MICHIGAN MEDICINE Genetic Medicine **Health History Questionnaire - New Patient - Medical Genetics Clinic**	MRN: NAME: BIRTHDATE: CSN:

Personal and Family History Questionnaire: This questionnaire will ask questions about medical conditions in you and your family members. This is important information to share with our clinic so that we can provide you with the most accurate information and address your questions and concerns. This form is separate from any questionnaire(s) you complete through your patient portal related to electronic check-in. If we do not receive your questionnaire **two weeks** prior to your appointment, your appointment may need to be rescheduled.

- Please provide information on biological relatives only.
  Do not provide information about adopted, foster, or step-relatives.
- If exact age is not known, please approximate: (for example, early 40s, late 60s).
- If requested information is not known, write "unknown."
- If additional space is needed, please attach another sheet of paper, and indicate which question is being addressed.

Family history information is helpful for your risk assessment and considering genetic testing options. When possible, please try to talk to family members to find out any needed information. Otherwise, provide what you know or indicate if you are not able to get the information. We understand that some of this information about your family may not be available to you.

Medical Records: Medical records will be requested from your referring provider if not already available to us. If other outside records are needed, you may be asked to sign a medical record release form. If you are being seen in our clinic because of a family history of a genetic condition, please try to obtain affected family member(s) genetic test results (if done) or a summary letter from their genetics clinic or specialists/healthcare providers.

Sending Your Completed Questionnaire: You may wish to make a copy of your completed questionnaire prior to sending it to keep for your records. If you have any questions, please do not hesitate to contact us. Please send your completed questionnaire to us by portal message, fax, or mail. If mailing, please keep a copy of the questionnaire for your records and send at least three weeks in advance of your appointment

Clinic Contact Information

Phone: 734-647-8902 Fax: 734-763-7672

Mailing Address
ATTN: Genetics Intake Coordinator
Michigan Medicine
NCAC Cancer Call Center
2901 Hubbard Road, Room 1621
Ann Arbor, MI 48109

MICHIGAN MEDICINE Genetic Medicine **Health History Questionnaire - New Patient - Medical Genetics Clinic**	MRN: NAME: BIRTHDATE: CSN:

Name: _____ Date of birth: _____ Date of appointment: _____

Pronouns: ☐ *She/Her* ☐ *He/Him* ☐ *They/Them* ☐ *Other:* ____ Occupation: _____

Referring provider: _____ Primary care provider: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Is this your primary care provider? ☐ *Yes* ☐ *No*

If NO, please provide this information in the second column.

Are you adopted? ☐ *Yes* ☐ *No*	If YES: Do you know family/medical history about either of your biological parents? ☐ *Yes* ☐ *No*
	If YES: please complete the family history form with this information.

What are the main questions or concerns you would like to talk about during your appointment in the Medical Genetics Clinic?

_____

_____

_____

_____

_____

_____ _____/_____/_____ (mm/dd/yy)

Printed name of person who completed the form

Health History Questionnaire - New Patient - Medical Genetics Clinic

MRN:
NAME:
BIRTHDATE:
CSN:

Past Surgical History (Check any surgeries you have had)

- ☐ Appendectomy
- ☐ Bariatric surgery
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ CABG (bypass)
- ☐ Cholecystectomy (gall bladder removal)
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ C-Section
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Hernia repair
- ☐ Hysterectomy with ovaries removed
- ☐ Hysterectomy without ovaries removed
- ☐ Joint replacement
- ☐ Other (list) _____
- ☐ Prostate surgery
- ☐ Small intestine surgery
- ☐ Spine surgery (other)
- ☐ Tonsillectomy and Adenoidectomy
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Vasectomy

Family History: *You will receive a separate Family History form to complete prior to your appointment.*

Social History

Do you ever drink alcohol? ☐ Yes ☐ No
If yes, please indicate number of alcoholic drinks per week: _____
Do you use street/recreational drugs? ☐ Yes ☐ No
If you use street/recreational drugs, how many times per week? _____
What type(s) of street/recreational drugs do you use? _____
Check one of the following about smoking tobacco:
☐ Never smoked ☐ Former smoker ☐ Smoke some days ☐ Smoke every day ☐ Exposed to secondhand smoke
If you smoke or used to smoke, how many packs do/did you smoke per day? _____
How many years did you smoke/have you smoked? _____
If you quit, when did you quit? _____
Do you use “smokeless tobacco”? (Select one below)
☐ Former user ☐ Current user ☐ Never used
If you quit, when did you quit? _____
Are you ready to quit smoking and / or using smokeless tobacco? ☐ Yes ☐ No ☐ Unsure

MICHIGAN MEDICINE

Genetic Medicine

Health History Questionnaire - New Patient - Medical Genetics Clinic

MRN:
NAME:
BIRTHDATE:
CSN:

Please check “Yes”, “No”, or “Unsure” to indicate whether you or a relative have a diagnosis of one of the listed health problems. If you check “Yes” for conditions that your relatives have, please list these under the “Significant Medical Problems” column when completing the following pages.

PERSONAL AND FAMILY HEALTH HISTORY		
Health problems diagnosed at any age	I have this condition	A relative has this condition
Intellectual disability, developmental delay, or autism spectrum disorder (not including ADD/ADHD)	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Seizures or epilepsy (not related to head trauma)	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Nerve or muscle disease	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Skeletal disorder	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Hormone problem affecting puberty, development, or fertility	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Infertility	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
More than 2 pregnancy losses or stillbirths	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Children who passed away young	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Birth defects (for example, heart defect, clubfoot, cleft lip)	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Known genetic condition, include here: _____	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Chromosome abnormality/rearrangement (for example, translocation)	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Health problems diagnosed before age 35		
Diabetes mellitus	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Hyperlipidemia (high cholesterol, triglycerides, etc.)	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Health problems diagnosed before age 50		
Cancer	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Heart attack or myocardial infarction	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Lung disease	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Kidney disease	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Blindness and/or deafness	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Health problems diagnosed before age 65		
Aneurysm (aorta, brain, etc.)	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Stroke	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*
Dementia, including Alzheimer's dementia	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No* ☐ *Unsure*

Your Biological Mother's Family

Your biological mother's family's countries of origin (i.e., China, Ireland, Nigeria): _____ ☐ *Unsure*

Have related family members (for example, first cousins) married each other? ☐ *Yes* ☐ *No* ☐ *Unsure*

	Initials	Sex assigned at birth Female, Male, Intersex *Note if this differs from gender identity*	Living or Deceased	Current Age or Age at Death	Significant Medical Conditions and Age of Onset (if known)	Cause of Death	Living Children (#)	Deceased Children (#)
Your Mother		☐ F ☐ M ☐ I _____	☐ L ☐ D					
Your Mother's Mother		☐ F ☐ M ☐ I _____	☐ L ☐ D					
Your Mother's Father		☐ F ☐ M ☐ I _____	☐ L ☐ D					
Your Mother's Siblings		☐ F ☐ M ☐ I _____	☐ L ☐ D					
If your biological mother does not have siblings, please check here: ☐		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					

Have any of the relatives above or their partners had pregnancy losses or stillbirths? ☐ *Yes* ☐ *No* ☐ *Unsure*

Initials	Number of pregnancy losses or stillbirths	Number of weeks pregnant when each occurred

Your Biological Father's Family

Your biological father's family's countries of origin (i.e., China, Ireland, Nigeria): _____ ☐ *Unsure*

Have related family members (for example, first cousins) married each other? ☐ *Yes* ☐ *No* ☐ *Unsure*

	Initials	Sex assigned at birth Female, Male, Intersex *Note if this differs from gender identity*	Living or Deceased	Current Age or Age at Death	Significant Medical Conditions and Age of Onset (if known)	Cause of Death	Living Children (#)	Deceased Children (#)
Your Father		☐ F ☐ M ☐ I _____	☐ L ☐ D					
Your Father's Mother		☐ F ☐ M ☐ I _____	☐ L ☐ D					
Your Father's Father		☐ F ☐ M ☐ I _____	☐ L ☐ D					
Your Father's Siblings		☐ F ☐ M ☐ I _____	☐ L ☐ D					
If your biological father does not have siblings, please check here: ☐		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					
		☐ F ☐ M ☐ I _____	☐ L ☐ D					

Have any of the relatives above or their partners had pregnancy losses or stillbirths? ☐ *Yes* ☐ *No* ☐ *Unsure*

Initials	Number of pregnancy losses or stillbirths	Number of weeks pregnant when each occurred

Your Biological Siblings

If you do not have biological siblings (i.e., full-siblings, half-siblings, etc.), please check here ☐

Initials	**Full or Half-Sibling** If half-sibling, through mother (Maternal) or father (Paternal)	**Sex assigned at birth** Female, Male, Intersex *Note if this differs from gender identity*	**Living or Deceased**	**Current Age or Age at Death**	**Significant Medical Conditions and Age of Onset (if known)**	**Cause of Death**	**Living Children (#)**	**Deceased Children (#)**
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ______	☐ L ☐ D					

Have any of the relatives above or their partners had pregnancy losses or stillbirths? ☐ *Yes* ☐ *No* ☐ *Unsure*

Initials	Number of pregnancy losses or stillbirths	Number of weeks pregnant when each occurred

Your Biological Children

If you do not have biological children, please check here ☐

Initials	**Sex assigned at birth** Female, Male, Intersex *Note if this differs from gender identity*	**Living or Deceased**	**Current Age or Age at Death**	**Significant Medical Conditions and Age of Onset (if known)**	**Cause of Death**	**Your Children's Children** Living Children (#)	Deceased Children (#)
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					
	☐F ☐M ☐I ____	☐L ☐D					

Have any of the relatives above or their partners had pregnancy losses or stillbirths? ☐ *Yes* ☐ *No* ☐ *Unsure*

Initials **Number of pregnancy losses or stillbirths** **Number of weeks pregnant when each occurred**

____
____
____
____

Your Relatives with a Genetic Condition

Please complete this page with information about relatives with a known genetic condition.

Initials	Relationship to You	Sex assigned at birth Female, Male, Intersex *Note if this differs from gender identity*	Living or Deceased	Current Age or Age at Death	Genetic Condition	Age at Diagnosis
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			
		☐ F ☐ M ☐ I ________	☐ L ☐ D			

Have you or any of your relatives had genetic testing? ☐ *Yes* ☐ *No* ☐ *Unsure* If YES, please obtain a copy of the report and send with this form. If not available, note below.

Initials	Laboratory that Performed Testing	Result

Michigan Medicine **Family and Friends Outpatient**	MRN: NAME: BIRTHDATE:

This form does not give the people listed below the right to access medical information or medical records. * To give a Michigan Medicine employee authorization to electronically access the patient's electronic medical record, please fill out the form titled "AUTHORIZATION TO VIEW ELECTRONIC PATIENT INFORMATION". **

This form documents my request to allow family members and/or friends to be involved in **verbal** discussions regarding my health care. The people listed below may receive any **verbal** information needed to participate in my care or to help me make decisions. By signing this form, I permit staff within outpatient clinics*** at Michigan Medicine to discuss information about me with the people listed below. This information may include diagnoses, test results, treatment options and other information from previous outpatient or inpatient services.

- I understand that signing this form is voluntary and that information may be released to family members or others without this form, if allowed by federal and state law. ****
- I understand that listing people on this form does not give them the right to receive or copy my medical records.
- It does not allow them to consent for health care services on my behalf.
- I understand this form is NOT to be used to request a restriction of my information.

☐ I grant permission to those persons listed below to receive verbal communication regarding billing related to my care.

NAME	PHONE	RELATIONSHIP

The following information has special protection under Michigan law and **will not be disclosed** without the **patient's (or, in the case of a minor patient (under age 18), the parent's/personal representative's)** explicit permission. This information will be made available to the people I've listed above **only if I indicate my approval by initialing the line(s) below:**

_____ HIV/AIDS or other communicable diseases including sexually transmitted diseases, venereal disease, tuberculosis, and hepatitis

_____ Birth control / birth control devices / pregnancy / prenatal services / abortion

_____ Mental health services

Substance Use Disorder information will not be disclosed by signing this form. Federal law requires a separate written authorization.

I can update this form at any time by completing a new form and either giving it to my clinical staff or forwarding it to: Michigan Medicine, Revenue Cycle Mid Service – Release of Information, 3621 S. State 700 KMS Place, Bay 11 – Mid Service, Ann Arbor, MI 48108-1633 (Fax 734-936-8571). I can revoke or cancel this form at any time by sending written notification to the same address (or fax). This form does not expire unless revoked or updated.

_____ ____/____/_____

Signature of Patient or Legally Authorized Representative (if patient is unable to sign) Date (mm/dd/yyyy)

_____

Printed Name of Legally Authorized Representative (proof of power of attorney or legal guardianship required)

Relationship: ☐ Spouse ☐ Parent ☐ Next-of-Kin ☐ Legal Guardian ☐ DPOA for Healthcare ☐ Other (specify): _____

* For AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD and other required forms, go to: https://www.uofmhealth.org/patient-visitor-guide/medical-records or call (734) 936-5490.

** For Authorization to View Electronic Patient Information go to: Authorization to View Electronic Information

*** For Admissions, Emergency Department Visits and Observation Unit Stays use 70-10011 Family and Friends Inpatient - Current Admission, Emergency Department Visit and Observation Unit Stay.**** Refer to our Notice of Privacy Practices at: https://www.uofmhealth.org/patient-visitor-guide/protecting-your-privacy-hipaa