ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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

FAMILIAL HYPERCHOLESTEROLEMIA *(FH)* 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 ☐ French Canadian ☐ Other: _____

List country of origin (if known): _____

Laboratory Findings

LDL cholesterol (**untreated**) _____ mg/dL ☐ Abnormal ☐ Normal ☐ Unknown

Total cholesterol (**untreated**) _____ mg/dL ☐ Abnormal ☐ Normal ☐ Unknown

Does the patient have symptoms of FH? ..... ☐ No ☐ Yes (check all that apply) ☐ Unknown

☐ Premature coronary artery disease (CAD) or cardiovascular disease (CVD)
- ☐ Chest pain
- ☐ Myocardial infarction
- ☐ Peripheral vascular disease
- ☐ Aortic stenosis
- ☐ Stroke

☐ Tendon/skin xanthomas

☐ Corneal arcus

☐ Other symptom(s): _____

Is there a family history of FH or premature CAD? ..... ☐ 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 family member(s)? ..... ☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial variant testing).

Has the patient undergone previous germline DNA testing for FH? ..... ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

_____

Master Label

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