Cincinnati Children's

MOLECULAR GENETICS LABORATORY

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PATIENT AND FAMILY HISTORY

Patient Name: _____

Date of Birth: _____

Maternal Ethnicity: _____

Paternal Ethnicity: _____

Consanguinity: Are the parents of the patient related to each other by blood (e.g., second cousins)? ☐ Yes ☐ No

If so, How are they related?: _____

_____

_____

Please describe the patient's symptoms and family history using the checklist below as a guideline. Please attach a pedigree if available:

_____

_____

_____

Please describe previously abnormal tests— e.g. Metabolic tests, MRI, Echo, muscle histology, and functional studies:

_____

_____

_____

Neurological/Muscular Symptoms - Does anyone in the family have:

Patient	Family	
☐	☐	Seizures or epilepsy
☐	☐	Tremor
☐	☐	Sensory Neuropathy
☐	☐	Cerebral Palsy
☐	☐	Contractures
☐	☐	Ataxia
☐	☐	Stroke-like episodes
☐	☐	Chronic fatigue syndrome
☐	☐	Recurrent Headaches
☐	☐	Recurrant vomiting
☐	☐	Muscle pain
☐	☐	Muscle weakness
☐	☐	Dysphagia
☐	☐	Muscle wasting
☐	☐	ALS (Lou Gehrig's disease)
☐	☐	Alzheimer's disease
☐	☐	Paget Disease
☐	☐	Multiple Sclerosis
☐	☐	Fibromyalgia
☐	☐	Muscular Dystrophy
☐	☐	Autoimmune Disease

Developmental Histories - Is there anyone in the family with:

Patient	Family	
☐	☐	Autism
☐	☐	Developmental delay
☐	☐	Learning disabilities
☐	☐	Mental retardation
☐	☐	Other _____

Psychiatric Issues - Does anyone in the family have a psychiatric disorder, such as:

Patient	Family	
☐	☐	Anxiety
☐	☐	OCD
☐	☐	Depression
☐	☐	Panic attacks
☐	☐	Dementia
☐	☐	Bipolar Disorder
☐	☐	Schizophrenia
☐	☐	Memory Loss
☐	☐	Other _____

Auditory Problems - Is there anyone in the family with:

Patient	Family	
☐	☐	Hearing impaired or deaf (Please describe):

_____

Gastrointestinal & Metabolic disease - Is there anyone in the family with:

Patient	Family	
☐	☐	Chronic constipation
☐	☐	Irritable Bowel Syndrome
☐	☐	Recurrant vomiting
☐	☐	A known metabolic disorder
☐	☐	Other _____

Ophthalmologic Problems - Does anyone in the family have:

Patient	Family	
☐	☐	CPEO (Ophthalmoplegia)
☐	☐	Ptosis (droopy eyelids)
☐	☐	Macular degeneration
☐	☐	Corneal deposits
☐	☐	Cataracts
☐	☐	Retinitis Pigmentosa
☐	☐	Visual field defect
☐	☐	Photophobia
☐	☐	Blindness
☐	☐	Color blindness
☐	☐	Optic atrophy

Cardiac disease/symptoms - Does anyone in the family have:

Patient	Family	
☐	☐	Chest pains
☐	☐	Irregular heart beat
☐	☐	Cardiomyopathy
☐	☐	Shortness of breath
☐	☐	Stroke
☐	☐	Heart murmur
☐	☐	Other _____

Other health concerns - Is there anyone in the family with:

Patient	Family	
☐	☐	Diabetes (adult or juvenile)
☐	☐	Early childhood deaths
☐	☐	Chronic infections
☐	☐	Kidney problems
☐	☐	SIDS
☐	☐	Multiple miscarriages or infertility
☐	☐	Short stature
☐	☐	Skin disorder
☐	☐	Cancer (Please describe):

_____

☐ ☐ Any other condition not listed here (Please describe):

_____