

WISCONSIN CLINICAL GENETICS CENTER  
PATIENT HISTORY—RETURN VISIT

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NAME \_\_\_\_\_ SEX \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
(Last name) (First) (Middle)

**PLEASE ANSWER THE FOLLOWING:**

What questions and/or concerns would you like to have addressed at this visit?

When were these concerns or problems first noted?

Was a specific diagnosis made? If so, what was it, when was it made, and who made it?

Are there changes in your family situation, health of other family members, personal, insurance, or other issues you wish us to know about?

**IF MEDICAL RECORDS ARE NOT AVAILABLE, PLEASE SUPPLY THE FOLLOWING INFORMATION ABOUT YOURSELF:**

Have you had any medical problems or treatment since last visit? \_\_\_\_\_. If yes, please complete the following, including ages and dates where known:

*SURGERIES OR HOSPITALIZATIONS*

*ILLNESSES, CHRONIC INFECTIONS AND OTHER HEALTH PROBLEMS*

*SPECIFIC MEDICAL TESTING (include hearing and vision tests)*

*SPECIAL TREATMENT, THERAPY, PRESCRIPTIONS*

Name of person completing this form \_\_\_\_\_

Current date \_\_\_\_\_