Name: _____ DOB:_____

Adult Genetics Clinic
Baylor College of Medicine
General Intake Form

Welcome to the Baylor College of Medicine Adult Genetics Clinic

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, email at adultgenetics@bcm.edu or mail to One Baylor Plaza Mailstop 228, Houston, TX, 77030 (by regular mail, 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. Writing only "genetic testing or evaluation" will lead to delays in scheduling.	

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

Name: _____ DOB:_____

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. 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.

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 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**

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 _____

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:

1. _____
   _____
   _____
   _____

2. _____
   _____
   _____
   _____

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? _____ yes, which subtype? _____ Age at diagnosis? _____
Name and **Specialty** of the doctor who made the 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 complete the following 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 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, focus problems
- ☐ Cognitive impairment
- ☐ Poor concentration
- ☐ Difficulty with memory/recall
- ☐ Depression
- ☐ Anxiety
- ☐ Other. Please specify: _____

_____

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

Name: _____ DOB:_____

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?_____