

## Genetic History Questionnaire

- The answers to these questions will help in your care.
- Please answer these questions as well as you can *with your partner*. The answers remain private.
- If you need help answering the questions, please ask.

*Where both of your ancestors came from may sometimes give us important information about your genetic history.*

- 1 Is your family...
- |  |                             |                              |                                   |
|--|-----------------------------|------------------------------|-----------------------------------|
| ...from Southeast Asia, Taiwan, China or the Philippines?      | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| ...from Italy, Greece or the Middle East?                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| ...African American (Black)?                                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| ...Hispanic/Puerto Rican?                                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| ...French Canadian?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| ...American Indian?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| ...Caucasian, Northern European (French, German, Scandinavia)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| ...Other? (Please specify) _____                               | <input type="checkbox"/> No |                              |                                   |
- 2 Is your family, or your partner's family, European (Ashkenazi) Jewish?
- No  Yes  Not Sure

*The next eight questions will be about you, your partner, and both of your families. When we say "blood relative", we mean your mother, father, sister, brother, grandparent, aunt, uncle, niece, nephew, or cousin.*

- 3 Were you, or your partner, or any blood relative born with an opening in the back or the spine, also called spina bifida?
- No  Yes  Not Sure
- 4 Was there ever a baby (or an unborn baby) in your family or your partner's family who had an opening in the head, also called anencephaly?
- No  Yes  Not Sure
- 5 Is any blood relative in your family or your partner's family mentally retarded?
- No  Yes  Not Sure
- 6 Have you, or your partner, or any blood relative had an unborn baby or a child who had Down syndrome (some call it Trisomy 21)?
- No  Yes  Not Sure
- 7 Do you, or your partner, or any blood relative have any other chromosome problem?
- No  Yes  Not Sure
- 8 Do you, or your partner, or any blood relative have:
- |  |                             |                              |                                   |
|--|-----------------------------|------------------------------|-----------------------------------|
| a. ...cystic fibrosis (CF)?                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| b. ...fragile X syndrome?                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| c. ...muscular dystrophy?                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| d. ...hemophilia or other bleeding disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |
| e. ...Huntington's disease?                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure |

- 9 Were you, or your partner, or any blood relative born with:
- a. ...a heart defect?  No  Yes  Not Sure
  - b. ...a cleft lip and/or cleft palate?  No  Yes  Not Sure
  - c. ...any other birth defect?  No  Yes  Not Sure
- 10 Do you, or your partner, or any blood relative have any other disease or health problem that is inherited (passed on in the family)?  No  Yes  Not Sure

*The next two questions will be about medical conditions that you (the patient) may have.*

- 11 Do you have diabetes?  No  Yes
- 12 Do you have, or have you ever had treatment for, PKU (phenylketonuria) or hyperphenylalaninemia (hyperphe)?  No  Yes  Not Sure

**Patient Name:** \_\_\_\_\_ **Date:**    /    /  
**Reviewed By:** \_\_\_\_\_ **Date:**    /    /