GENASSIST™ FAMILY PROFILE FORM

INSTRUCTIONS: Please complete this form with your partner by placing an "X" on each line that applies:

- **If you are FEMALE: Patient's Name_____ Date of Birth_____**

How many children have you had?:

Have you had previous genetic testing? YES NO

Have you had previous genetic counselling? YES NO

If yes, please give results in detail:

Are you pregnant now? YES NO If you are pregnant now :

What is the first day of your last menstrual period?:

When is your due date?:

How many times have you been pregnant prior to now?:
(includes miscarriages & abortions)

How many children/live births have you had?:

How many **documented** spontaneous miscarriages have you had?:

Have you ever had an "elective termination of a pregnancy – abortion)? YES NO

If yes, how many?:

- **If you are MALE: Patient's Name:_____ Date of Birth_____**

How many children have you fathered?:

Have you had previous genetic testing? YES NO

Have you had previous genetic counselling? YES NO

If yes, please give results in detail:

1) **Are you and your spouse/partner related (i.e. do you have any blood relatives in common)?** YES NO

If yes, specify who:

2) **Are your or your spouse/partner adopted?** YES NO

If yes, specify who:

3) What is your ethnic/racial background? (Some inherited diseases are more common in certain ethnic groups).

	SELF	PARTNER
Black/African American	_____	_____
Caucasian/White	_____	_____
Jewish	_____	_____
Mediterranean (Greek, Italian)	_____	_____
Asian/Oriental	_____	_____
Hispanic/Latino/Chicano/Central or S. American	_____	_____

Other, or combinations of above:

(Specify):

Does anyone in your family, or do you or your partner have any of the following? ***Include any previous partners with whom you have had children.**DO NOT include those who have been adopted.***

1. Infertility (Difficulty becoming pregnant for more than 6 months).

YES NO WHO:

DESCRIBE

2. More than one miscarriage and/or loss of baby.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

3. History of diabetes and/or diabetes during pregnancy.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

4. History of rapid or "painless" labor and/or premature birth.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

5. History of stillbirth infant and/or child that died shortly after birth (Include SIDS/Sudden Infant Death Syndrome).

YES____ NO_____ WHO_____

DESCRIBE_____
_____

6. History of medical difficulties during the newborn period.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

7. Development Delay (i.e motor, speech, etc.) or Learning Problems.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

8. Mental Retardation.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

9. Chronic Psychiatric, Psychological, Emotional or Behavioral Problems.

YES____ NO_____ WHO_____

DESCRIBE_____

_____

10. Brain Abnormality/Fluid on the Brain (Hydrocephalus).

YES____ NO_____ WHO_____

DESCRIBE_____
_____

11. Deafness/Ear Abnormalities.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

12. Blindness/Eye Abnormalities.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

13. Lip/Mouth Deformity.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

14. Cleft Palate/Cleft Lip.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

15. Skin Abnormalities.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

16. Spine Deformity/Spina Bifida.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

17. Bone Deformity.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

18. Hand/Feet Abnormalities.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

19. Club Foot.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

20. Heart Defect at Birth/Hole in Heart.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

21. Heart Attack before Age 50.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

22. Seizures/Epilepsy/Convulsions/"Fits".

YES____ NO_____ WHO_____

DESCRIBE_____
_____

23. Muscle/Nerve Disorder.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

24. Polycystic Kidneys/Horseshoe Kidney.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

25. Bleeding Disorders.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

26. Cystic Fibrosis.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

Have you been tested for Cystic Fibrosis?

YES___ NO___ RESULTS_____

Has your partner been tested for Cystic Fibrosis?

YES___ NO___ RESULTS_____

27. Asthma/Severe Allergies.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

28. Phenylketonuria (PKU).

YES____ NO_____ WHO_____

DESCRIBE_____
_____

29. Hypothyroidism/Hyperthyroidism (Low/High Thyroid Function).

YES____ NO_____ WHO_____

DESCRIBE_____
_____

30. Thalassemia/Blood-Disorder.

YES____ NO_____ WHO_____

DESCRIBE_____

_____

Have you been tested for Thalassemia?

YES___ NO___ RESULTS_____

Has your partner been tested for Thalassemia?

YES___ NO___ RESULTS_____

31. Hemophilia.

YES____ NO_____ WHO_____

DESCRIBE_____

_____

32. Sickle Cell Disease or Trait.

YES____ NO_____ WHO_____

DESCRIBE_____

_____

Have you been tested for Sickle Cell Disease?

YES___ NO___ RESULTS_____

Has your partner been tested for Sickle Cell Disease?

YES___ NO___ RESULTS_____

33. Tay Sachs Disease.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

Have you been tested for Tay Sachs Disease?

YES___ NO___ RESULTS_____

Has your partner been tested for Tay Sachs Disease?

YES___ NO___ RESULTS_____

34. Are you or your partner taking any prescription medication for any medical disease (e.g. high blood pressure etc. Specify the name of the drug (if known).

YES____ NO_____ WHO_____

DESCRIBE_____
_____

35. Diagnosed genetic (inherited) disease.

YES____ NO_____ WHO_____

DESCRIBE_____
_____

36. Are there any other serious specific disorders, conditions, or unusual traits that run in your family or your partner's family with or about which you are concerned?

YES____ NO_____ WHO_____

DESCRIBE_____
_____

Have you or your partner been exposed to the following:

Prescription Drugs

YOU_____PARTNER_____

DESCRIBE_____
_____

CHECK IF USED DURING THIS PREGNANCY_____

Over-the-Counter Drugs (i.e. aspirin, laxatives, sleeping pills, cold tablets, weight control medication, etc.)

YOU_____PARTNER_____

DESCRIBE_____
_____

CHECK IF USED DURING THIS PREGNANCY_____

Drugs (i.e. Marijuana, Cocaine, LSD, etc)

YOU_____PARTNER_____

DESCRIBE_____
_____

CHECK IF USED DURING THIS PREGNANCY_____

Environmental Agents (i.e. Chemicals, cleaning agents, etc at home or work)

YOU_____PARTNER_____

DESCRIBE_____
_____

CHECK IF USED DURING THIS PREGNANCY_____

Alcohol: Describe amount consumed per day._____

YOU_____PARTNER_____

DESCRIBE_____

CHECK IF USED DURING THIS PREGNANCY_____

Cigarettes: Amount smoked per day_____

YOU_____PARTNER_____

DESCRIBE_____

CHECK IF EXPOSED DURING THIS PREGNANCY_____

X-rays:

YOU_____PARTNER_____

DESCRIBE_____

Are you or your partner being followed by a specialty physician for any chronic disease or condition?

YOU____

YES_____NO_____

DESCRIBE_____

PARTNER_____

YES_____NO_____

DESCRIBE_____