Welcome to the Baylor College of Medicine Adult Genetics Clinic

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

Thank you for choosing the Baylor College of Medicine Adult Genetics Clinic. We may be the next step in your diagnostic journey or this may be a first step towards understanding your risk for a genetic condition. Whatever the case, the paperwork in the following pages is designed to help us best meet your needs.

Please complete these forms if the patient is 18 years of age or older. If younger than 18 years, please contact the Texas Children's Hospital Genetics clinic at 832-822-4261 or 832-822-4283. Please check that you have completed each of the following requirements.

☐ Please activate **MyChart**. A code is needed to activate MyChart. If you have not received a MyChart activation code you can go to mychart.bcm.edu, select the *Sign Up Now* button and then the *Request Online* button.

☐ Please complete the **General Intake** Form

☐ Please complete the **Family History** Form

☐ Please complete the **Health Care Providers** Form

☐ Please complete ONLY Section B and C of the **Alternative Communications and Designated Contacts** Form.
We take our patients' privacy very seriously. If a family member contacts us for information regarding your genetic diagnosis /medical care and they are not listed on this form we will be unable to discuss your information with them until you provide permission.

☐ Please complete the **Authorization for Release of Protected Health Information** Form

☐ If you are coming for evaluation for any of the following: chronic pain, joint hypermobility, Ehlers-Danlos Syndrome [EDS], dysautonomia, dizziness, syncope [fainting], joint dislocations or other connective tissue disorder, also please complete the **Connective Tissue Disorder Intake** Form.

☐ Please complete the **Patient Question List** Form

☐ Some of our patients are under the care of a parent / guardian. Is there a guardian or person with medical power of attorney for the patient? □ No □ Yes **(Please send documentation of guardianship or medical power of attorney)**

We have three methods you can use to submit your completed forms:

1. Mail the forms: Adult Genetics, Baylor College of Medicine, One Baylor Plaza; Mailstop 228 Houston, TX 77030
2. Fax the forms: 713-798-6450
3. Upload to MyChart

☐ Please keep a copy of these intake forms for your records. In the event that something beyond our control happens (i.e. weather affecting mail / unclear faxes), you may be asked to resend your forms.

Upon review of your materials you will be contacted by the Genetics Clinic. Also note that in an effort to be serve all patients, we are unable to offer an appointment to individuals who have not submitted all forms and signed up for MyChart.

Name: _____ DOB:_____

Adult Genetics Clinic
Baylor College of Medicine
General Intake Form

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

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
Emergency Contact (Name)	Relationship	Emergency Contact Information

Social History		
Highest level of education	Current occupation	Currently working?

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.

Name: _____ DOB:_____

Section 2. General Genetics Medical History

In the table below, please check the box if **you** have a personal history of any of the following:

Diagnosis	Check Here	Specify Diagnosis If Known	Age At Diagnosis	Diagnosis Made By: Physician Name And Specialty
Neurological				
Abnormal Movements				
ADD/ADHD				
Alzheimer Disease				
Ataxia				
Autism				
Cognitive Decline				
Huntington Disease				
Intellectual Disability				
Seizures				
Other Neurological Symptoms				
Other Neurological Symptoms				
Other Neurological Symptoms				
Auditory/Visual/Dental				
Cataracts				
Eye Condition (Specify)				
Glaucoma				
Hearing Loss				
Retinal Detachment				
Tinnitus				
Vision Loss				
Other Auditory/Visual/ Dental Condition				
Other Auditory/Visual/ Dental Condition				

Name: _____ DOB:_____

Diagnosis	Check Here	Specify Diagnosis If Known	Age At Diagnosis	Diagnosis Made By: Physician Name And Specialty
Pulmonary				
Cystic Fibrosis				
Bronchiectasis				
Pulmonary Hypertension				
Other Pulmonary Condition				
Cardiovascular				
Aortic Aneurysm or Dissection				
Arrhythmia				
Cardiomegaly				
Cardiomyopathy				
Congenital Heart Defect				
Long QT				
Mitral Valve Prolapse				
Other Cardiovascular Condition				
Other Cardiovascular Condition				
Gastrointestinal Condition				
Hemochromatosis				
Colon Polyps				
Intestinal Intussusception				
Other Gastrointestinal Condition				
Other Gastrointestinal Condition				
Renal				
Absent Kidney (from birth)				
Recurrent Kidney Stones				
Renal Cysts				
Other Renal Condition				

Name: _____ DOB:_____

Diagnosis	Check Here	Specify Diagnosis If Known	Age At Diagnosis	Diagnosis Made By: Physician Name And Specialty
Reproductive/Genital/Urological				
Hypogonadism				
Infertility				
Low Testosterone (ales)				
Recurrent Pregnancy Loss (ex. Miscarriages)				
Other Reproductive/GU Condition				
Endocrine				
Elevated Cholesterol				
Metabolic Condition				
Mitochondrial Condition				
Other Endocrine Condition				
Other Endocrine Condition				
Musculoskeletal				
Muscular Dystrophy				
Muscle Weakness				
Osteoporosis				
Osteopenia				
Osteopetrosis				
Osteogenesis Imperfecta				
Paget Disease				
Pectus Deformity				
Short Stature				
Spina Bifida				
Tall Stature				
Other Musculoskeletal Condition				
Other Musculoskeletal Condition				

Name: _____ DOB:_____

Diagnosis	Check Here	Specify Diagnosis If Known	Age At Diagnosis	Diagnosis Made By: Physician Name And Specialty
Skin				
Benign Tumors				
Neurofibromas				
Café-au-lait Spots				
Cancer (Specify where on your body the cancer occurred.)				
Cancer Diagnosis #1				
Cancer Diagnosis #2				
Cancer Diagnosis #3				
Miscellaneous				
Other Physical Birth Defects				
Other Known Genetic Syndrome				
Other Miscellaneous Condition				

Section 3. Medical Health History

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

Past Surgical History			Date of Procedure
Medications and Supplements (List all current prescriptions and supplements. If	**Dosage**	**Frequency**	**Date Started**

you have more medications please attach an additional sheet.)			

Health Behaviors		
Do you currently use tobacco (cigars/cigarettes/ chew?)	How much alcohol do you drink on average?	Do you currently use any illicit drugs?
☐ Yes ☐ No ☐ No, but previously used tobacco If yes: Approximate age started: Approximate age stopped: Average number of packs a day:	☐ Drinks per day _____ ☐ Drinks per week _____ *A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Standard drink equivalents: 12 oz. beer, 5 oz. wine, 8 oz. liquor)*	☐ Yes ☐ No ☐ No, but previously used illicit drugs If yes: What type of drug: Approximate age started:
Do you exercise?		
☐ No ☐ Yes How much? _____ How often? _____		

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 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. Failure to provide these records may result in a delay of scheduling.

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.

Section 5. Cancer Surveillance/Screening

If you have not had any of the procedures listed below, respond with N/A.

When was the date of your last colonoscopy? _____

Were any polyps found? If so, what type and how many? _____

If any polyps were removed please send the colonoscopy report and the pathology report with this form.

When was the date of your last upper endoscopy? _____

Do you have a history of sun exposure? _____

If yes: Did you typically wear sunscreen? _____

Have you had any moles removed for concern of cancer? _____

If yes: Did the biopsy find melanoma, basal cell carcinoma, and/or squamous cell carcinoma?

_____

If yes: Where on the body was the mole? _____

When was the date of your last pap smear? _____

When was the date of your last mammogram? _____

Have you had any other breast screening (i.e. MRI/ultrasound)? _____

Have you had any breast biopsies? _____

If yes: how many? Were they normal or abnormal? _____

Section 6. Reproductive Health Questions (*only females need to complete*)

How old were you at the time of your first menstrual period? _____

Are you: pre-menopausal, peri-menopausal, post-menopausal? _____

If peri- or post-menopausal: Age at menopause? _____

Do/Did you ever take hormone replacement? _____

If yes: How long? _____

Have you taken birth control pills? _____

If yes: How long? _____

Your age when your first child was born:_____

Name: _____ DOB:_____

Baylor College of Medicine
DEPARTMENT OF MOLECULAR & HUMAN GENETICS

Family History Form

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 Half-Brothers and Half-Sisters (same mother as you 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 Half-Brothers and Half-Sisters (same father as you but different mother)						
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 Aunts/ Uncles (Mother'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**
	Your cousins (Mother's side) – List only those diagnosed with cancer or a known genetic condition						
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 Aunts/ 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**
	Your Cousins (Father's side) – List only those diagnosed with cancer or a known genetic condition						
Male/ Female	**Age**	**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**

Baylor College of Medicine
DEPARTMENT OF MOLECULAR & HUMAN GENETICS

Name:______________________________ DOB: _____________________________

HEALTH CARE PROVIDERS

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: ______________________ Specialty: __________________________ Address: ___________________________ _________________________________ Phone: ____________________________ Fax: ______________________________ Period of Care: From ____________ To ______________	Physician Name: ______________________ Specialty: __________________________ Address: ___________________________ _________________________________ Phone: ____________________________ Fax: ______________________________ Period of Care: From ____________ To ______________
Physician Name: ______________________ Specialty: __________________________ Address: ___________________________ _________________________________ Phone: ____________________________ Fax: ______________________________ Period of Care: From ____________ To ______________	Physician Name: ______________________ Specialty: __________________________ Address: ___________________________ _________________________________ Phone: ____________________________ Fax: ______________________________ Period of Care: From ____________ To ______________
Physician Name: ______________________ Specialty: __________________________ Address: ___________________________ _________________________________ Phone: ____________________________ Fax: ______________________________ Period of Care: From ____________ To ______________	Physician Name: ______________________ Specialty: __________________________ Address: ___________________________ _________________________________ Phone: ____________________________ Fax: ______________________________ Period of Care: From ____________ To ______________

Baylor College of Medicine

ALTERNATIVE COMMUNICATIONS AND DESIGNATED CONTACTS FORM

Patient Name:	***Date of Birth:***

This form allows you to request that Baylor College of Medicine (BCM) verbally communicate health information regarding your care, communicate with you at an alternative location or by alternative means, or terminate or modify a previously granted request. You are entitled to ask that BCM communicate with you in certain ways. Unless you state otherwise, BCM may contact you by phone, e-mail, text or mail to send out statements, leave messages regarding treatment or appointments, or file insurance claims. If you do not want us to contact you in this manner, please indicate that below.

BCM will accommodate your request if it is reasonable and you provide another reasonable alternative for us to communicate with you.

A written HIPAA Authorization is required to release written copies (paper or electronic) of your health record. If you want to release your written health record, please contact BCM's ROI Office at: Email: roi@bcm.edu; Phone: 713-798-5259; Fax: 713-798-1464; Address: Two Greenway Plaza, Suite 900 Houston, TX 77046 Mailstop: 2GR-900

Section A: Alternative Communication Request
☐ *Please communicate with me by the following means or at the following location:*
Address:
Phone:
Text:
Other:

Section B: Communication with Family/Friends

It is the policy of BCM not to discuss medical information regarding your treatment with family or friends except for (i) a parent of minor/legal guardian; (ii) as we may reasonably infer from the circumstances (for example, if you have a family member or friend with you during the visit); (iii) as permitted by Federal and Texas laws, or (iv) when you give us written permission. The persons you designate on this form will be marked as your Preferred Contacts.

Please list names of people to whom you give BCM permission to discuss your health information including routine test results, based on provider's professional judgement, prescription information, appointment reminders, or account status. This permission will remain until revoked in writing.

☐ I give BCM permission to communicate with the following person(s) unless noted as revoked.

Name	***Date***	***Revoked***	***Initials***	***Date Revoked***

Section C: Signature –Signed by the individual, or the individual's Legal Representative

_____ _____

Signature[1] Printed Name

Date: _____

Relationship to the individual

☐ Parent of minor ☐ Guardian/Ward ☐ Other:_____

[1] If you are signing as a Power of Attorney or Legal Guardian, please attach a copy of the legal documents. You do NOT need to attach copies if they are already on file with BCM.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Baylor College of Medicine

Patient Name: _____ Date of Birth: _____
PLEASE PRINT

I, the undersigned, authorize: _____
NAME AND ADDRESS

to release or give access to the protected health information of the above-named patient to:

Adult Genetics Clinic , Baylor College of Medicine One Baylor Plaza; Mailstop 228, Houston, TX 77030

NAME AND ADDRESS (STREET, STATE, ZIP) OF INDIVIDUAL OR ENTITY RECEIVING/ACCESSING RECORDS

Phone: 713-798-7764 Fax: 713-798-6450

1. METHOD OF DELIVERY
☐ Mail ☐ Fax ☐ Pick-up

2. FORMAT
☐ Paper ☐ Electronic ☐ Other: _____

--> if less than 20 pages, ok to fax; please mail if greater than 20 pages

3. EFFECTIVE TIME PERIOD
This authorization is valid until the earlier of the patient's death, the patient reaching the age of majority, or permission is withdrawn; or the following specific date or event occurs (optional):

4. PATIENT INFORMATION IS NEEDED FOR: (Please select at least one option)
☐ Treatment ☐ Disability ☐ Billing/Claims ☐ Legal ☐ Other: _____

5. INFORMATION TO BE RELEASED OR ACCESSED: ☐ All health records from _____ (DATE) to _____ (DATE)

☐ Immunization ☐ Billing ☐ Diagnostic Reports ☐ Other: _____

Your initials are required to release the following information. (Initial in box)

☐ Mental Health (excluding psychotherapy notes)
☐ Genetic Information (including test results)
☐ Drug, Alcohol, or Substance Abuse Records
☐ HIV/AIDS Test results/Treatment

SIGNATURE AUTHORIZATION: By signing below, I understand the following:

a. I may revoke this authorization at any time by sending a written revocation to the person/organization listed above. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization.
b. Any treatment, payment, or my enrollment in any health plan, or my eligibility for benefits will not be affected if I do not sign this Authorization.
c. Any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.
d. I am entitled to receive a copy of this signed authorization.

SIGNATURE X _____ _____
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

_____
PRINTED NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

Specify relationship to the patient: ☐ Self ☐ Parent of minor* ☐ Guardian/Ward† ☐ Other†: _____

†Attach documents demonstrating your authority to act on behalf of the patient.

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*A minor's signature is required for release of certain health information, such as information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol or substance abuse and mental health treatment (Tex. Fam. Code §32.003)

SIGNATURE X _____
SIGNATURE OF MINOR DATE

(Photo identification will be requested to verify the identity of the person signing this authorization.)

Thank you for choosing Baylor College of Medicine for your healthcare needs.
For Questions Contact: roi@bcm.edu ▪ 713.798.5259

Baylor College of Medicine
DEPARTMENT OF MOLECULAR & HUMAN GENETICS
EDS Clinic

Name: _____ DOB:_____

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 diagnosis? _____

Surgical History
Please list any past surgeries and your age at the time of surgery:

1. _____ 3. _____
2. _____ 4. _____

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 complete the following table:

Joint	# of Dislocations	**Joint**	# of Dislocations

☐ "Popping" joints. Please specify which joints: _____
☐ "Double-jointed"
☐ Flat feet
☐ Scoliosis or kyphosis
☐ Other. Please specify: _____

Have you (check all that apply):

☐ Participated in ballet/gymnastics?
☐ Had a DEXA (Bone Density Scan)?

If yes to DEXA, When?_____ Where?_____ Was osteopenia/osteoporosis noted? _____

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: _____

Name: _____ DOB:_____

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)?

Review of Symptoms Please mark all symptoms you are experiencing:

- ☐ Episodes of fainting
- ☐ Symptoms of standing (e.g. light headedness) that are relieved by sitting down.
- ☐ Vertigo (room spinning around you)
- ☐ Episodes of flushing (face or neck turning red)
- ☐ Profuse sweating
- ☐ Reduced sweating
- ☐ Fatigue when standing
- ☐ Hypotension (low blood pressure)
- ☐ Blood pooling in legs
- ☐ Red/purple discoloration in lower legs/feet

Are you on medications for dysautonomia? _____ if yes, Please list: _____

Cardiac features

Please mark all the symptoms you are experiencing:

- ☐ Heart arrhythmia
- ☐ Palpitations

Please check and complete if you have had the following assessments:

- ☐ Echocardiogram When: _____ Where: _____ Normal? _____
- ☐ Tilt Table Test When: _____ Where: _____ Normal? _____
- ☐ EKG When: _____ Where: _____ Normal? _____

Skin features

Please mark all the symptoms you are experiencing:

- ☐ Easy or frequent bruising
- ☐ Stretchy skin
- ☐ Poor wound healing
- ☐ Stretch marks
- ☐ Scarring
- ☐ Unusual scars
- ☐ Scars widening over time

If yes to scarring**,** please indicate where on the body and how you got the scar: _____

_____

Other. Please Specify: _____

Neurological/Psychiatric features

Please mark all the symptom you are experiencing:

- ☐ Migraines
  - o Most recent date: _____ Frequency: _____ Duration of migraine: _____
- ☐ "Brain Fog", confusion, difficulty focusing
- ☐ Cognitive impairment
- ☐ Poor concentration
- ☐ Difficulty with memory/recall
- ☐ Depression
- ☐ Anxiety
- ☐ Other. Please specify: _____

Name: _____ DOB:_____

Eyes and Vision

Please mark all the symptoms you are experiencing:

- ☐ Retinal detachment
- ☐ Dislocated lens
- ☐ Blurred vision not corrected with glasses
- ☐ Tunnel vision
- ☐ Other. Please specify: _____
  _____

Have you been seen by an ophthalmologist in the last 12 months? _____

Do you wear glasses? _____ Please circle all that apply: Near-sightedness Far-sightedness Astigmatism

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Sleep Disturbances

Please mark all the symptoms you are experiencing:

- ☐ Insomnia
- ☐ Other. Please specify: _____

How many hours do you sleep at night? _____ During the day? _____

Gastrointestinal features

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

- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Crohn's Disease
- ☐ Celiac Disease

Review of Symptoms: Please mark all the symptoms that 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. Age at menopause: ____

Please mark all the symptoms you are experiencing:

- ☐ Heavy menstrual bleeding
- ☐ Pelvic congestion (heavy, full feeling in pelvis)
- ☐ Menstrual cramping
- ☐ Endometriosis
- ☐ Other. Please specify: _____

Miscellaneous

Please mark all the symptoms you are having:

- ☐ Chronic recurrent infections. Please elaborate _____
- ☐ Dental problems. Please elaborate _____
- ☐ Temporomandibular Joint Disorders (TMJ)
- ☐ Tinnitus (ringing in ears)

Have you had a hearing evaluation? _____ If yes, When: _____ Where: _____ Normal?_____

Name: _____ DOB: _____

Baylor College of Medicine
DEPARTMENT OF MOLECULAR & HUMAN GENETICS

Adult Genetics Patient Question List

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

1. _____
   _____
   _____
   _____

2. _____
   _____
   _____
   _____

Thank you for filling out this intake packet. This will be very helpful to determine the most appropriate appointment for your genetic care.

TELL US ABOUT YOUR EXPERIENCE

You may receive an email or letter from Baylor College of Medicine via our partner, Press Ganey AFTER your visit in the Genetics clinic. Press Ganey is a survey about your experience in the Genetics clinic.

- Your feedback is important to us so we can improve.
- Our goal is to ensure you have an exceptional experience at Baylor College of Medicine. If for any reason you cannot rate your experience as "very good," please let a member of our staff know so we can make immediate improvements.
- If any question does not apply to your visit, please leave it blank.