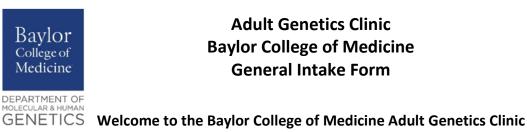
DOB:



Clinic Director: Shweta Dhar, MD, MS, FACMG Clinic Manager: Tanya Eble, MS, CGC

Please note that Baylor College of Medicine is an academic institution. We have students and residents rotating through our clinics.

Thank you for choosing the Baylor College of Medicine Adult Genetics Clinic. **Once complete, please return these forms via one of the following**: Fax to (713)798-6450, Send as an attachment in a MyChart message at mychart.bcm.edu, or mail to One Baylor Plaza Mailstop 228, Houston, TX, 77030 (<u>by regular mail</u>, NOT FedEx, UPS, etc.)

Date Intake Form Completed	Completed By	Relationship to Patient	

Please note that in all questions below "YOU" refers to the patient. If someone other than the patient is completing this form please answer the questions about the patient, not yourself.

Section 1. Demographic Information

Personal Information					
Last Name (Surname)	First Name (Given Name)	Date of Birth	Current Age		

Contact Information		
Primary Phone Number	Secondary Phone Number	Email

Referral Information						
Referring Provider (The referring provider is the doctor who referred you to this clinic. If no doctor referred you, please write "self referred.")						
Referring Provider Phone Number	Referring Provider Fax Number					
Reason For Visit *A specific medical concern	must be noted.					

*The reason listed above will be the focus of your visit.

Section 2. Medical Health History

*Please be sure to include any medical concerns/diagnoses relevant to the reason for your visit.

Past Medical History (such as Cancer, Diabetes, Hypertension, Asthma etc.)	Date of Diagnosis

Past Surgical History	Date of Procedure

Section 4: Past Work-up/Investigations

Have you had any of the following testing: DXA, echocardiogram, muscle biopsy, skin biopsy?

If yes, please send a copy of the result report with this form. Please note that we only have access to past records that were obtained at Baylor College of Medicine, not at Texas Children's Hospital.

Have you had genetic testing (i.e. karyotype, chromosomal microarray, other genetic testing)?

If yes, please specify test name and result here _____

Please provide a copy of the genetic test report with this form. <mark>Failure to provide these records may result</mark> <mark>in a delay of scheduling.</mark>

Have any of your family members had genetic testing that identified a mutation?

If yes: Please specify here _____

Please send a copy of your family members genetic test report with this form. A genetic counseling letter is also an accepted form of documentation if it specifies the genetic test result, but the test report is preferred. Failure to provide these records may result in a delay of scheduling.

Name:

Baylor College of Medicine

Family History Form

DEPARTMENT OF MOLECULAR & HUMAN

Are you adopted? 🛛 No 🔅 Yes (If you have information about your biological family please complete the form with the available information.)

Section 1 Ethnic Background (example: English, Irish, German, Spanish, Mexican, African American, Indian, Iranian, Chinese etc.)

Please list your father's ethnicity (if known)______Please list your mother's ethnicity (if known)______

Do you have any Ashkenazi Jewish ancestry?
No Yes

Is there any chance that your parents are related by blood, for example first cousins? 🗌 No 🛛 Yes, Specify how are they related?

Section 2 Family Member Health History

Please fill out the following information regarding your family history. Please include all family members, both affected with disease and healthy.

Your Parents, & Your Grandparents							
	Age (Current, if alive)	Age at Death	Cause of Death	Affected with cancer? Yes or No	Location of cancer (breast, colon, lung, etc)	Age when cancer was diagnosed	Diagnosed Medical Conditions and Age at Diagnosis
Your mother							
Your father							
Your mother's mother (maternal grandmother) Your mother's father (maternal grandfather)							
Your father's mother (paternal grandmother) Your father's father (paternal grandfather)							

Name:							DOB:	
		Your FULL Brothers and Sisters (same mother and same father as you)						
Male/ Female	Age (Current, if alive)	Age at Death	Cause of Death	Affected with cancer? Yes or No	Location of cancer (breast, colon, lung, etc)	Age when cancer was diagnosed	Diagnosed Medical Conditions and Age at Diagnosis	
			Your MATERNAL Ha	alf-Brothers and H	Half-Sisters (same mother as y	ou but different	father)	
Male/ Female	Age (Current, if alive)	Age at Death	Cause of Death	Affected with cancer? Yes or No	Location of cancer (breast, colon, lung, etc)	Age when cancer was diagnosed	Diagnosed Medical Conditions and Age at Diagnosis	
			Your PATERNAL Ha	If-Brothers and H	lalf-Sisters (same father as you	J but different m	other)	
Male/ Female	Age (Current, if alive)	Age at Death	Cause of Death	Affected with cancer? Yes or No	Location of cancer (breast, colon, lung, etc)	Age when cancer was diagnosed	Diagnosed Medical Conditions and Age at Diagnosis	

Name:							DOB:	
	Your Children							
Male/ Female	Age (Current, if alive)	Age at Death	Cause of Death	Affected with cancer? Yes or No	Location of cancer (breast, colon, lung, etc)	Age when cancer was diagnosed	Diagnosed Medical Conditions and Age at Diagnosis	
				Your Aun	ts/ Uncles (Mother's side)			
Male/	Age	Age at	Cause of Death	Affected	Location of cancer	Age when	Diagnosed Medical Conditions	
Female	(Current, if alive)	Death		with cancer? Yes or No	(breast, colon, lung, etc)	cancer was diagnosed	and Age at Diagnosis	
				Your Aur	nts/ Uncles (Father's side)			
Male/ Female	Age (Current, if alive)	Age at Death	Cause of Death	Affected with cancer? Yes or No	Location of cancer (breast, colon, lung, etc)	Age when cancer was diagnosed	Diagnosed Medical Conditions and Age at Diagnosis	

Name:	

DOB:

HEALTH CARE PROVIDERS

DEPARTMENT OF MOLECULAR & HUMAN GENETICS

 $\underset{\rm College\,of}{Baylor}$

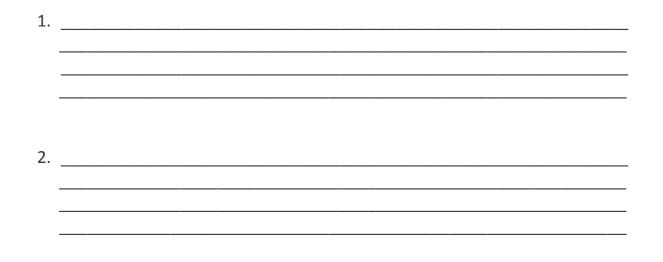
Medicine

Communication between health care providers can be very important in one's overall medical care. Please list all current physicians who are involved in the care for your condition. Please continue on the back if needed and be as complete as possible when providing contact information.

Physician Name:	Physician Name:
Specialty:	Specialty:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Period of Care:	Period of Care:
From To	From To

Adult Genetics Patient Question List

Please utilize this sheet to write down **your two most important questions related to your visit** that you would like answered during your Genetics appointment:





DEPARTMENT OF MOLECULAR & HUMAN **GENETICS EDS** Clinic

Connective Tissue New Patient Questionnaire

STOP! Only complete this form if you are coming in to be evaluated for chronic pain, joint hypermobility, Ehlers-Danlos Syndrome [EDS], dysautonomia, dizziness, syncope [fainting], joint dislocations or other connective tissue disorder.

Do you have a clinical diagnosis of EDS?	_ If yes, which subtype?	Age at diagnosis?
Name and Specialty of the doctor who made the	e diagnosis?	

Medical History

Please answer the following questions or place a check mark next to the symptoms that you are experiencing.

Musculoskeletal features

Please mark all of the features that apply to you (check all that apply):

	Joint dislocations?	If yes,	please com	plete the following	ng table:
--	---------------------	---------	------------	---------------------	-----------

Joint	# of Dislocations	Joint	# of Dislocations

"Popping" joints. Please specify which joints:

Other. Please specify: ______

Pain History

Do you have (check all that apply):

Pain that wakes you from sleep? If yes, please note the location and severity of the pain

Location	Neck	Back	Shoulders	Elbows	Wrists	Hips	Knees	Ankles	Feet
Pain Score (1-10)									
10 most severe									

□ Numbness/tingling in your hands or feet?

□ Burning pain in your hands or feet?

Are you (Check all that apply):

- Currently doing physical therapy? Start date: ______ Frequency: ______
- Getting any form of chronic pain treatment? Specify: ______
- On pain medication? Please list: ______

Autonomic Dysfunction

Prior Diagnosis: Have you been given a diagnosis of (check all that apply):

- Dysautonomia or Autonomic Dysfunction?
- Postural Orthostatic Tachycardia Syndrome (POTS) or Orthostatic Intolerance or Inappropriate Tachycardia on standing?
- □ Orthostatic Hypotension (drop in blood pressure on standing)?
- Pure Autonomic Failure (PAF)?

	Name:			DOB:
Review	v of Symptoms Please mark all symptoms yo			
	Episodes of fainting			Profuse sweating
	Symptoms of standing (e.g. light			Reduced sweating
	headedness) that are relieved by sitting			Fatigue when standing
	down.			Hypotension (low blood pressure)
	Vertigo (room spinning around you)			Blood pooling in legs
	Episodes of flushing (face or neck turning			Red/purple discoloration in lower legs/feet
	red)			
Are yo	u on medications for dysautonomia?	if yes, P	leas	e list:
Cardia	ac features			
Please	mark all the symptoms you are experiencing	g:		
	Heart arrhythmia			Palpitations
Please	check and complete if you have had the foll	owing asse	ssm	•
	Echocardiogram When:			
				Normal?
				Normal?
	eatures			
	mark all the symptoms you are experiencing	g:		
	Easy or frequent bruising			Stretch marks
	Stretchy skin			□ Scarring
	Poor wound healing			Unusual scars
				Scars widening over time
If yes t	o scarring, please indicate where on the boo	and how	you	got the scar:
Other.	Please specify:			
	ological/Psychiatric features		_	
-	mark all the symptom you are experiencing			
	Migraines	•		
	-	oquonov:		Duration of migraine:
	"Brain Fog", confusion, focus problems			Difficulty with memory/recall
	Cognitive impairment			Depression
	Poor concentration			•
	Other. Please specify:			Anxiety
	Ind Vision			
Please	mark all the symptoms you are experiencing	g:		
	Retinal detachment			Tunnel vision
	Dislocated lens			Other. Please specify:
	Blurred vision not corrected with glasses			
	ou been seen by an ophthalmologist in the l			
Do γοι	u wear glasses? Please circle all tha	it apply: Ne	ar-si	ightedness Far-sightedness Astigmatism
				8 of 9 Pages

Name:		DOB	:
Sleep Disturbances			
Please mark all the symptoms you are experiencing:			
🗆 Insomnia		Other. Please specif	y:
How many hours do you sleep at night?			
Gastrointestinal features			
Prior Diagnosis: Have you been given a diagnosis of (che	eck all tha	t apply):	
Irritable Bowel Syndrome (IBS)		Crohn's Disease	
Celiac Disease			
Review of Symptoms: Please mark all the symptoms that	nt you are	experiencing:	
Constipation. Frequency:			
Diarrhea. Frequency:			
Other. Please specify:			
Gynecological features			
Please indicate if either of the following apply to you:			
 Not applicable (male) 		Post-menopausal. A	ge at menopause:
Please mark all the symptoms you are experiencing:			
Heavy menstrual bleeding		Menstrual cramping	
Pelvic congestion (heavy, full feeling in		Endometriosis	
pelvis)		Other. Please specif	y:
<u>Miscellaneous</u>			
Please mark all the symptoms you are having:			
 Chronic recurrent infections. Please elaborate 			
 Dental problems. Please elaborate 			
 Dental problems: Trease claborate Temporomandibular Joint Disorders (TMJ) 			
 Tinnitus (ringing in ears) 			
Have you had a hearing evaluation? If yes, Wher	n:	Where:	Normal?