Children's Hospital of Eastern Ontario
Family History Questionnaire

Please fill out the attached questionnaire as completely as possible and either mail or fax it to the clinic ***before*** your appointment.

Instructions

The information you provide in this questionnaire allows us to draw your family tree. A detailed family tree helps us provide you with more accurate information. Here are a few things to keep in mind when completing the questionnaire:

1. The reason we send the form in advance is because some of the questions may require that you contact other family members. By returning the form ***at least one week before*** your appointment date, you allow us to be better prepared for your visit.

2. In some families no one has been born with a problem but there is some concern about a present or future pregnancy. In this case, the PATIENT is your current or future pregnancy, the MOTHER refers to the mother-to-be, and the FATHER refers to the father-to-be.

3. Please be sure to read the questionnaire thoroughly before starting so you have a good idea of what information you will need to provide. Be aware that the questionnaire is double sided, print neatly, and give as much detail as possible.

If you have any problems understanding how to complete this form, please call the clinic.

The Eastern Ontario Regional Genetics Program
3rd Floor, Max Keeping Wing (Clinic WC-2)
Children's Hospital of Eastern Ontario
401 Smyth Road
Ottawa, Ontario
K1H 8L1

FAX: (613) 738-4220

TELEPHONE: (613) 737-7600 Ext 2275

FOR DEPARTMENT USE ONLY:

CHART NO._____

PROVIDER:_____

Children's Hospital of Eastern Ontario
Family History Questionnaire

Please complete this form to the best of your ability.
If the person referred to Genetics is your child, please fill out the form from their perspective (i.e. your child is the PATIENT, and you would include your information as the parent).

PATIENT'S HISTORY

	NAME	GENDER (M/F)	BIRTH DATE (dd/mm/yyyy)	LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)
Patient				

PATIENT'S PARENTS and GRANDPARENTS

	NAME	GENDER (M/F)	BIRTH DATE (dd/mm/yyyy)	LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)
Patient's Mother				
Patient's Father				
Patient's Mother's Mother				
Patient's Mother's Father				
Patient's Father's Mother				
Patient's Father's Father				

PATIENT'S BROTHERS and SISTERS
(Please include any half-siblings, and indicate if you share the same mother or the same father)

RELATIVE	NAME	GENDER (M/F)	BIRTH DATE (dd/mm/yyyy)	LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)

PATIENT'S CHILDREN

RELATIVE	NAME	GENDER (M/F)	BIRTH DATE (dd/mm/yyyy)	LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)

PATIENT'S AUNTS AND UNCLES (Mother's side)

RELATIVE	NAME	GENDER (M/F)	BIRTH DATE (dd/mm/yyyy)	LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)

PATIENT'S AUNTS AND UNCLES (Father's side)

RELATIVE	NAME	GENDER (M/F)	BIRTH DATE (dd/mm/yyyy)	LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)

PLEASE USE THIS SECTION TO LIST THOSE RELATIVES NOT PREVIOUSLY LISTED WHO HAVE ANY BIRTH DEFECTS, MEDICAL CONDITIONS, OR CONDITIONS SIMILAR TO THE YOURS (nieces/nephews, cousins, great grandparents, etc.)

RELATIVE	NAME	GENDER (M/F)	BIRTH DATE (dd/mm/yyyy)	LIST ANY BIRTH DEFECTS OR MEDICAL CONDITIONS (INCLUDING DEVELOPMENTAL DELAY, AUTISM AND/OR INTELLECTUAL DISABILITY)

LIST ANY OTHER IMPORTANT INFORMATION HERE (ie: has anyone in the family been seen in a Genetics clinic and/or had genetic testing, etc.):