

**THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.**

**PERIODIC FEVER SYNDROMES TESTING PATIENT HISTORY FORM**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Sex Assigned at Birth:**  Female  Male  Intersex **Gender Identity (optional):**  Female  Male  \_\_\_\_\_

**Ordering Provider:** \_\_\_\_\_ **Provider's Phone:** \_\_\_\_\_

**Practice Specialty:** \_\_\_\_\_ **Provider's Fax:** \_\_\_\_\_

**Genetic Counselor:** \_\_\_\_\_ **Counselor's Phone:** \_\_\_\_\_

**Patient's Ethnicity/Ancestry** (check all that apply)

African American/Black  Asian  Hispanic  White  Other: \_\_\_\_\_

**List country of origin (if known):** \_\_\_\_\_

**Suspected Diagnosis (select all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Blau syndrome/pediatric granulomatous arthritis | <input type="checkbox"/> Neonatal onset multisystem inflammatory disease (NOMID)/chronic infantile neurological cutaneous and articular syndrome (CINCA) |
| <input type="checkbox"/> Cyclic neutropenia                              | <input type="checkbox"/> Severe congenital neutropenia   |
| <input type="checkbox"/> Familial cold autoinflammatory syndrome (FCAS)  | <input type="checkbox"/> Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)   |
| <input type="checkbox"/> Familial Mediterranean fever (FMF)              | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Hyperimmunoglobulinemia D syndrome (HIDS)       | <input type="checkbox"/> Unknown   |
| <input type="checkbox"/> Majeed syndrome                                 |  |
| <input type="checkbox"/> Muckle-Wells syndrome                           |  |

**Does the patient have symptoms?** .....  No  Yes (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abdominal pain                  | <input type="checkbox"/> Hearing loss         | <input type="checkbox"/> Pyoderma gangrenosum       |
| <input type="checkbox"/> Amyloidosis                     | <input type="checkbox"/> Joint pain/arthritis | <input type="checkbox"/> Recurrent fever            |
| <input type="checkbox"/> Chronic/severe infections       | <input type="checkbox"/> Osteomyelitis        | <input type="checkbox"/> Skin eruption/inflammation |
| <input type="checkbox"/> Colchicine treatment responsive | <input type="checkbox"/> Peritonitis          | <input type="checkbox"/> Anemia (describe: _____)   |
| <input type="checkbox"/> Contractures                    | <input type="checkbox"/> Pleuritis            | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> Developmental delay             |   |   |

**Lab Results:**

Absolute neutrophil count.....	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not performed	<input type="checkbox"/> Unknown
Erythrocyte sedimentation rate (ESR).....	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not performed	<input type="checkbox"/> Unknown
Leukocytosis (WBC).....	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not performed	<input type="checkbox"/> Unknown
Fibrinogen serum concentration.....	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not performed	<input type="checkbox"/> Unknown

**Is there any relevant family history?**.....  No  Yes  Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

**Has DNA testing been performed for the family member(s)?** .....  No  Yes  Unknown

If yes, indicate: The relative is .....  a healthy carrier  affected with the disorder

**Please attach a copy of the relative's DNA laboratory result (REQUIRED for familial variant testing).**

**Indicate the name of the disorder diagnosed and the variants identified:** \_\_\_\_\_

**For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.**

