Genetic Counseling Format for Adult Bangladeshi AML Patients

Please use remark or tick mark (√) if necessary

A. General Information

1.	ID No.	:	
2.	Patient Name	:	
3.	Age in year	:	
4.	Sex	:	□ Male □ Female □ Other
5.	Marital status	:	□ Single □ Married □ Divorced □ Widowed □ Separated
6.	Number of children	:	_____boy(s) ____girl(s)
7.	Educational status	:	
8.	Occupation	:	
9.	Address		
	Permanent	:	
	Present	:	
	Cell phone	:	
	E-mail	:	
10.	Please mention who referred you for genetic counseling	:	□ Physician □ Patient □ Family member □ Self □ Other

B. Personal Information

1.	Birth history	:	Full term- □ Yes □ No Delivery- □ Vaginal □ C-section
2.	Consanguinity of marriage	:	□ Yes □ No
3.	Female patient		
i)	Do you have menstrual periods?	:	□ Yes □ No
	If yes, then your periods	:	□ Regular □ Irregular □ Painful
	Age at start of menstrual period	:	
	How often do they occur?		Every____ days
	How long do they last?	:	____ days
	If no, when it stop?	:	
	After that if any Vaginal bleeding, discharge	:	
ii)	Have you ever been pregnant?	:	□ Yes □ No if yes, then fill the following- Total number of pregnancies_____ Total number of miscarriages/ abortions_____ Total number of living children _____
4.	History of substance use		
i)	Did you use ever tobacco?	:	□ Yes □ No If yes, then □ Cigarette □ Chew □ Snuff If current smoker, then _____ per day
ii)	Do you drink alcohol?	:	□ Yes □ No If yes, then mention detail _____
iii)	Have you ever shared needles?	:	□ Yes □ No If yes, then mention detail (medication/addiction purpose)

C. Medical History

1.	When have your disease first diagnosed?	:	_____age in year
2.	Which of the following symptoms before diagnosis of the present disease you were going to the doctor	:	□ Fever □ Weakness □ Headache □ Night sweats □ Shortness of breath □ Loss of appetite □ Swelling in the abdomen □ Bleeding gum □ Weight loss □ Frequent nose bleeding □ Excess bruising □ Bone/joint pain
3.	Before diagnosis of AML, have you taken doctor advice for any other blood disease?	:	□ Yes □ No
4.	Do you any birth disease (congenital) diagnosed previously?	:	□ Yes □ No
5.	Have you had any other cancer?	:	□ Yes □ No
6.	When you were born, how old was your father and mother?	:	
7.	Do you have any big brother or sister?	:	□ Yes □ No If yes, then how much age difference from your immediate big brother/sister?
8.	Did you ever take chemotherapy/radiotherapy for treatment purpose?	:	□ Yes □ No
9.	Did you frequently encounter industrial or medical science radiation (X-ray, CT scan)?	:	□ Yes □ No

D. Environmental Factor Exposure History

1.	Have you ever exposed to over/unusual smoke in your life?	:	□ Yes □ No If yes, then □ Motor vehicle □ Industrial □ Formalin □ Insecticide □ Others
2.	Have you ever worked in the industries/factories?	:	□ Yes □ No If yes, then □ Cement factory □ Coal mine □ Fertilizer factory □ Petroleum refining □ Paint factory □ Paper factory □ Rubber factory □ Shoe factory □ Others

E. Family History

Take 3 generations of the family history to draw the pedigree to identify the inheritance patterns

Pedigree chart [Follow the instruction]

Family Origin _____

I

II

III

F. Laboratory investigation

Blood examination finding :
Bone marrow examination finding :
CSF marrow examination finding :
Immunophenotype examination finding :
Genomic examination finding :
Karyotype :
FISH :
PCR :
Molecular analyses :

G. Summary of the case

H. Comments of the genetic counselor

Types of AML	:	□ Sporadic □ Familial □ Hereditary
Inheritance pattern	:	□ Autosomal Dominant/ Recessive □ X-linked Dominant/ Recessive □ Mitochondrial
Genetic test:	:	□ Done □ Desire to be done □ Not desire to be done

Name of Genetic counselor with Seal

Address of Genetic counselor

Place of Genetic counseling

Card for Consultand

Institution name: _____

Name of Consultand: _____ Age in Year_____

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Suggested genetic Test: _____

Follow up (provable date and time):

Genetic counseling Summary: _____