

Diet:- Diabetic diet.

TEST REQUISITION FORM/PATIENT INTAKE FORM

Name: MR. NAGENDRA RAO KONIDELA	Phone Number: -
Date of Sample collection:	Email:
Age/Gender: 64 M	Referral Doctor/Hospital:
Address:	Pre-Counselor/ Sample Co-ordinator:

TEST NAME

Whole Exome Sequencing (WES)	<input checked="" type="checkbox"/>	Clinical Exome Sequencing (CES)	<input type="checkbox"/>
WES + Mitochondrial Sequencing	<input type="checkbox"/>	CES + Mitochondrial Sequencing	<input type="checkbox"/>
Hereditary Cancer Screening (HCS)	<input type="checkbox"/>	Targeted Sequencing for Oncology	<input type="checkbox"/>
Sanger Sequencing	<input type="checkbox"/>	Whole transcriptome analysis (WTA)	<input type="checkbox"/>
mRNA analysis (mRNA seq)	<input type="checkbox"/>	small RNA seq	<input type="checkbox"/>
Others _____	<input type="checkbox"/>		

1. Indications for genetic testing:

2. Any Specific condition or genes to look for:

SAMPLE TYPE

Whole Blood in EDTA	<input checked="" type="checkbox"/>	Whole Blood In Heparin	<input type="checkbox"/>
Whole Blood in cfDNA Tubes	<input type="checkbox"/>	FFPE Blocks	<input type="checkbox"/>
Sputum	<input type="checkbox"/>	Swab/Specimen/Culture	<input type="checkbox"/>
Tissue (in PBS/Saline/RNA Later/Others)	<input type="checkbox"/>	Urine	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>		

Current Complaints

Complaint 1: Osteoarthritis - Severe pain in both knee + painful knee movement and difficulty in walking and climbing stairs.
 a. Onset (Knee replacement surgery done)
 b. Duration

Complaint 2: Hypertension

a. Onset → 4: Asthma.
 b. Duration

Complaint 3: T2DM

a. Onset
 b. Duration

Reason for Genetic Testing?

Why do you want to do this genetic testing	
1	I want to know if there is any genetic cause for my Medical Condition. <input type="checkbox"/>
2	I want to know if there is any genetic cause for a symptom I have been having since a long time. <input type="checkbox"/>
3	My family or close relatives are having history of chronic disease. <input type="checkbox"/>
4	There is a history of cancer in me/ history of cancer in the family. <input type="checkbox"/>
5	Have a history of genetic disease in the immediate family or close relatives. <input type="checkbox"/>
6	I want to know the future risks and possibilities regarding my health. <input type="checkbox"/>
7	I want to check if we are carriers for any genetic illness. <input type="checkbox"/>
8	I want to know treatment plans based on genetics for our illness. <input type="checkbox"/>
9	I have received an abnormal prenatal screening test or Amniocentesis. <input type="checkbox"/>
10	I want to do it because my other family members have taken genetic testing. <input type="checkbox"/>
11	I want to know my Genetic makeup. <input type="checkbox"/>

Past Medical History

Asthma	<input checked="" type="checkbox"/>	Peptic Ulcer disease	<input type="checkbox"/>
High Blood Pressure	<input checked="" type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Frequent Constipation	<input type="checkbox"/>
Diabetes	<input checked="" type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Cerebrovascular Accidents/ Stroke	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Myocardial Infarction/ Heart Attack	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Frequent Sinus Infections	<input type="checkbox"/>	Psoriasis/Skin Conditions	<input type="checkbox"/>
Others	<input type="checkbox"/>		

Past Surgical History

Appendectomy	<input type="checkbox"/>	Joint Replacements	<input checked="" type="checkbox"/>
Tonsillectomy	<input type="checkbox"/>	Cardiac Stent Placements	<input type="checkbox"/>
Coronary Artery Bypass Grafting (CABG)	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>
Splenectomy	<input type="checkbox"/>	Oophorectomy	<input type="checkbox"/>
Bariatric Surgery	<input type="checkbox"/>	Cholecystectomy	<input type="checkbox"/>
Others	<input type="checkbox"/>		

knee replacement

Family History

Condition		If Yes, which member of the Family							
Allergies	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Depression/Suicide Attempts	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Premature Myocardial Infarction	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Sudden Death	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Consanguineous Marriage	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>				
Cerebrovascular Accident	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Hearing/Speech Problems	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Liver Cirrhosis	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Connective Tissue Diseases	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Others	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other	<input type="checkbox"/>

Mental Health History (Subjective)

Do you face any difficulty concentrating on your work?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Have you lost much sleep/difficulty sleeping?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you are not playing a useful part in your work?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you are under constant stress?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you could not overcome difficulties?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel unhappy or depressed most days of the week?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you are losing confidence?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have any stressors in family or professional life more than ordinary?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you consider yourself an anxious person?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Details if Yes for any question above			

Sexual History

Women		
Menstrual Cycles	Regular <input type="checkbox"/>	Irregular <input type="checkbox"/>
History of Infertility	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Men		
Erectile Dysfunction	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Current and Past Medications

Please name the list of Medications being used currently

	Name of the Medicine	Dose	Frequency
Limdee 1	Sipropramox XR 62.5mg Other	Regular Dose	8. Januset 50/50
Uteacet 1 tab 2	Espiratium CV 62.5mg	1. Seroflo inhaler	
Duphalac 3	Nexpare-LA 1 gm	2. Montek LC	
Zomig 4	Gabapin-NT 400/100mg	3. Telma 40 mg	
	Efotegia-XR 400mg	4. Zolfresh 5mg	
	Exotin 100mg	5. Nexitone	
	Ecoprin 75mg	6. Pantocid-DSR 40/30 MG.	
	Happynerve LC	7. Glycomet 500mg	

Review of Systems

Constitutional	ENT
Lack of Energy	<input type="checkbox"/>
Unexplained Weight Gain/Loss	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>
Fever	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>
Cardiovascular	Respiratory
Heart Racing/Palpitations	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>
Swelling of legs/feet	<input type="checkbox"/>
Pain in calf while walking	<input type="checkbox"/>
GU	Gastrointestinal
Painful Urination	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>
Musculoskeletal	
	<input type="checkbox"/>

Skin	
Itching	<input type="checkbox"/>
Persistent Rash	<input type="checkbox"/>
New Skin Lesions	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>
Excessive Hair	<input type="checkbox"/>
Neurologic	
Frequent Headaches	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>
Weakness	<input type="checkbox"/>
Change in Sensation	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Tremors	<input type="checkbox"/>
Episodes of Vision Loss	<input type="checkbox"/>
Endocrine	
Intolerance to Heat or Cold	<input type="checkbox"/>
Frequent Hunger or Thirst	<input type="checkbox"/>
Changes in Sex Drive	<input type="checkbox"/>
Allergic/Immunologic	
Food Allergies	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>
Itching Eyes/ Sneezing	<input type="checkbox"/>
Frequent Infections	<input type="checkbox"/>

Personal History/Health

Do You Drink Alcohol?	Yes <input type="checkbox"/>	Previous Drinker <input type="checkbox"/>	Never <input type="checkbox"/>	
How Many Drinks Per Week?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	More Than 3 <input type="checkbox"/>
Do You Smoke Cigarettes	Yes <input type="checkbox"/>	Previous Smoker <input type="checkbox"/>	Never Smoker <input type="checkbox"/>	
If Yes, How Many Packets of Cigarettes Per Day?	Less than 1 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>
What is your wake up time	Before 6 am <input type="checkbox"/>	After 6 am <input type="checkbox"/>		
What is your go to bed time	Before 8 pm <input type="checkbox"/>	After 8 pm <input type="checkbox"/>		
Do You Workout	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
If Yes, How Many Times Per Week?	Less than 4 <input type="checkbox"/>	More than 4 <input type="checkbox"/>		
Any participation in active sport when young?	Yes <input type="checkbox"/>	Never <input type="checkbox"/>		

Diet

How many meals/day	Less than 3 <input type="checkbox"/>	3 <input type="checkbox"/>	More than 3 <input type="checkbox"/>	
How many times do you eat processed foods per week(Chips,Fried Items, Fast Food)?	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>
How many times do you eat outside food?	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>
How many times do you have soft/carbonated drinks per Week?	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>

Physical Examination

- a. Blood Pressure: _____
- b. Pulse Rate: _____
- c. Height: _____
- d. Weight: _____
- e. BMI: _____

Blood Work

Mandatory Tests	
1	Complete Blood Count <input type="checkbox"/>
2	Thyroid Profile <input type="checkbox"/>
3	HbA1C <input type="checkbox"/>
4	Liver Function Test <input type="checkbox"/>
5	Kidney Function Test <input type="checkbox"/>
6	Lipid Profile <input type="checkbox"/>



