Name:_____ Age:____
Address:_____
_____
Phone:_____ Birthdate:__/__/_____

O&O Alpan LLC
Adult Genetics
Patient Questionnaire

Instructions: Please answer all questions to the best of your ability.

Referring Physician:
Name: _____
Address: _____
_____
Phone: (____) _____

What is the reason your doctor has requested this genetic evaluation?

_____

What do you hope to learn from this visit with Genetics?

_____

What is your main health concern?

_____

General Health (circle one): Excellent Good Fair Poor
If you answered "fair" or "poor", please explain:

Imaging: Please list any X-rays, MRI's, etc. you have had. We will need to review the reports so we can perform a better evaluation on you.

Type (MRI, CT, EMG)	Year	Body Part	Reason	Imaging Facility

Past Medical History

Medical Illnesses	No	Yes	Year	Complications	Comments
Cancer					
Diabetes					
Blood disorder					
Heart disease					
High blood pressure					
Liver disease					

Glandular disorder					
Skin disease					
Neurologic disorder					
Emotional disorder					

Please list any other illnesses you have had: _____
_____
_____

Surgery Please list any surgery you have had

Procedure	Year	Complications	Comments

Medications Please list all medications which you now take regularly

Medication	Amount Per Day

Allergies: Please list all drugs or substances, to which you are allergic and specify your type of reaction [i.e. rash, hives, wheezing, etc…]

Allergy	Reaction

Review of Systems: Please place a check mark in the appropriate boxes following each symptom. If you are not sure, leave blank.

No	Yes	General	Comments
		Weakness	
		Tiredness Early Morning Late Afternoon	
		Lack of appetite	

		Excess appetite	
		Weight loss	
		Weight gain	
		Chills	
		Fever	
		Night sweats	
		Difficulty in sleeping	

Eyes, Ears, Nose Throat

Date of Ophthalmology Evaluation: Location of Ophthalmology Evaluation:

Date of Audiology Evaluation: Location of Audiology Evaluation:

If you have had an opthal/audiology evaluation, please provide a copy of the result for your evaluation.

No	Yes	Symptoms	Comments
		Blurred vision	
		Spots before your eyes	
		Difficulty in hearing	
		Ringing in your ears	
		Pain in your ears	
		Discharge from the ears	
		Nosebleeds	
		Running of the nose	
		Stuffiness of your nose	
		Sneezing	
		Sinus trouble	
		Hay fever	
		Sore throat	
		Pain in the neck	
		Dental trouble	
		Bleeding gums	

Respiratory

No	Yes	Symptoms	Comments
		Dry cough	
		Wheezing	
		Asthma	
		Sleep Apnea	
		Shortness of breath at rest	
		Shortness of breath at exertion	

Cardiovascular

Date of Cardiology Evaluation: Location of Cardiology Evaluation:

Date of EKG/Echo: Location of EKG/Echo Evaluation:

If you have had any EKGs or Echocardiograms, please provide us a copy of results prior your evaluation

Yes	No	Symptoms	Comments
		Chest pain, tightness or squeezing	
		Shortness of breath lying down	
		Heart racing	
		Irregular heart beat (palpitations)	
		Heart murmur	
		Swelling of the legs	
		Blue or purple discoloration of hands or feet	

Gastrointestinal

Date of GI Evaluation: Location of GI Evaluation:

Date of GI Procedures: Location of GI procedure:

If you have had a gastroenterology evaluation, we need a copy of this record for your evaluation.

No	Yes	Symptoms	Comments
		Vomiting	
		Diarrhea	
		Constipation	
		Abdominal pain	

Urinary

No	Yes	Symptoms	Comments
		Urinary tract infections	
		Frequent urination - day	
		Frequent urination - night	
		Extreme urge to urinate	
		Kidney stones	

Genito-Reproductive

No	Yes	Genito-Reproductive (female)	Comments
		Age of onset of menstrual periods	
		Age which periods stopped (menopause)	
		Are you taking any female hormones?	

Do you have any medical concerns? _____

_____

Musculoskeletal

No	Yes	Symptoms	Comments
		Painful joints	
		Swelling of any joints	
		Deformities of the joint extremities	
		Muscle pain	

Endocrine

No	Yes	Symptoms	Comments
		Goiter	
		Heat intolerance	
		Cold intolerance	
		Loss of periods (disregard if from normal menopause)	

Neurologic/ Psychiatric

Date of Neurology Evaluation: Location of Neurology Evaluation:
Date of MRI/CT: Location of MRI/CT Evaluation:
If you have had any head/brain MRIs or CTs, please provide us a copy of results prior your evaluation.

No	Yes	Symptoms	Comments
		Nervousness	
		Depression	
		Difficulty going to sleep	
		Early morning awakening	

Skin

No	Yes	Symptoms	Comments
		Nail changes	
		Birthmarks	

Please list names, addresses, and phone/fax numbers , if available, for doctors who you would like to receive a copy of your genetic clinical note.

Doctor	Address	Phone/Fax