UTHealth
The University of Texas
Health Science Center at Houston

McGovern
Medical School
Department of Pediatrics
Division of Medical Genetics

THE UNIVERSITY OF TEXAS MEDICAL GENETICS PATIENT INTAKE FORM

CONNECTIVE TISSUE DISORDERS CLINIC

PLEASE COMPLETE THE FOLLOWING PAPERWORK AND RETURN BY MAIL, FAX, OR E-MAIL.

To return by mail: (NOT where patient appointments are held)

UT Medical Genetics
6431 Fannin Street
MSB 3.142
Houston, TX, 77030

To return by fax: (713) 383 - 1475

To return by e-mail: Jennifer.m.lemons@uth.tmc.edu or maria.castillo@uth.tmc.edu

Once the forms listed below are completed and returned, someone from the office will contact you to schedule an appointment.

- ☐ Patient Information
- ☐ Photo/Video Consent
- ☐ E-mail Consent
- ☐ Medical History Intake
- ☐ Medical Records Release
- ☐ Front and Back Copy of Insurance Card

Patient appointments are held at the University of Texas Professional Building (UTPB):

UTPB
6410 Fannin Street
Suite 500, 5th Floor
Houston, TX, 77030

UTHealth
The University of Texas
Health Science Center at Houston

McGovern
Medical School
Department of Pediatrics
Division of Medical Genetics

THE UNIVERSITY OF TEXAS MEDICAL GENETICS PATIENT INTAKE FORM

CONNECTIVE TISSUE DISORDERS CLINIC

SECTION 1 – PATIENT PERSONAL INFORMATION

First Name: _____ Last Name: _____ Current Age: _____
Date of Birth: Month _____ Day _____ Year _____ Ethnicity/Ancestry: _____
Cell #: (____) _____ - _____ Home #: (____) _____ - _____ Email:_____
Street Address: _____ City/State/Zip Code: _____

IF UNDER 18 YEARS OLD:
Mother's name: _____ Father's Name: _____
OR
Legal Guardian's name: _____

SECTION 2 – INSURANCE INFORMATION

Insurance Provider: _____ Insurance ID: _____
Insurance Group: _____ Insurance Phone: _____
Policy Holder's Name: _____ Policy Holder's Date of Birth: _____
Policy Holder's Phone: _____ Relationship to Patient: _____

SECTION 3 – VIDEO/PHOTO CONSENT

In consideration of the purposes, objectives, and work of the University of Texas – McGovern Medical School, Department of Pediatrics, Division of Medical Genetics, I (We) the undersigned grant permission to the University of Texas – McGovern Medical School, Department of Pediatrics, Division of Medical Genetics to photograph and/or video record me/my child.

I hereby grant full permission to the University of Texas – McGovern Medical School, Department of Pediatrics, Division of Medical Genetics to conduct such photography and/or video for the purposes of clinical decision-making, research, and/or education. My consent and permission will remain in effect until revoked by me in writing.

I have read the above statement, given my consent, and had the opportunity to ask questions regarding this consent.

Patient Name: _____
Patient/Guardian Signature: _____ Date: _____
Witness Name/Signature: _____ Date: _____

UTHealth
The University of Texas
Health Science Center at Houston

McGovern
Medical School
Department of Pediatrics
Division of Medical Genetics

THE UNIVERSITY OF TEXAS MEDICAL GENETICS PATIENT INTAKE FORM

CONNECTIVE TISSUE DISORDERS CLINIC

SECTION 4 – CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS IN THE MEDICAL CARE OF:

Patient Name: _____ Date of Birth: _____

In consideration of the purposes, objectives, and work of the University of Texas – McGovern Medical School, Department of Pediatrics, Division of Medical Genetics, I (We) the undersigned grant permission to the University of Texas – McGovern Medical School, Department of Pediatrics, Division of Medical Genetics to communicate through e-mail for me/my child. All communications should be directed to: _____ (e-mail address).

I hereby grant full permission to the University of Texas – McGovern Medical School, Department of Pediatrics, Division of Medical Genetics to use this form of communication and understand the inherent risks associated with its use. I understand that e-mail is not secure and it is possible that mine or my child's personal medical information may be accessed by others. My consent and permission will remain in effect until revoked by me in writing. I understand that the University of Texas – McGovern Medical School will do everything in their power to avoid unauthorized access of this material. My consent and permission will remain in effect until revoked by me in writing.

I have read the above statement, given my consent, and had the opportunity to ask questions regarding this consent.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

Witness Name/Signature: _____ Date: _____

THE UNIVERSITY OF TEXAS MEDICAL GENETICS PATIENT INTAKE FORM

CONNECTIVE TISSUE DISORDERS CLINIC

SECTION 5 – HEALTHCARE PROVIDERS:

Please list all providers who are currently involved in your healthcare. Continue on the back of this page if needed. Be as complete as possible when providing contact information.

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

Provider Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________

UTHealth
The University of Texas
Health Science Center at Houston

McGovern
Medical School
Department of Pediatrics
Division of Medical Genetics

THE UNIVERSITY OF TEXAS MEDICAL GENETICS PATIENT INTAKE FORM

CONNECTIVE TISSUE DISORDERS CLINIC

SECTION 6 – MEDICAL RECORDS RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Patient Address: _____ Phone: _____
_____ Email: _____

I hereby authorize (Facility Name): _____
to release medical records of (Patient's Name): _____
to The University of Texas Medical Genetics Clinic at 6431 Fannin St, MSB 3.142, Houston, TX, 77030

Phone: (713) 500 – 5875 Fax: (713) 383 – 1475

For treatment dates: _____
Specify dates and/or date ranges treatment occurred

Patient information is for the following purposes:

☐ Medical Care ☐ Patient Request ☐ Legal ☐ Other: _____

Information to be used or disclosed:

☐ Lab ☐ Imaging/Radiology ☐ MD Progress Reports ☐ Emergency Room

☐ Other: _____

SIGNATURE AUTHORIZATION:

By signing below, I understand that I may revoke this authorization at any time by sending a written revocation to the person/ organization listed above. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization. I understand that any treatment, payment, or my enrollment in any health plan, or my eligibility for benefits will not be affected if I do not sign this Authorization. I understand that any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations. I also understand that I am entitled to receive a copy of this signed authorization.

Patient/Parent/Legal Guardian Name: _____
Patient/Parent/Legal Guardian Signature: _____ Date: _____
Relationship to Patient/Authority to Sign: _____
Witness: _____ Date: _____

THE UNIVERSITY OF TEXAS MEDICAL GENETICS PATIENT INTAKE FORM

CONNECTIVE TISSUE DISORDERS CLINIC

Answer the following questions (Sections 7 – 12) on for the patient being referred.

SECTION 7 – REFERRAL

1. **Who referred you for a Genetics evaluation?**
   a. Name of provider: _____
   b. Provider specialty/Type of provider: _____
   c. Where is this provider located: _____
   d. When did you last have an appointment with the provider who referred you: _____

2. **What is your understanding for why you have an appointment with Genetics:**
   a. Reason for referral: _____
   _____

3. **Is this your first appointment with Genetics?** Circle one: YES / NO
   a. If "NO", please explain: _____

SECTION 8 – PAST MEDICAL HISTORY

1. **Have you ever been diagnosed with Ehlers – Danlos syndrome (EDS) or other connective tissue condition?** Circle one: YES / NO
   a. If "YES", answer the following questions:
      i. What condition were you diagnosed with: _____
      ii. When were you diagnosed: (Month/Year) _____
      iii. Who diagnosed you?
         1. Name of provider: _____
         2. Provider specialty/Type of provider: _____
         3. Where is this provider located: _____
         4. When did you last have an appointment with the provider who diagnosed you: _____

2. **In general, how would you describe your overall health?**
   Circle one: EXCELLENT / GOOD / POOR
   a. If "POOR", briefly explain your answer: _____
   _____
   _____
   _____

3. **List all medical problems and/or diagnoses (e.g. diabetes, asthma, etc.) Include your age and date of problem or diagnosis.** Use the back of this page if you need more space.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

4. **List all surgeries you have had. Include your age at that time and the year the surgery took place.** Write on the back of this page if you need more space.

Type of Surgery	Age/Year	Type of Surgery	Age/Year
1.		4.	
2.		5.	
3.		6.	

5. **List all hospitalizations you have had. Include your age at that time, the year, and length of stay.** Write on the back of this page if you need more space.

Reason for Hospitalization	Age/Year	Length of Stay	Reason for Hospitalization	Length of Stay	Age/Year
1.			4.		
2.			5.		
3.			6.		

6. **List all current medications, including supplements. Include dosage and how often you take each one.** Use the back of this page if you need more space.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

7. **List all medical specialists you have seen in the past and/or currently see.** Use the back of this page if you need more space.

Name and Type of Medical Specialist	Date/Year Under Specialist's Care
1.	
2.	
3.	
4.	
5.	
6.	

8. **List all therapies you have received, such as physical, occupational, aquatic, speech, etc.?** Use the back of this page if you need more space.

Type of Therapy	Reason for Therapy	Date/Year Received
1.		
2.		
3.		

9. **Do you currently exercise?** Circle one: YES / NO
    a. If "YES", answer the following questions:
        i. What type of exercise? _____
        ii. How often? _____
    b. If "NO", did you ever exercise regularly? Circle one: YES / NO
        i. If "YES", please answer the following questions:
            1. What type: _____
            2. How often: _____
            3. Why you stopped exercising: _____

SECTION 9 – PREVIOUS IMAGING/LABS/ETC.

Provide a copy off ALL tests and labs before your appointment by fax (713 – 383 – 1475), if not already done.

1. **Provide a list of diagnostic and screening tests that you have had, such as** (Use the back of this page if you need more space)**:**

a. Echocardiogram (i.e. hear ultrasound)
b. Electrocardiogram (i.e. ECG/EKG)
c. Holter monitor
d. Electromyogram (i.e. EMG)
e. DEXA (i.e. bone density scan)
f. Skin biopsy
g. Muscle biopsy
h. Tilt-table test
i. Rheumatology/immunology workup to rule-out arthritis or other autoimmune

SECTION 9 – PREVIOUS IMAGING/LABS/ETC.CONTINUED

Type of Test	Reason for Test	Date/Year Received	Results
1.			
2.			
3.			
4.			
5.			

2. Have you had genetic testing? Circle one: YES / NO

a. If "YES," provide the following information:

Name of Test	Date Performed	Result
1.		
2.		

3. Has any of your family members had genetic testing? Circle one: YES / NO

a. If "YES," provide the following information:

Name of Test	Date Performed	Result
1.		
2.		

SECTION 10 – FAMILY HISTORY

1. Are you adopted? Circle one: YES / NO

a. If "YES," complete this section about your biological family only, if this information is available.

2. Do you know your ethnic background? Circle one: YES / NO / UNKNOWN
(e.g. English, Irish, German, Spanish, Mexican, African American, Indian, Iranian, Chinese, etc.)

a. If "YES," answer the following questions:
   i. Ethnic background on mother's side: _____
   ii. Ethnic background on father's side: _____

3. Do you have any Ashkenazi Jewish ancestry? Circle one: YES / NO / UNKNOWN

a. If "YES," Circle one: Mother's side / Father's side

4. **Is there any chance that your parents are related by blood, i.e. first cousins?** Circle one: YES / NO
   a. If "YES," Specify how are they related: _____

5. **Fill out the following information regarding your family history, healthy and those with health conditions.** Use the back of this page if you need more space.

	Current Age	Age at Death	Cause of Death	Diagnosed Medical Conditions and Age at Diagnosis
Your mother				
Your father				
Your mother's mother (maternal grandmother)				
Your mother's father (maternal grandfather)				
Your father's mother (paternal grandmother)				
Your father's father (paternal grandfather)				

	Your Children			
Male/ Female	**Current Age**	**Age at Death**	**Cause of Death**	**Diagnosed Medical Conditions and Age at Diagnosis**
	Your FULL Brothers and Sisters			
Male/ Female	**Current Age**	**Age at Death**	**Cause of Death**	**Diagnosed Medical Conditions and Age at Diagnosis**

SECTION 10 – FAMILY HISTORY, CONTINUED

Fill out the following information regarding your family history, healthy and those with health conditions.
Use the back of this page if you need more space.

	Your MATERNAL Half-Brothers and Half-Sisters (i.e. you share the same mother, different father)			
Male/ Female	**Current Age**	**Age at Death**	**Cause of Death**	**Diagnosed Medical Conditions and Age at Diagnosis**
	Your PATERNAL Half-Brothers and Half-Sisters (i.e. you share the same father, different mother)			
Male/ Female	**Current Age**	**Age at Death**	**Cause of Death**	**Diagnosed Medical Conditions and Age at Diagnosis**

	Your MATERNAL Aunts and Uncles (i.e. on your Mother's Side)			
Male/ Female	**Current Age**	**Age at Death**	**Cause of Death**	**Diagnosed Medical Conditions and Age at Diagnosis**
	Your PATERNAL Aunts and Uncles (i.e. on your Father's Side)			
Male/ Female	**Current Age**	**Age at Death**	**Cause of Death**	**Diagnosed Medical Conditions and Age at Diagnosis**

SECTION 11 – REVIEW OF SYSTEMS

For each body system, circle the symptoms you are currently experiencing or have experienced recently.

If you would like, provide an explanation or reason for the symptom(s) you circled in the space below that body system**:**

- **CONSTIUTIONAL**: Fatigue (*extreme tiredness*), Fever, Recent weight change

  _____

  _____

- **EYES**: Vision problems or blindness, Wears glasses, Abnormal eye movements

  _____

  _____

- **EARS/NOSE/MOUTH/THROAT**: Nose bleeds , Loss of ability to smell, Dental problems, History of cleft lip or palate, Difficulty swallowing, Hearing impairment or deafness, Frequent ear infections, Tinnitus (*ringing in ears*), Vertigo (*loss of balance, usually due to an inner ear issue*)

  _____

  _____

- **CARDIOVASCULAR**: Murmur, High or Low blood pressure, Fainting, Cyanosis (*turning blue*), Edema (*Fluid buildup in any part of body*)

  _____

  _____

- **RESPIRATORY**: Asthma, Cough, Pain while breathing, Frequent pneumonias

  _____

  _____

- **GASTROINTESTINAL**: Nausea, Vomiting, Bloody stool, Jaundice, Heartburn, Indigestion

  _____

  _____

- **GENITOURINARY**: History of kidney stones, Pain while urinating, Blood in urine, Frequent urinary tract infections, Using contraception/birth control, History of sexually transmitted infections (STIs), Sexual difficulties or problems

  _____

  _____

- **MUSCULOSKELETAL**: Joint laxity, Joint pain or stiffness, History of fractures, Joint Dislocations/Subluxations

  _____

  _____

- **INTEGUMENTARY** (skin, nails, and/or breast): Denies: Birthmarks, Rashes, Hypo - or Hyperpigmented macules, Excessively "stretchy" skin, Keloids, Poor wound healing, brittle nails, slow/rapidly growing nails

  _____

  _____

- **NEUROLOGICAL**: History of seizures, Headaches/Migraines, Difficulty and/or abnormalities with walking, Numbness or tingling, Memory loss

  _____

  _____

- **PSYCHIATRIC**: Anxiety, Bipolar Disorder, Depression, ADHD, Schizophrenia, Other

  _____

  _____

- **ENDOCRINE**: Heat or Cold intolerance, Excessive thirst, Excessive hunger/eating, Thyroid problems, Diabetes, Excessive bodily hair growth

  _____

  _____

- **HEMATOLOGY/LYMPHATIC**: Easy bruising, Easy bleeding, History of transfusions, Anemia

  _____

  _____

- **ALLERGIC/IMMUNOLOGIC**: Drug allergies, Allergies to other substances, Seasonal allergies, Immune problems

  _____

  _____

SECTION 12 – PAIN HISTORY

1. **For pain that has lasted ≥ 3 months, check all that apply.**
   Underneath, indicate the month/year the pain started and cause of pain, if known:

- ☐ Neck
  _____
- ☐ Upper back
  _____
- ☐ Mid-back
  _____
- ☐ Lower back
  _____
- ☐ Shoulder (Left/Right/Both)
  _____
- ☐ Elbow (Left/Right/Both)
  _____
- ☐ Hip (Left/Right/Both)
  _____
- ☐ Knee (Left/Right/Both)
  _____
- ☐ Ankle (Left/Right/Both)
  _____
- ☐ Foot (Left/Right/Both)
  _____
- ☐ Hand (Left/Right/Both)
  _____
- ☐ Other:
  _____
  _____
  _____
  _____

2. **Are you receiving, or have you in the past received, pain management or treatment for your pain?**
   Circle one: YES / NO

   a. If "YES," specify: 1.) month/year of treatment 2.) Type of treatment 3.) For which joint(s)
   _____
   _____
   _____
   _____
   _____
   _____