Genetic Counseling New Patient Intake

Please Note: this intake form is for NEW patient appointments only.

Name: _____

Date of Birth: _____

Please select the category that best fits the reason for your visit.

- ☐ Prenatal consultation
- ☐ Prenatal diagnosis or high-risk screening results
- ☐ Infertility/reproductive consultation
- ☐ Other: _____

What is your primary reason for this appointment?

_____

What other questions or concerns would you like to discuss?

_____

_____

Medical History

Please list any personal medical concerns relevant to the reason for your visit.

_____

_____

_____

Family History

Please check the boxes below if any of the following medical concerns have occurred for yourself or a family member.

Consider yourself, your spouse, your children, parents, grandparents, and extended family including aunts, uncles, or cousins.

- ☐ Physical differences at birth (spina bifida, heart defects, cleft lip/palate, etc).
  Please specify: _____
- ☐ Multiple miscarriages or stillbirth
- ☐ Infertility or difficulty conceiving
- ☐ Chromosome differences (Down syndrome, Trisomy 13, Trisomy 18, etc)
  Please specify: _____
- ☐ Nerve, muscle, or seizure disorders (epilepsy, etc.)
  Please specify: _____
- ☐ Other genetic conditions (cystic fibrosis, PKU, sickle cell anemia, neurofibromatosis, etc)
  Please specify: _____
- ☐ Cancer diagnosis before age 50
- ☐ Intellectual disability or autism spectrum disorder
- ☐ Hearing or vision loss at a young age

Please list any other family history concerns relevant to the reason for your visit.

_____

Genetic Records

Have you seen a genetic counselor before?

- ☐ Yes
- ☐ No

Have you had genetic testing performed?

- ☐ Yes
- ☐ No

If yes, what kind of testing? _____

Do you have a copy of the genetic testing results?

- ☐ Yes
- ☐ No

Pregnancy History

Note: Complete this section only if you are currently pregnant.

When is your due date? _____

Total number of pregnancies (including this one): _____

During this pregnancy, have you had an ultrasound?

- ☐ Yes
- ☐ No

If yes, when? _____

Did it show any abnormalities? _____

During this pregnancy, have you had any screening tests?

- ☐ Yes
- ☐ No

If yes, when? _____

Did it show any abnormalities? _____

During this pregnancy, have you had any of the following?

- ☐ Vaginal bleeding or spotting?
- ☐ X-ray exposure?
- ☐ Exposure to alcohol, tobacco, or drugs?
- ☐ Infections, fevers, or illnesses?

Are you currently taking any medications or have you taken any during this pregnancy?

- ☐ Yes
- ☐ No

If so, what are you taking? _____

Is there any chance that you and the father of the baby are blood relatives (i.e., cousins)?

- ☐ Yes
- ☐ No