Institut für Humangenetik
Neue Stiftingtalstraße 2, 8010 Graz
humangenetik@medunigraz.at
Tel. +43 / 316 / 385-73800
Fax +43 / 316 / 385-79620

Anamnesis Male / Father

The completion of this questionnaire helps to prepare the consultation and thus facilitates the conveyance of as much information as possible in this conversation. All information is given voluntarily. **Naturally, all information is subject to medical confidentiality and data protection and will be treated strictly confidential.** If you have any questions or problems when filling in this questionnaire, please contact us on telephone (0316) 385-73800.

First- and surname: _____ Title: _____

Street: _____Postal code: _____ City: _____

Date of birth: _____Place of birth: _____Name of birth: _____

Email: _____

Health insurance: _____ (zB. ÖGK, BVAEB, SVS-GW,...) Social Security number. _____

Current occupation: _____ Telephone/Mobile: _____/_____

area code telephone number

1. **Reason for request**:_____

2. Please give the following information on your **wife / partner**:
   Are you related to your wife/partner? If yes, how? _____

3. Please answer the following questions concerning your own medical history **(personal anamnesis):**
   Previous diseases, operations, hospital stays, x-ray examinations, medication, etc.:_____
   _____
   Work-related pollution: _____ Nicotine consumption: _____
   Alcohol intake: _____ Further desire to have children? _____
   Further supplements: _____
   _____

4. The following questions refer to medical problems within your family **(family history)**:
   Do any specific diseases accumulate within your family? Which and who?
   _____

4a. If your wife / partner has filled in the respective form and if it already contains information on your **children**, please skip this point. Otherwise, or if you have children with another partner, please give the following information:

	Child 1	Child 2	Child 3	Child 4
First- and surname:				
Date of birth:				

If one or more of these children have/have had any medical problems (developmental retardation, hospital stays, etc., please give the following additional information:

	Child 1	Child 2	Child 3	Child 4
Pregnancy:				
Complications:				
Medication? When: Which:				
X-ray examinations?				
Results from ultrasound scans?				
Did you have rhesus incompatibility?				
Birth:				
Place of birth:				
Hospital:				
Spontaneous delivery or caesarean section?				
Duration of labour:				
Birth weight/-length:				
Complications:				
Head circumference/APGAR (see Mutter-Kind-Pass)				
Congenital diseases/ alterations:				
Which?				
Treated where?				
Development:				
Sucking weakness:				
Failure to thrive:				
Steady holding of head:				
First teeth:				

Medizinische Universität Graz, Neue Stiftingtalstraße 6, 8010 Graz - www.medunigraz.at

Sitting:				
Walking:				
Speaking:				
Other problems (e.g. Epileptic seizures, etc.):				
Previous diseases:				
Hospital stays:				
Medication:				
School attendance:				
Occupation:				
If deceased:				
When:				
Where:				
Cause of death:				

4b. The following information on your **parents** is required:

	Mother	Father
First- and surname:		
Birth name:		
Date of birth:		
Occupation:		
Particular diseases:		
If deceased: when: Cause of death:		
Were there miscarriages or stillbirths?		

4c. How many siblings / half-siblings do you have: _____

Please give the following information on your siblings (if more than 4 siblings, please attach separate sheet):

	1.	2.	3.	4.
First- and surname:				
Date of birth:				
S. or HSM. or HSP.*				
Particular diseases:				
Were there miscarriages or stillbirths?				

Medizinische Universität Graz, Neue Stiftingtalstraße 6, 8010 Graz - www.medunigraz.at

If daughters: Number and age: Diseases:				
If sons: Number and age: Diseases:				

* S=siblings, HSM = half-siblings maternal, HSP = half-siblings paternal

4d. Is there any health-related information concerning your grandparents?

_____

5. Name and address of your

Family doctor	**Medical specialist** (incl. discipline)

6. I agree that the consultation letter and the results of the genetic analysis may be forwarded to the following doctor:

_____

Name of the doctor, medical specialty, address

7. Date:_____ Signature:_____