NG-E

QUESTIONNAIRE

General Information

SCHELL GENETICS
chayim.schell@schellgenetics.uk

Personal details

Surname: _____
Forenames: _____
Date of birth: _____
Place of birth: _____
Gender: _____
Address: _____
_____
Telephone: _____
E-Mail: _____

Referring Physician /Neurologist/ Mental Health Specialist

Surname: _____
Forenames: _____
Hospital: _____
Address: _____
_____
Telephone: _____
E-Mail: _____

Do you have children?

[ ] Yes
[ ] No

If YES:

Surname: _____
Forenames: _____
Date of birth: _____
Gender: _____

Surname: _____
Forenames: _____
Date of birth: _____
Gender: _____

Please provide details on further children on a separate sheet if necessary

Did you or your partner have miscarriages or abortions?

[ ] Yes
[ ] No

If YES, please provide further particulars hereto (e.g. how many miscarriages/ abortions, at which gestational week, reason for abortion [fetal malformation/ disorder?]):

_____
_____
_____
_____

Please provide details on further miscarriages/ abortions on a separate sheet if necessary
Please provide medical reports/ documents etc., if applicable

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Family History / Pedigree

The following question refers to your family over three generations. It comprises your own children – if applicable –, your own brothers and sisters and their children as well as your parents, your parents' siblings and their descendents. The question refers also to deceased relatives

Are there any medical problems or health issues in your family? [ ] Yes [ ] No
(e.g. disabilities, malformations, epilepsy, gait/ neurological/ muscular issues, mental health problems, cardiovascular disorders, cancer, diabetes, hearing or visual impairments)

If YES, please provide further particulars hereto (e.g. indicate the affected individual [exact relationship], and which medical problem/ issue occurred at what age; if deceased: at what age and cause of death):

Please provide details on further relatives on a separate sheet if necessary

Do other family members of yours have the same medical problem/ health issue or display similar symptoms ? [ ] Yes [ ] No

If YES, please provide further particulars hereto (e.g. exact relationship to affected individual, age at which first symptoms displayed; if deceased: at what age and cause of death):

Please provide details on further relatives on a separate sheet if necessary

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Medical History

Which medical problem/ health issue do you display?
Please describe your symptoms and health problems as accurate as possible (e.g.at what age did you experience first symptoms, did they present differently over time [in intensity, severity or peculiarity], wich symptoms/ peculiarities did display at what age):

Please provide medical reports/ documents etc., if applicable

Which kind of treatments have been performed to date?
(e.g. surgeries, radiotherapy, physiotherapy, medication, psychotherapy):

Please provide medical reports/ documents etc., if applicable

Do you have any other health issues or pre-existing conditions? [ ] Yes [ ] No

If YES, please provide further particulars hereto (e.g. malformations, epilepsy, gait/neurological/ muscular issues, mental health issues, cardiovascular disorders, liver/ kidney disorders, cancer, diabetes, thyroid problems, surgeries, clotting disorders, hearing or visual impairments) including treatments/ therapies/ medication/ in-patient stays, if applicable:

Please provide medical reports/ documents etc., if applicable

Do you consume alcohol, illegal substances [drugs] or do you smoke? [ ] Yes [ ] No

If YES, please provide further particulars hereto (e.g. which substance, since when and how long for):

Please provide your most recent body measurements

Height:	_____	Date measured:	_____
Weight:	_____	Date weighted:	_____
Head circumference:	_____	Date measured:	_____

QUESTIONNAIRE

Comments

Is there anything else you would like to share, anything special or remarkable? Please tell us about it here:

Thank you for your time and patience.