VMP, llc
Expanding Genetic Horizons

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HISTORY QUESTIONNAIRE - Adult

Patient's Name _____ Patient's Date of Birth _____

The attached questionnaire is important. It is designed to provide important information in a consistent manner and is needed even if you supply some other narrative of the history. Much of this information is regarding early childhood development, milestones, and family relationships & history. Looking through your "baby book" or other records you may have will frequently generate answers.

To take full advantage of the time you have with your physician in your appointment:

- please answer as many of the questions as possible, but we understand if you cannot answer all
- answer as fully as possible
- **return to us as soon as possible but at least 2-3 weeks prior** to your scheduled appointment.

What do you hope to accomplish with this appointment?

_____

_____

_____

_____

_____

What are the most important questions that need to be addressed during your appointment?

_____

_____

_____

_____

_____

_____

Have you been vaccinated against COVID, and if so which one? _____

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PREGNANCY: Please answer to the best of your ability. If unknown, please indicate UKN.

1. How old was your mother when she became pregnant with you? _____

2. What number pregnancy was this pregnancy for your mother? _____

3. Was prenatal care provided? ☐ yes ☐ no
   If so, do you at what point in pregnancy prenatal care was initiated? _____

4. Was an ultrasound done as a part of the prenatal care? ☐ yes ☐ no

5. How many ultrasounds were done? _____
   When during the pregnancy were the ultrasounds completed?

   #1. _____ #4. _____
   #2. _____ #5. _____
   #3. _____ #6. _____

   (Please list on back page any additional ultrasound studies completed.)

6. Were any of the ultrasounds abnormal? ☐ yes ☐ no
   If **yes**, explain in the space below:

   _____

   _____

7. Were other special studies done during this pregnancy? ☐ yes ☐ no
   Include alpha-fetoprotein, amniocentesis, glucose tolerance test, and other study results here. If **yes**, please explain in the space below:

   _____

   _____

8. List all over-the-counter and prescription medications, vitamins, health preparations, cigarettes, etc. used during this pregnancy (include name/brand, amount, and when taken during the pregnancy).

   _____

   _____

   _____

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9. The pregnancy was complicated by (answer yes or no):

	Yes	No	Time in Pregnancy
Bleeding/spotting	_____	_____	_____
Cold or Flu-like illness	_____	_____	_____
Bladder Infection	_____	_____	_____
Fever	_____	_____	_____
Yeast Infection	_____	_____	_____
Other Vaginal Infection	_____	_____	_____
Skin Rash	_____	_____	_____
Dehydration from Vomiting	_____	_____	_____
Abnormal growth of the baby	_____	_____	_____
Premature labor	_____	_____	_____
High blood pressure	_____	_____	_____
Blood sugar problems	_____	_____	_____
Exposure to x-rays or chemicals	_____	_____	_____
Other	_____	_____	_____

10. Would your mother describe your activity in the womb during the pregnancy as (check only one):
☐ Very active ☐ Moderately active ☐ Occasionally active ☐ Rarely moved

11. How much weight did your mother gain during pregnancy? _____

DELIVERY:

Due Date: _____ Birth date: _____ Birth Hospital: _____

1. Born biologically as: ☐ female ☐ male ☐ unknown Currently identify as:_____
2. Born at full-term? ☐ yes ☐ no
   If not, how premature was the birth? _____
3. How long was your mother's labor? _____ hours
4. What type of delivery ? (Check one):
   a)_____Vaginal _____C-section _____ Repeat C-section because of previous delivery was this way
   b)_____Head first _____Shoulder(s) first ____Bottom first ___Feet first

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BIRTH:

1. Weight?_____ Length?_____Chest size?_____ Head size?_____

2. Do you know of any problems at birth? If so, please describe in the space below
(You may use the attached blank sheet)

_____

_____

_____

3. Babies are given special scores at birth called Apgar scores based on the baby's color, breathing, heartbeat, muscle tone, and cry.

If you have records of the Apgar scores, please record them here:

_____ at 1 minute _____ at 5 minutes

4. After birth, how were you fed? (check one)

____Breast ____Bottle ____Other

5. You were discharged from the hospital to home at _____ (days/weeks) of age.

FIRST YEAR:

1. Did you have any complications during the first month of life? ☐ yes ☐ no
If **yes**, please explain in the space below:

_____

_____

2. Were there any complications in the first year of life?

_____

_____

DEVELOPMENTAL MILESTONES HISTORY:

1. Please record your age beside the milestones you met as a child and circle months or years (as best you can):

Rolled over ____ months/years Sat alone ____ months/years

Crawled ____ months/years First word ____ months/years

Walked holding onto furniture ____ months/years

Walked alone ____ months/years

2. Did you ever receive any special services (OT, PT, speech)? If **yes**, list type and number of services (e.g. PT 3 times a week for one hour) each session.

_____

_____

4. Were you ever enrolled in a special education program? ☐ yes ☐ no
If **yes**, at what age? _____
(Please bring a copy of any developmental evaluation reports)

What level of education did you complete? (circle one)
Grade school High School Technical School College ____ #yrs

5. Do you feel that you have lost ability to perform skills or life activities that you previously had? ☐ yes ☐ no
If **yes**, please explain in the space below.

_____

_____

_____

6. Do you have vision problems? ☐ yes ☐ no
If yes, please explain in the space below.

_____

7. Do you have hearing problems? ☐ yes ☐ no
If yes, please explain in the space below.

_____

TOP PROBLEMS/DIAGNOSES:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

GENETIC TESTING TO DATE: (List all genetic testing and which lab performed them)

_____

_____

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HOSPITALIZATIONS/SURGERIES: (List length of stay/procedures/reason) *Please use back of this sheet if additional space is needed*.

_____

_____

_____

_____

Date of last MRI: _____ **Result of MRI:** _____

MEDICATIONS: What medications/supplements, if any, are you currently taking?

Please use back of this sheet if additional space is needed.

Name of Medication	Dosage	Time

_____

_____

_____

_____

ALLERGIES: Do you have any allergies? ☐ yes ☐ no

If so, to what medications? _____

Other allergies: _____

_____

_____

FAMILY HISTORY

1. What is the ethnicity of your parents' families (i.e. are you Scottish, Irish, German, Polish, Mayan, Vietnamese, Spanish, Portuguese, African American, etc.)?

   Your mother's family: _____

   Your father's family: _____

2. As far back as you can trace your ancestors; do your parents' have any common relatives? (i.e. do you share a grandparent, great grandparent, etc) ☐ yes ☐ no

Notes: _____

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Children (Children related to the patient)

Please include in list any miscarriages that you/spouse may have had. Differentiate between children who have different mothers. If any children have had children, include this information and note any problems these children may or may have had.

Children	Gender	Date of Birth	Parents	Medical Issues (indicate if deceased, age, & cause)
	☐ M ☐ F		☐ Current (both) ☐ Other (previous partner, adopted, IVF)	
	☐ M ☐ F		☐ Current (both) ☐ Other (previous partner, adopted, IVF)	
	☐ M ☐ F		☐ Current (both) ☐ Other (previous partner, adopted, IVF)	
	☐ M ☐ F		☐ Current (both) ☐ Other (previous partner, adopted, IVF)	
	☐ M ☐ F		☐ Current (both) ☐ Other (previous partner, adopted, IVF)	

Parents

Parent Names	Date of Birth	Medical Issues (indicate if deceased, age, & cause)

Siblings (brothers or sisters related to the patient)

Siblings	Gender	Date of Birth	Full or Half	Medical Issues (indicate if deceased, age, & cause)
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	

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Grandparents

Grandparent	Date of Birth	Medical Issues (indicate if deceased, age, & cause)
Mother's Mother		
Mother's Father		
Father's Mother		
Father's Father		

Maternal Family (brothers or sisters related to the patient's mother)

Aunts/Uncles	Gender	Date of Birth	Full or Half	Medical Issues (indicate if deceased, age, & cause)
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	

Paternal Family (brothers or sisters related to the patient's father)

Aunts/Uncles	Gender	Date of Birth	Full or Half	Medical Issues (indicate if deceased, age, & cause)
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	

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REVIEW OF SYSTEMS: circle/underline/highlight those issues you are experiencing

Constitutional: fatigue, fever, weight loss, weight gain, altered taste/smell, unable to sleep, excessive sleepiness, abnormal growth, lost interest in activities, Birthmark

Cardiovascular: sensation of chest pain/pressure/squeezing, shortness of breath on exertion, lower extremity swelling, chest pressure, fainting, heart failure, high blood pressure, shortness of breath, coronary disease, heat/cold intolerance, fainting

Endocrine: diabetes, thyroid disease, growth disorders, sexual dysfunction, excessive thirst or hunger, frequent urination, nausea

Eyes: double vision, blurred vision, floaters, glaucoma, cataracts, loss of peripheral vision, macular degeneration, drooping eye lids

Gastrointestinal: vomiting, diarrhea, reflux, constipation, abdominal pain, gastritis, hepatitis, hiatal hernia, rectal bleeding, ulcer, indigestion, nausea

Genitourinary: urine incontinence, stool incontinence, sexual dysfunction, constipation

Heme-Lymph: lymph node enlargement or tenderness, blood disorder, diabetes, sickle cell disease, thyroid disease, HIV, AIDS

HENT: loss of hearing, balance problems, nasal congestion, postnasal drip, neck pain, sore throat, tinnitus, allergies/hayfever, trouble breathing through nose, sinus disease, mouth sores, trouble swallowing, snoring

Respiratory: cough, bronchitis, emphysema, pneumonia, tuberculosis, asthma

Integument: rash, breast disease, melanoma, basal cell cancer, abnormal scars, easy bruising

Immunologic: frequent illnesses, recurrent infections

Musculoskeletal: joint pain, joint swelling, back pain, neck pain, hypermobile joints, muscle weakness, loss of muscle mass, lack of endurance

Neurologic: speech difficulties, incoordination, aggressive, trouble learning, trouble hearing, memory difficulties, seizures, tremors, head injuries, dizziness, hallucination, personality change, weakness, pain, facial numbness/tingling, numbness-arms, numbness-legs, nausea, stiffness, difficulty chewing, stares off into space, choking, difficulty tasting, drooling, trouble walking, vertigo, difficulty concentrating, fainting or passing out, difficulty sleeping, swallowing problems, trouble with smell, spells/fits, confusion, hostile/angry

Psychiatric: anxiety, depression, hallucinations, trouble concentrating, schizophrenia, in trouble at school, shy, panic attacks

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