenatal care provided? ☐ yes ☐ no
   If so, do you at what point in pregnancy prenatal care was initiated? ____________

4. Was an ultrasound done as a part of the prenatal care? ☐ yes ☐ no

5. How many ultrasounds were done? ___________
   When during the pregnancy were the ultrasounds completed?

   #1. _____________ #4. _____________
   #2. _____________ #5. _____________
   #3. _____________ #6. _____________

   (Please list on back page any additional ultrasound studies completed.)

   Where was each ultrasound completed? (i.e. OB's office, hospital, etc.)

   #1. _____________ #4. __________
   #2. _____________ #5. __________
   #3. _____________ #6. __________

   (Please list on back page any additional ultrasound studies completed.)

6. Were any of the ultrasounds abnormal? ☐ yes ☐ no
   If **yes**, explain in the space below:

   ____

   ____

7. Were other special studies done during this pregnancy? ☐ yes ☐ no
   Include alpha-fetoprotein, amniocentesis, glucose tolerance test, and other study results here. If **yes**, please explain in the space below:

   ____

   ____

8. List all over-the-counter and prescription medications, vitamins, health preparations, cigarettes, etc. used during this pregnancy (include name/brand, amount, and when taken during the pregnancy).

____

____

____

9. The pregnancy was complicated by (answer yes or no):

	Yes	No	Time in Pregnancy
Bleeding/spotting	______	______	____________
Cold or Flu-like illness	______	______	____________
Bladder Infection	______	______	____________
Fever	______	______	____________
Yeast Infection	______	______	____________
Other Vaginal Infection	______	______	____________
Skin Rash	______	______	____________
Dehydration from Vomiting	______	______	____________
Abnormal growth of the baby	______	______	____________
Premature labor	______	______	____________
High blood pressure	______	______	____________
Blood sugar problems	______	______	____________
Exposure to x-rays or chemicals	______	______	____________
Other	______	______	____________

10. Would your mother describe your activity in the womb during the pregnancy as (check only one):

______ Very active ______ moderately active

______ Occasionally active ______ rarely moved

11. How much weight did your mother gain during pregnancy? ______________

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DELIVERY:

Due Date: __________ Birth date: _________ Birth Hospital: ______________________________

1. Born biologically as: ☐ female ☐ male ☐ unknown Currently identify as:________

2. Born at full-term? ☐ yes ☐ no
   If not, how premature was the birth? ____

3. How long was your mother's labor? _____________ hours

4. What type of delivery ? (Check one):
   a)_______Vaginal ________C-section _________ Repeat C-section because of previous delivery was this way
   b)_______Head first ________Shoulder(s) first _____Bottom first ___Feet first

BIRTH:

1. Weight?___________ Length?____________Chest size?__________ Head size?______

2. Do you know of any problems at birth? If so, please describe in the space below
   (You may use the attached blank sheet)
   ____
   ____
   ____

3. Babies are given special scores at birth called Apgar scores based on the baby's color, breathing, heartbeat, muscle tone, and cry.

   If you have records of the Apgar scores, please record them here:

   ___________ at 1 minute _______________ at 5 minutes

4. After birth, how were you fed? (check one)

   _____Breast _____Bottle _____Other

5. You were discharged from the hospital to home at _________ (days/weeks) of age.

FIRST YEAR:

1. Did you have any complications during the first month of life? ☐ yes ☐ no
   If **yes**, please explain in the space below:
   ____
   ____

2. Were there any complications in the first year of life?
   ____
   ____

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DEVELOPMENTAL MILESTONES HISTORY:

1. Please record your age beside the milestones you met as a child and circle months or years (as best you can):

Rolled over ____ months/years   Sat alone ____ months/years

Crawled ____ months/years   First word ____ months/years

Walked holding onto furniture ____ months/years

Walked alone ____ months/years

2. Did you ever receive any special services (OT, PT, speech)? If **yes**, list type and number of services (e.g. PT 3 times a week for one hour) each session.

____

____

4. Were you ever enrolled in a special education program? ☐ yes ☐ no
If **yes**, at what age? ______________________
(Please bring a copy of any developmental evaluation reports)

What level of education did you complete? (circle one)
Grade school   High School   Technical School   College ____ #yrs

5. Do you feel that you have lost ability to perform skills or life activities that you previously had? ☐ yes ☐ no
If **yes**, please explain in the space below.

____

____

____

6. Do you have vision problems? ☐ yes ☐ no
If yes, please explain in the space below.

____

7. Do you have hearing problems? ☐ yes ☐ no
If yes, please explain in the space below.

____

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TOP PROBLEMS/DIAGNOSES:

(1) ______________________________

(2) ______________________________

(3) ______________________________

(4) ______________________________

(5) ______________________________

GENETIC TESTING TO DATE: (List all genetic testing and which lab performed them)

____

____

HOSPITALIZATIONS: (List all hospital admissions—name of hospital, length of stay and reason for admission) *Please use back of this sheet if additional space is needed.*

____

____

SURGERIES: ______________________________

____

____

PROCEDURES: ______________________________

____

____

Date of last MRI: ____________ **Result of MRI:** ______________________________

MEDICATIONS: What medications/supplements, if any, are you currently taking?

Please use back of this sheet if additional space is needed.

Name of Medication	Dosage	Time

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REVIEW OF SYSTEMS: circle or underline those issues you are experiencing

Constitutional: fatigue, fever, weight loss, weight gain, altered taste/smell, unable to sleep, excessive sleepiness, abnormal growth, lost interest in activities, Birthmark

Cardiovascular: sensation of chest pain/pressure/squeezing, shortness of breath on exertion, lower extremity swelling, chest pressure, fainting, heart failure, high blood pressure, shortness of breath, coronary disease, heat/cold intolerance, fainting

Endocrine: diabetes, thyroid disease, growth disorders, sexual dysfunction, excessive thirst or hunger, frequent urination, nausea

Eyes: double vision, blurred vision, floaters, glaucoma, cataracts, loss of peripheral vision, macular degeneration, drooping eye lids

Gastrointestinal: vomiting, diarrhea, reflux, constipation, abdominal pain, gastritis, hepatitis, hiatal hernia, rectal bleeding, ulcer, indigestion, nausea

Genitourinary: urine incontinence, stool incontinence, sexual dysfunction, constipation

Heme-Lymph: lymph node enlargement or tenderness, blood disorder, diabetes, sickle cell disease, thyroid disease, HIV, AIDS

HENT: loss of hearing, balance problems, nasal congestion, postnasal drip, neck pain, sore throat, tinnitus, allergies/hayfever, trouble breathing through nose, sinus disease, mouth sores, trouble swallowing, snoring

Respiratory: cough, bronchitis, emphysema, pneumonia, tuberculosis, asthma

Integument: rash, breast disease, melanoma, basal cell cancer, abnormal scars, easy bruising

Immunologic: frequent illnesses, recurrent infections

Musculoskeletal: joint pain, joint swelling, back pain, neck pain, hypermobile joints, muscle weakness, loss of muscle mass, lack of endurance

Neurologic: speech difficulties, incoordination, aggressive, trouble learning, trouble hearing, memory difficulties, seizures, tremors, head injuries, dizziness, hallucination, personality change, weakness, pain, facial numbness/tingling, numbness-arms, numbness-legs, nausea, stiffness, difficulty chewing, stares off into space, choking, difficulty tasting, drooling, trouble walking, vertigo, difficulty concentrating, fainting or passing out, difficulty sleeping, swallowing problems, trouble with smell, spells/fits, confusion, hostile/angry

Psychiatric: anxiety, depression, hallucinations, trouble concentrating, schizophrenia, in trouble at school, shy, panic attacks

ALLERGIES: Do you have any allergies? ☐ yes ☐ no

If so, to what medications? ____

Other allergies: ____

____

____

____

PHYSICIANS TO RECEIVE A COPY OF OUR LETTER (s):

Please include fax number as this is how we provide copies.

Name of Physician	Practice/Website	Phone	Fax (important)

(Use another sheet or the back of this page if required)

FAMILY HISTORY

Please complete all sections on this form. If there is not sufficient space provided, use the back of the pages, indicating the section letter being supplemented.

Section A - Information about your brothers and sisters.

Please list these – include any miscarriages that your mother may have had. Differentiate between sisters and brothers who have the same 2 parents as you and those who share only 1 parent. Indicate the parent in common. If any sisters or brothers have had children, include this information and note any problems these children may or may have had.

Name, birth date, sex, living or age at death, medical problems, if any

(1) ____

(2) ____

(3) ____

(4) ____

(5) ____

Section B - Information about your children

Please include in list any miscarriages that you/spouse may have had. Differentiate between children who have different mothers. If any children have had children, include this information and note any problems these children may or may have had.

Name, birth date, sex, living or age at death, medical problems, if any

(1) ____

(2) ____

(3) ____

(4) ____

(5) ____

SECTION C – Information about the your parents and aunts and uncles (parents' brothers and sisters)

In this section, list the patient's "Father" and the "Mother", their sisters and brothers, their children and any medical problems in these individuals.

(Your) Father & His Brothers & Sisters

Your Father: ____________________________
Birth Date: ____________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: __________________
Number of children: _______________________

Name: ____________________________
Age (if living): ____________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: __________________
Number of children: _______________________

Name: ____________________________
Age (if living): ____________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: __________________
Number of children: _______________________

(Your) Mother & Her Brothers & Sisters

Your Mother (maiden): ____________________
Birth date: ____________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: __________________
Number of children: _______________________

Name (maiden): ____________________
Age (if living): ____________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: __________________
Number of children: _______________________

Name (maiden): ____________________
Age (if living): ____________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: __________________
Number of children: _______________________

SECTION D – Information about your Grandparents

In these next 2 sections, list the parents of the "Father" and the "Mother" from Section C (grandparents to you), and each grandparent's sisters and brothers, their children and any medical problems in these individuals. Use additional sheets of paper if necessary.

Father's Family

(His Parents, Aunts, Uncles, Cousins)

Father's Father & His Brothers/Sisters

Father's Father: ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name: ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name: ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name: ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name: ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Father's Mother & Her Brothers/Sisters

Father's Mother (maiden): ____________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name (maiden): ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name (maiden): ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name (maiden): ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Name (maiden): ______________________
Age (if living): ______________________
Medical problems, if known: ______________
If deceased, age at time of death: ________
Cause of death, if known: ______________
Number of children: ___________________

Mother's Family

(Her Parents, Aunts, Uncles, Cousins)

Mother's Father & His Brothers/Sisters

Mother's Father: ________________________
Age (if living): ___________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: _________________
Number of children: _______________________

Name: ________________________________
Age (if living): ___________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: _________________
Number of children: _______________________

Name: ________________________________
Age (if living): ___________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: _________________
Number of children: _______________________

Name: ________________________________
Age (if living): ___________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: _________________
Number of children: _______________________

Name: ________________________________
Age (if living): ___________________________
Medical problems, if known: ________________
If deceased, age at time of death: ___________
Cause of death, if known: _________________
Number of children: _______________________

Mother's Mother & Her Brothers/Sisters

Mother's Mother (maiden): _______________
Age (if living): _________________________
Medical problems, if known: ______________
If deceased, age at time of death: _________
Cause of death, if known: _______________
Number of children: ____________________

Name (maiden): ________________________
Age (if living): _________________________
Medical problems, if known: ______________
If deceased, age at time of death: _________
Cause of death, if known: _______________
Number of children: ____________________

Name (maiden): ________________________
Age (if living): _________________________
Medical problems, if known: ______________
If deceased, age at time of death: _________
Cause of death, if known: _______________
Number of children: ____________________

Name (maiden): ________________________
Age (if living): _________________________
Medical problems, if known: ______________
If deceased, age at time of death: _________
Cause of death, if known: _______________
Number of children: ____________________

Name (maiden): ________________________
Age (if living): _________________________
Medical problems, if known: ______________
If deceased, age at time of death: _________
Cause of death, if known: _______________
Number of children: ____________________

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GENERAL FAMILY INFORMATION:

1. What is the ethnicity of your parents' families (i.e. are you Scottish, Irish, German, Polish, Mayan, Vietnamese, Spanish, Portuguese, African American, etc.)?

   Your mother's family: ______________________________

   Your father's family: ______________________________

2. As far back as you can trace your ancestors; do your parents' have any common relatives? (i.e. do you share a grandparent, great grandparent, etc) ☐ yes ☐ no

GENERAL NOTES: