



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.

PULMONARY ARTERIAL HYPERTENSION (PAH) 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: _____

Does the patient have symptoms?..... No Yes Unknown

If yes, check all that apply:

Shortness of breath Fatigue Syncope
 Chest pain Palpitations Edema

Other: _____

Does the patient have other risk factors for pulmonary hypertension? No Yes Unknown

If yes, check all that apply:

Lung disease Heart disease Cirrhosis
 Pulmonary embolism Connective tissue disease HIV

Other _____

Has the patient's mean pulmonary artery pressure been measured? No Yes Unknown

If yes, what was result at rest? _____mmHg Normal Abnormal Unknown

What was result during exercise? _____mmHg Normal Abnormal Unknown

Has the patient undergone previous DNA testing for this condition? No Yes Unknown

If yes, describe the test performed and results: _____

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

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

Master Label