GENETICS HEALTH QUESTIONNAIRE

Full Name………………………………………………................ **Referred by**…………………………………………………..........

Ethnicity...............................**Date of birth**................... **Age**................................**Gender/Sex**.................................

Contact Tel Numbers…………………………………........ **Email**………………………....…………………………………...

Reason for genetic testing:					
Previous genetic tests performed:					
Medical Condition	**Patient** (Y/N)	**Age of Onset**	**Current medication of patient**	**Family Relationship** (e.g. mother, brother)	**Age of Onset**
Cancers					
Breast cancer					
Colorectal cancer					
Ovarian cancer					
Prostate cancer					
Other (specify) …………………………..					
Hereditary biochemical diseases					
Hemochromatosis					
Hypercholesterolemia					
Metabolic and brain disorders					
Alzheimer's disease					
Anaemia / iron deficiency					
Angina / Coronary heart disease					
Arthritis / Osteoarthritis					
Chronic periodontitis					
Deep vein thrombosis					
Diabetes Type II					
High blood cholesterol					
High blood iron					
High blood pressure					
Multiple Sclerosis					
Non-alcoholic fatty liver disease					
Osteoporosis					
Peripheral vascular disease					
Porphyria (specify type)					
Pulmonary embolism					
Recurrent pregnancy loss					
Restless legs syndrome					
Stress, Anxiety, Depression					
Stroke					
Other conditions (circle): recurrent sport injury, sleep apnoea, polycystic ovary syndrome OR………………………..					

Form ADM RQT-0043-9

Patient Name……………………………................ **Date completed**……………………………………........

MEDICATION USE			
Treatment failure / side effects?	Y	N	Name medication
Chronic medication taken previously	Y	N	Name medication
Change of medication / dosage considered?	Y	N	Name medication

MEDICATION SIDE EFFECTS (Please Specify)					
Anti-depressants (e.g. weight gain)	Y	N	Anti-retrovirals (e.g. weight gain, dyslipidaemia)	Y	N
Cholesterol-lowering statins (e.g. muscle pains)	Y	N	Immunomodulating drugs (e.g. depression)	Y	N
Other medication side effects (Please Specify):					

Did You Previously [P] or Currently Take:				**Blood Pressure Medication:**	Y	N	P
Oral Contraceptive Pill (OCP)?	Y duration	N	P	Systolic Blood Pressure	mmHg		
Hormone Replacement Therapy?	Y duration	N	P	Diastolic Blood Pressure	mmHg		
Blood/Nutrient deficiencies?	Y	N	P	Iron injections?		Vit B12 injections?	
Blood donor?	Y	N	P	Pregnant (females)?	Y N		

HOW MANY UNITS OF ALCOHOL DO YOU CONSUME ON AVERAGE PER WEEK? One unit of alcohol equals: 250 ml beer or lager, 1 glass (125 ml) of wine, 1 pub measure of spirits						
Abstain	1 – 2 units			1 – 13 units	14 – 21 units	22+ units
Do you smoke?	Y	N	P	Tobacco/Other:	Brand and frequency	
Prolonged exposure to environmental toxins (e.g. agricultural pesticides, occupational solvents)					Y	N

Weight	kg	Height	cm	Waist	cm	Hips	cm

IN THE PAST 3 MONTHS, HOW MANY TIMES A WEEK HAVE YOU CONSUMED THE FOLLOWING FOODS (please underline foods taken or exclude those not relevant)			
[0] Never	**[1] Once per week**	**[2] Twice per week**	**[3] Three times per week**
[4] Four times per week	**[5] Five times per week**	**[6] Six times per week**	**[7] Every day**

Food		Food	
Hamburgers, Pizza		All legumes (beans, peas, lentils)	
Red meat (e.g. beef, lamb, mutton)		Potatoes with skin	
Fried chicken / cooked chicken with skin		At least 5 portions fruits and vegetables (per day)	
Hot dogs / Sausages		Whole grain breads. cereals (low GI wheat, oats)	
Salad dressings (excludes 'Lite' versions)		Broccoli, cauliflower, mushrooms	
Butter and margarine (excluding pro-active versions)		Turnips, artichokes, asparagus	
Fried eggs (excludes cooking, boiling and baking)		Avocado, spinach	
Full cream milk and dairy products (fresh, sour or powdered)		Oranges, grapefruits (pure fruit versions)	
Fried hot potato chips, potato crisps, corn chips, popcorn		Organ meats (e.g. liver, kidney, giblets)	
Biscuits, cake, cookies, pastries		Fizzy drinks, tea/coffee with sugar	

Supplements taken	Daily:	Occasionally:	
Food allergy / intolerance:			
Are you following a specific style of eating? (e.g. Vegetarian, Banting)	Y	N	My Preference

WHICH BEST DESCRIBES YOUR PHYSICAL ACTIVITY STATUS? (Includes walking, swimming, cycling, attending exercise classes, each lasting **more than 30 minutes**)			
Complete lack of exercise	Exercise once a week	Exercise 2 – 3 times/week	Exercise 4+ times/week

WHICH BEST DESCRIBES YOUR OCCUPATIONAL ACTIVITY?		
Sedentary (e.g. desk work, driving)	Moderate (e.g. housework)	Physical labour (e.g. gardener)

PLEASE ALSO PROVIDE RELEVANT/AVAILABLE PATHOLOGY RESULTS (Lipid profile/cholesterol, homocysteine, glucose, ferritin levels, and histology/immunohistochemistry in the case of cancer patients), OR
APPROVAL TO REQUEST INFORMATION FROM YOUR DOCTOR / LABORATORY □ YES □ NO