Thunder Bay Regional Health Sciences Centre

GENETICS PROGRAM

FAMILY HISTORY FORM (GENERAL)

Place Patient Label with Barcode Here

Ped Number: _____ DATE: _____

Dear _____,

You have been referred to our department by Dr. _____ .Our genetics program holds 5 genetic outreach clinics per year. Geneticists from Southern Ontario travel to Thunder Bay to hold these clinics here at the TBDHU. In some situations, a genetic appointment can be done by video conference.

You were referred because your personal and/or family history may be genetic in nature. To prepare for your genetic appointment, it is important that we have more family history information. Confirmation of certain information is often necessary so copies of medical records are sometimes requested.

Please complete this form, giving as much information as possible about your family. If there is any information you do not know, perhaps someone in your family will be able to help you, otherwise please leave the box empty.

All the information that you give will be held in confidence in the clinical genetics department and we will not contact any of your relatives without your permission.

Your Details:

Home Tel:	Daytime Tel:
Cellular Tel:	A good time to contact me between 8:30am and 4:30pm is:
Is it OK to leave a brief message if you are not available?: YES ☐ NO ☐	
Primary Health Care Professional (include address):	
Have you/your relatives seen a Geneticist in the past?: If yes, please provide details.	

ETHNIC ORIGIN – We ask this because some inherited conditions are more common in some ethnic groups

Father's Ethnic Background: _____ Mother's Ethnic Background: _____

Please return this form by _____. Please note we will not be able process your referral until you return your completed questionnaire.

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Relative	Full Name (including maiden name and any previous names)	Date of Birth (or approximate year if unknown)	Alive (Y/N)	Date of Death (or approximate year if unknown)	Please list any birth defects, diseases, conditions and/or cause of death
Patient					
Children of Patient (if applicable) *(circle as appropriate)	Son Daughter				
	Son Daughter				
	Son Daughter				
Patient's Sisters (Full or Half) If half please indicate which parent you share					
Patient's Brothers (Full or Half) If half please indicate which parent you share					
Patient's Mother					
Patient's Father					
Patient's Mother's Mother					
Patient's Mother's Father					
Patient's Father's Mother					
Patient's Mother's Brothers and Sisters *(circle as appropriate)	Brother Sister				
	Brother Sister				
	Brother Sister				
	Brother Sister				

Patient's Father's Brothers and Sisters *(circle as appropriate)	Brother Sister				
	Brother Sister				
	Brother Sister				
	Brother Sister				
	Brother Sister				

Please use this section to complete the details of any other relatives who have had any relevant birth defects, diseases or conditions who have not yet been asked for or there was not space for.

Relative	Full Name (including maiden name and any previous name)	Date of Birth (or approx. year if unknown)	Alive (Y/N)	Date of Death (or approx. year if unknown)	Please list any birth defects, diseases, conditions and/or cause of death

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