
# GENASSIST™ LINEAR PROFILE FORM © 2018

**[For 35 Years, Helping Patients Access Breakthrough Technologies – Information Optimizes Outcome]**

**8200 E Belleview Ave Suite 410C Greenwood Village, CO 80111**
800-359-9412, (303) 694-4665, (303) 694-3473 – FAX kswexler@genassistabcs.com - email

***(This form should be completed to the best of the patient's ability)***. This form has been designed to allow you to provide more detail about your family history. If you have any questions about this form or how to fill it out, please call GENASSIST™ at ***800-359-9412*** between the hours of 8 am and 5 pm (MST) Monday through Friday or email us at kswexler@genassist.com. As with all medical history, this information will remain confidential.

Name_____Date of Birth_____ Chronological Age_____
Patient is Male___ Female___
Patient Mother's Ethnic Background_____Patient Father's Ethnic Background_____

Address_____

E-mail Address_____

Telephone Home #_____ Work #_____

Doctor's Name_____
Doctor Address_____
City State Zip

Doctor's Phone #_____

**INSTRUCTIONS:**

1. Please answer every question to the best of your knowledge. For example, if the cause of death is unknown, fill in unknown.
2. Please include the last name (surname) of the individuals listed.
3. Include all blood relatives, even if they were stillborn.
4. Add any additional information on a separate sheet of paper that would help us evaluate your family history or that cannot fit into the space provided.

****Do not list any relatives that were adopted****
****SAMPLE****

**CHILDREN:**

| **NAMES:** | **KNOWN DISEASES AND DISORDERS:** |
|---|---|
| Anne Smith | None |
| Kelly Smith | Cleft Lip, Hole-in-Heart |
| Eddie Smith | Autism Spectrum Disorder |
| John Smith | Intellectual and/or Developmental Disabilities |
| Jane Doe | Unknown – Adopted |

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**Do you have any serious and/or chronic medical problems?** Yes____ No_____ If yes, please describe:

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**Are you presently using any prescription medications, over-the-counter drugs, or recreational drugs?**
Yes_____ No_____ If yes, please specify_____

**THE FOLLOWING QUESTIONS RELATE TO YOUR KNOWN RELATIVES AND THEIR CURRENT HEALTH STATUS AND PAST MEDICAL HISTORY:**

**YOUR CHILDREN:** Please list all children oldest to youngest:
NONE_____

| NAMES: | SEX | AGE | KNOWN DISEASES | IF DECEASED, CAUSE OFDEATH & AGE AT DEATH |
|---|---|---|---|---|

**STEP CHILDREN:** Please list all your step children from oldest to youngest:
NONE_____

| NAMES: | SEX | AGE | KNOWN DISEASES | IF DECEASED, CAUSE OF DEATH & AGE AT DEATH |
|---|---|---|---|---|

**BROTHERS/SISTERS**: Please List all full brothers and sisters from oldest to youngest:

NONE_____

NAMES: SEX AGE KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

**HALF BROTHERS/SISTERS**: Please List all half brothers and sisters from oldest to youngest and indicate the parents (mother or father) that is in common to both of you:

NONE_____ UNKNOWN_____

NAMES: SEX AGE KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

**YOUR MOTHER:**

KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

NAME:_____ AGE_____

**YOUR FATHER:**

KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

NAME:_____ AGE_____

***Please list other relatives on your mother or father's side*** who have a specific disorder, intellectual and/or developmental disabilities and state their relationship (maternal or paternal relationship, the name of the disorder if known, their age and whether they are alive or deceased***):***

KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

NAME:_____ AGE_____

_____

KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

NAME:_____ AGE_____

_____

KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

NAME:_____ AGE_____

_____

KNOWN DISEASES IF DECEASED, CAUSE OF DEATH & AGE AT DEATH

NAME:_____ AGE_____

_____

***Other Comments, Questions or Concerns Not Already Mentioned:***

_____
_____
_____
_____
_____
_____
_____

## Appendix: Questions for Patient or Parent (Guardian): **Patient Name**: DOB:

| | | | |
|---|---|---|---|
| 1. | Do you have difficulty interacting, playing, relating to others? | YES | NO |
| 2. | Do you have difficulty maintaining eye contacts with others? | YES | NO |
| 3. | Do you have difficulty with others understanding you when you speak? | YES | NO |
| 4. | Do you demonstrate repetitive movements or speech? | YES | NO |
| 5. | Do you demonstrate little or no interest in things around you or the people? | YES | NO |
| 6. | Do you have difficulty communicating with other people? | YES | NO |
| 7. | Would you rather be by yourself than with other people? | YES | NO |
| 8. | Have you had problems learning or reading or speaking? | YES | NO |
| 9. | Is your behavior unusual for the situation (e.g. laughing, crying)? | YES | NO |
| 10. | Have you been evaluated for your ability to learn, communicate, motor skills? | YES | NO |
| 11. | Has anyone or any professional given you a diagnosis. | YES | NO |
| | If so, what is the diagnosis?_____ | | |
| 12. | Have you been evaluated? | YES | NO |
| | If yes, approximate age of evaluation_____ and where was the evaluation performed?_____ | | |
| | If yes, do you know what testing has been performed?_____ | | |
| 13. | Have you had chromosome analysis? | YES | NO |
| 14. | Have you had Fragile X testing? | YES | NO |
| 15. | Have you had Chromosomal Microarray Testing? | YES | NO |
| 16. | Have you had Whole Exome Sequencing? | YES | NO |

*I understand that no screening and/or diagnostic testing is 100% reliable and will detect all illnesses. Further I understand that no laboratory will declare the patient to be a "non-carrier" due to unknown mutations and some mutations have not been definitely associated with any known disorders.

***Microarray Testing*** can detect carriers of many autosomal recessive diseases and can identify some duplications and deletions. A positive test should initiate similar testing in the other parent or presumptive parent of a child. A negative test does NOT rule out carrier status for all patients nor does it rule out the possible interaction between a mutation found and other mutations or genes or mutations not studied. Rarely the same disorder or a similar disorder (phenocopy) can result from a different cause and possibly even the inheritance of the same abnormal mutation or gene from a single parent (isodisomy).

Most carrier tests using DNA extracted from the blood of an individual analyze the most common variations (mutations) known to be responsible for a particular disorder (disease). Evaluation of these variations (mutations) will Not detect all carriers of the disorder and are not designed to detect other disorders that may be similar to the disorder being studied. Depending on the disorder being studied, detection rates may vary considerably from as low as 40-60% to as high as 90-98%. Therefore, when there is a high degree of suspicion for a disorder or following negative testing, symptoms suggest that the disorder may be present, additional testing or more definitive testing should be used if available. The accuracy for detection of a specific disorder should continue to improve as additional deleterious mutations are identified.

***Patient Signature or Legal Parent/Guardian_____ Date_____**