

Date

FAMILY HISTORY QUESTIONNAIRE

You have been referred to the Wessex Clinical Genetics Service. It would be helpful to gather some more information about the family before the appointment. All information you give will be kept as part of your NHS record and will be kept confidential. Please return this questionnaire as soon as possible for us to process all the information.

If you have any queries or difficulties in completing the form please do not hesitate to contact us. If you are unable to complete all the sections, please still return the form.

Your Details (Person Referred):

Title: _____ Forename(s): _____ Surname: _____

Previous surname(s): _____

Name you prefer to be addressed by (optional): _____ Pronouns (optional): _____

Address: _____

Telephone number: _____ Email Address: _____

If you are completing this form on behalf of the person referred, please fill in below.

Name: _____

Relationship to patient: _____

Address: _____

Telephone number: _____ Email Address: _____

We may contact you by telephone if we need further details. We will not disclose where we are calling from to anyone apart from yourself, without your permission.

- Are you happy for us to contact you by telephone? YES/NO
- If you have an answer-phone, are you happy for us to leave a message? YES/NO
- Can we disclose where we are calling from should anyone apart from you answer the phone? YES/NO
- Would you prefer to receive a letter, asking to call the department, should we need further details? YES/NO

If the person referred is a Looked After Child, please provide the contact details for the social worker:

Social worker's Name: _____ Telephone No: _____

Address: _____

Email: _____

Your immediate family - We would like to know details of family members, both with and without any health or learning problems.

Please note any additional information, such as donor conception, adoption, or anything else you would like us to understand about this part of your family:

Relative (of person referred)	<u>Name</u> (including any previous names)	Date of Birth	Alive Y/N	Date of Death	Please give details of any health, developmental or learning problems (including any relevant genetic test results)	Hospital where treated
Person Referred						
Children of person referred (if applicable)						
Sisters of person referred full or half (if half, please state through mother or father)						
Brothers of person referred full or half (if half, please state through mother or father)						
Mother of person referred						
Father of person referred						

Additional Family History

Please include below anyone else in the family that has any similar health, developmental or learning problems related to the referral reason

Please note any additional information, such as donor conception, adoption, or anything else you would like us to understand about your family:

Other Relatives (please include how they are related to you i.e. mother's brother's son)	<u>Name</u> (including any previous names)	Date of Birth	Alive Y/N	Date of Death	Please give details of any health, developmental or learning problems (including any relevant genetic test results)	Hospital where treated

If you know of anyone else in your family who has been seen by another Genetics Service or referred to Wessex Clinical Genetics Service, it would be helpful to provide some details here:

Name: _____ Date of birth: _____

Diagnosis (if known): _____

Genetics Service where seen: _____

We may get in touch asking you to pass on a consent form to your relative to access their genetic report. Are you in contact with the above relative? YES/NO
If you already have a copy of this genetic result, it would be helpful to return this form with a copy attached.

About you

Some conditions are more common in certain ethnic groups. What is your ethnicity? _____

Are you or your partner currently pregnant? YES/NO If yes, what is the due date? _____

Are you and your partner biologically related? YES/NO

Have you been diagnosed with any major illness or undergone any surgery in the past? Please give details including dates, names of hospital and specialists seen. Please also list any current medications.

Is there **any other information** about you or your family members that you feel may be relevant?

What are **your main questions** you would like to be addressed by the genetics service?

Thank you for completing this questionnaire

For official use only

G Number:

Date Issued:

Date Returned:

Patient Number: