General Adult Genetics

Greater Baltimore Medical Center
The Harvey Institute for Human Genetics

If you are interested in scheduling an appointment, please complete the pre-visit questionnaire part of this packet and send it back to us either via e-mail, fax, or mail. **IF MAILING, PLEASE DO NOT SEND THIS PAPERWORK BACK TO US DOUBLE-SIDED.** This information is important for your visit and required prior to your appointment.

How to Contact Us:

Phone: (443) 849-3131
Email: clinicalgenetics@gbmc.org
Fax: (443) 849-2919

Our Web Site:

www.gbmc.org/adultgenetics

Our Location:

Greater Baltimore Medical Center
6701 N. Charles St, Ste 2326
Towson, MD 21204

We are located on the 2nd floor of the main hospital near labor and delivery.
Valet parking is available outside the maternity entrance,
or the nearest parking garage is the Lily garage.

Note: If you park in the Lily garage, we recommend you consider walking down the hill outside rather then through the hospital as this it the most direct route. If you walk through the hospital, follow the signs to Zone C/D for labor and delivery.

Pre-Visit Questionnaire
General Adult Genetics

Instructions:

1. If you received this questionnaire via e-mail or online, you can type your answers directly into the form via Adobe Reader and save it. This will enable you to e-mail it back to us directly. **Please also save a copy for your records.**

For Mac Users: If you type your answers directly into the form, you will need to make sure you use Adobe Reader and NOT the default PDF reader Mac computers use. If you use the default Mac PDF file reader, your form will be blank when opened on our PCs.

2. Please complete the following questionnaire to the best of your ability. It may be helpful to speak with other family members in order to obtain more accurate information. The more accurate your information, the better our assessment will be. If you are unsure of certain information or do not have certain information, please make your best guess or write "unknown."

3. Once complete, please send a copy of the completed questionnaire back to us either via e-mail, fax, or mail. **IF MAILING, PLEASE DO NOT SEND THIS PAPERWORK BACK TO US DOUBLE-SIDED.** Please see page 1 for contact information.

If You or a Family Member Had Genetic Testing Already:

If you or another family member had genetic testing already, please include a copy of the genetic test results for review. We will need this information if you want to be tested for a certain genetic risk factor found in another family member.

Part A: Basic Information

Last Name: _____ First Name: _____ Middle Initial: _____

Maiden Name: _____ Suffix: _____ Preferred Name: _____

Date of Birth: _____ Current Age: _____ Gender: _____

Ethnicity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____

Employment Information:

☐ Not Employed ☐ Employed ☐ Full-time ☐ Part-time

Employer: _____ Occupation: _____

Employer's Address: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Other: _____

How May We Contact You?

Check all that apply: ☐ Phone ☐ E-Mail ☐ Mail

What Phone Numbers May We Use? : ☐ Home ☐ Work ☐ Cell

If you are not present to receive a telephone call, may we leave a voice-mail message? ☐ Yes ☐ No

May we leave a detailed message with someone else? ☐ Yes ☐ No

If yes, whom? _____ Relationship to You? _____

Other comments:

_____

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

Insurance Information

Primary Insurance:

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

Secondary Insurance:

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

Patient's Name: _____

Were you referred by a specific physician? If yes, please provide his or her name and speciality below:

_____

If you were not referred by a specific physician, how did you hear about us?

What is the reason for the appointment? Do you have any specific concerns or questions?

Have YOU ever had genetic testing? ☐ Yes ☐ No

If yes, what was the test? and what were the results?

Important: **Please include a copy of your genetic test results with your completed questionnaire.**

Part B: Medical History

Medical Diagnoses, Conditions or Illnesses:

Surgical History:

Known Allergies and Reactions:

Patient's Name: _____

Do you recall any developmental delays or difficulty in school? If so, please describe.

What is your highest level of education?

☐ Yes ☐ No **I use or have have used tobacco**

If yes, what type (cigarettes, pipe, etc), at what ages, and how much a day? _____

☐ Yes ☐ No **I drink alcohol**

If yes, how much and how often? _____

Part C: Family History

Does anyone in your family have the following condtions? If you, please report relationship (example: father, maternal uncle)

	Yes	Relationship/explain
Cancer	☐	
Cystic fibrosis	☐	
Cleft lip or palate	☐	
Spina bifida	☐	
Bone problems	☐	
Bleeding problems (like hemophilia)	☐	
Muscular dystrophy or muscle weakness	☐	
Neurofibromatosis	☐	
Intellectual or learning disability	☐	
Hearing loss of deafness	☐	
Vision loss or blindness	☐	
Seizures	☐	
Heart problems from birth	☐	
Diabetes	☐	
Anemia ("low blood")	☐	
Lung problems	☐	
Other birth defect (Please explain)	☐	
Other inherited/genetic problem) (Please explain)	☐	

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

CURRENT MEDICATIONS

Date Completed: _____

Please list all prescription and non-prescription medications and supplements. Please provide dosage and frequency of use (for example: 10mg once a day OR 10mg three times a day)

MEDICATION	DOSE	FREQUENCY	REASON FOR MEDICATION	ROUTE (mouth, injections, eye drops, etc)