

## Genetic Counseling Intake

### PATIENT INFORMATION

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth (MM/DD/YY): \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County (CA only): \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### PARTNER INFORMATION (if the patient is pregnant, then "partner" is the father of the pregnancy)

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth (MM/DD/YY): \_\_\_\_\_ Occupation: \_\_\_\_\_

### PREGNANCY INFORMATION

Are you currently pregnant?      NO      YES      if yes, what is your due date: \_\_\_\_\_

Please list any medications you take on a regular basis: \_\_\_\_\_

If pregnant, please list any other medications you have taken during this pregnancy (other than prenatal vitamins or Tylenol): \_\_\_\_\_

### **Since becoming pregnant, have you had/used any:      Do you have any of the following conditions?**

Recreational Drugs	YES	NO	Diabetes?	YES	NO
Cigarettes	YES	NO	A seizure disorder?	YES	NO
Alcohol	YES	NO			
Fevers	YES	NO			
X-rays	YES	NO			

### CONTACT INFORMATION / PHONE NUMBERS

Patient Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Who else can we leave results with? \_\_\_\_\_ Phone: \_\_\_\_\_

If there is a phone number at which we may leave confidential messages, please sign the release below:

I, \_\_\_\_\_, give Genzyme Genetics permission to leave messages about confidential medical information and test results at the number noted below. I understand that no procedure(s)/test(s) can guarantee the birth of a normal healthy baby.

CONFIDENTIAL PHONE NUMBER: \_\_\_\_\_

I HAVE ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE:

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_