Dynacare®

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# Pharmacogenomics Medical and Family History Questionnaire

Patient Name: _____ DOB (MM/DD/YYYY): _____

Current gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other (Specify) _____

Biological Sex Assigned at Birth: ☐ Male ☐ Female ☐ Prefer not to say ☐ Other (Specify) _____

What pronouns do you prefer?: ☐ He/Him ☐ She/Her ☐ They/Them

Other (Specify) _____

Please indicate your preferred language of communication: ☐ English ☐ French

☐ English or French (bilingual) ☐ Mandarin ☐ Other: _____

Email address: _____ Telephone number: _____

Can we leave a message at this telephone number? ☐ Yes ☐ No

## Patient Health Information

Please complete this questionnaire to the best of your ability. You will meet with a genetic counsellor and/or geneticist at your appointment. Information provided on your personal medical and family history will be used to provide a genetic assessment based on the genetic variant that was found on your PGx testing. This information will be important to determine recommendations for yourself and other family members.

## General Health Information

What is your height? _____ ☐ ft/in ☐ M What is your weight? _____ ☐ lbs ☐ kg

Have you ever had a bone marrow transplant? ☐ Yes ☐ No

If yes, was the bone marrow transplant your own? ☐ Yes ☐ No

Have you or will you be having a blood transfusion? ☐ Yes ☐ No

Do you have any health concern(s) other than cancer for which you are taking medication(s), seeing a specialist, or are followed by your family doctor? ☐ Yes ☐ No

If you answered yes to having health concern(s), please list your health concerns:

_____

_____

_____

## Family History Information

☐ African
☐ Ashkenazi Jewish
☐ Asian
☐ Arab
☐ Acadian
☐ Carribbean
☐ European
☐ European (Eastern)
☐ French Canadian
☐ Hispanic
☐ Indigenous Canadian
☐ Pacific Islander
☐ Other (please specify):

_____

Are you adopted? ☐ Yes ☐ No

Are you and your partner related by blood? ☐ Yes ☐ No

If yes, how? (which side of family?)

☐ first cousins ☐ Third cousins

☐ second cousins ☐ other/ I dont know

## Pregnancy History

Do you have biological children? ☐ Yes ☐ No

If yes, how old were you when your first child was born? _____ years old

Are you currently pregnant? ☐ Yes ☐ No

If yes, what is your expected due date (EDD)? _____

Do you or any of your family members have a personal history of any of the following? If yes, please indicate which family member(s) in the space provided.

| Body system | Yes | No | Relative relationship to you |
|---|---|---|---|
| **Brain and blood vessels** | | | |
| Seizures | ☐ | ☐ | |
| Migraine | ☐ | ☐ | |
| Stroke | ☐ | ☐ | |
| Depression | ☐ | ☐ | |
| Dementia | ☐ | ☐ | |
| Psychosis | ☐ | ☐ | |
| Learning disabilities or mental handicap | ☐ | ☐ | |
| Memory loss | ☐ | ☐ | |
| Hearing loss | ☐ | ☐ | |
| Deafness | ☐ | ☐ | |
| **Vision** | | | |
| Cataract | ☐ | ☐ | |
| Blurred vision | ☐ | ☐ | |
| Loss of vision | ☐ | ☐ | |
| Drooping eye lids and/or paralysis of eye muscles | ☐ | ☐ | |
| **Muscular and Nervous System** | | | |
| Hypotonia (Decreased muscle tone) | ☐ | ☐ | |
| Parkinsonism (Slowed movements, stiffness and/or tremours) | ☐ | ☐ | |
| Loss of reflexes | ☐ | ☐ | |
| Unintended movements | ☐ | ☐ | |

| Muscular and Nervous System | | | |
|---|---|---|---|
| Loss of feeling/sensations, difficulty using legs/arms | ☐ | ☐ | |
| Loss of coordination/balance | ☐ | ☐ | |
| General muscle weakness/stiffness | ☐ | ☐ | |
| **Skin** | | | |
| Jaundice | ☐ | ☐ | |
| Thickening of skin | ☐ | ☐ | |
| Excessive sweating | ☐ | ☐ | |
| Abnormally thick finger/toenails | ☐ | ☐ | |
| **Organs** | | | |
| Cardiomyopathy (Enlarged Heart) | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Liver dysfunction | ☐ | ☐ | |
| Liver Failure | ☐ | ☐ | |
| Underdeveloped ovaries/ ovarian failure | ☐ | ☐ | |
| Testicular Failure (failure to produce sperm) | ☐ | ☐ | |
| Abnormal food digestion | ☐ | ☐ | |

**Additional information you think is important for us to know:**