CHILDREN'S AND WOMEN'S HEALTH CENTRE OF B. C. PROVINCIAL MEDICAL GENETICS PROGRAM	FAMILY HISTORY SCREENING QUESTIONNAIRE	MG #

PATIENT NAME:

You have been referred to Medical Genetics for counselling. Please complete this form to identify any history of genetic diseases or birth defects in your family.

1. These questions refer to **you**, your **partner** and your families (children, brother, sisters, mother, father, nieces, nephews, aunts, uncles and cousins). If you mark **YES**, state relationship to yourself. Are there any individuals in your family with:

			RELATIONSHIP
- Down syndrome (mongolism)	☐ NO	☐ YES	_____
- Other chromosomal abnormality/rearrangement	☐ NO	☐ YES	_____
- Neural tube defect, i.e. spina bifida (meningomyelocele or open spine), anencephaly	☐ NO	☐ YES	_____
- Other Birth Defects			
• Cleft lip/palate	☐ NO	☐ YES	_____
• Heart abnormalities	☐ NO	☐ YES	_____
• Limb abnormalities	☐ NO	☐ YES	_____
• Other: _____	☐ NO	☐ YES	_____
- Developmental delay/Mental retardation	☐ NO	☐ YES	_____
- Other genetic disease	☐ NO	☐ YES	_____
- Two or more miscarriages	☐ NO	☐ YES	_____
- Stillbirths	☐ NO	☐ YES	_____
- Childhood deaths (other than accidents)	☐ NO	☐ YES	_____

2. Have you or a family member been seen in any Medical Genetics clinic? ☐ NO ☐ YES
If **YES,** where?_____

3. Are you and your partner related by blood? (e.g., cousins) ☐ NO ☐ YES

4. What is your ethnic origin? _____ your partner's?_____

5. Do you take any medications (prescription or non-prescription) or more than two alcoholic drinks a day on a regular basis? ☐ NO ☐ YES
If **YES**, give name of medication or drug: _____

Patient Signature _____ Date: _____

Reviewed by: _____ Date: _____