GENETICS HEALTH QUESTIONNAIRE

Name: _____ **Referred by:** _____

Date of Birth: _____ **Age:** _____ **Gender/Sex:** _____

Contact Number(s): _____ **Email:** _____

Please complete all sections as necessary **[Y]** – Yes / **[N]** – No

Reason for genetic testing: *(e.g., disease with familial risk, lifestyle-triggered genetic risk, therapy-associated risk)*

Previous genetic tests performed: *(Please provide previous laboratory reports, if possible, e.g., BRCA1/2)*

Medical Condition	Patient (Y/N)	Age of onset	Current medication of patient	Family Member (Y/N)	Family Relationship (e.g., mother, brother)	Age of onset
COVID-19						
Cancers *(please provide histopathology, IHC, FISH reports etc.)*						
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 or symptoms Recurrent sports injury, Long Covid etc. (specify) ……						

Patient Name: _____ **Date completed:** _____

Please complete all sections as necessary **[Y]** – Yes / **[N]** – No / **[P]** – Previously

MEDICATION USE *(Please specify)*			
Chronic medication taken previously / currently?	***Y***	***N***	*Name of medication(s)*
Change of medication / dosage considered?	***Y***	***N***	*Name of medication(s)*
Treatment failure / side effects?	***Y***	***N***	*Name of medication(s)*

MEDICATION SIDE EFFECTS *(Please specify)*					
Anti-depressants *(e.g., weight gain)*	***Y***	***N***	Aromatase inhibitors *(e.g., muscular skeletal inflammation, bone density reduction/loss)*	***Y***	***N***
Cholesterol-lowering statins *(e.g., muscle pains)*	***Y***	***N***	Tamoxifen *(e.g., deep vein thrombosis)*	***Y***	***N***
Other medication side effects *(e.g., weight gain / dyslipidaemia with ARVs or depression with immunomodulating drugs)*					

DO YOU TAKE THE FOLLOWING?									
Oral Contraceptive Pill	*Name + duration*	***Y***	***N***	***P***	Iron injections	***Y***	***N***	***P***	
Hormone Replacement Therapy	*Name + duration*	***Y***	***N***	***P***	Vitamin B12 injections	***Y***	***N***	***P***	
Blood Pressure Medication	***Y***	***N***	***P***	Systolic Blood Pressure	*mmHg*	Diastolic Blood Pressure	*mmHg*		

ADDITIONAL QUESTIONS								
Any blood / nutrient deficiencies?	***Y***	***N***	***P***	Are you a blood donor?	***Y***	***N***	***P***	
Currently pregnant *(females)*?	***Y***	***N***	***P***	No. of pregnancies		No. of children		
Do you smoke?	***Y***	***N***	***P***	Tobacco/Other?	*Brand and frequency*			
Prolonged exposure to environmental toxins? (e.g., agricultural pesticides, occupational solvents)	***Y***	***N***	***P***					
Weight	*kg*	Height	*cm*	Waist	*cm*	Hips	*cm*	

How many units of alcohol do you consume on average per week? *(One unit of alcohol equals 250 ml beer / lager, 1 glass (125 ml) of wine, 1 pub measure of spirits)*

None	1 – 2 units	3 – 13 units	14 – 21 units	22+ units

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] *Less than once per week*	***[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*

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 of fruits + vegetables (per day)	
Hot dogs / Sausages		Whole grain breads, cereals (low GI wheat, oats)	
Salad dressings (excludes 'Lite' versions)		Broccoli, cauliflower, mushrooms	
Butter + margarine (excluding pro-active versions)		Turnips, artichokes, asparagus	
Fried eggs (excludes cooking, boiling and baking)		Avocado, spinach	
Full cream milk + dairy products (fresh, sour or powdered)		Oranges, grapefruits (pure fruit versions)	
Fried 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., Vegan, 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

(e.g. Lipid profile / cholesterol, homocysteine, glucose, iron / ferritin levels, and histology / immunohistochemistry in the case of cancer patients)

OR

APPROVAL TO REQUEST INFORMATION FROM YOUR DOCTOR / LABORATORY ☐Yes ☐No