

GENETIC TESTING FOR PRIMARY CILIARY DYSKINESIA (PCD)
CLINICAL HISTORY FORM

Patient Name: _____ Medical Record #: _____

Please assess history of the following:

Dx of primary ciliary dyskinesia	yes/no		<u>Ethnic Background</u>
Neonatal respiratory distress (in full term infants)	yes/no	Age of onset: _____	<input type="checkbox"/> Caucasian
Chronic otitis media	yes/no	_____	<input type="checkbox"/> Hispanic
Chronic nasal congestion	yes/no	_____	<input type="checkbox"/> African American
Chronic sinusitis	yes/no	_____	<input type="checkbox"/> Asian
Chronic cough (not seasonal)	yes/no	_____	<input type="checkbox"/> Other
Chronic bronchitis (not assoc w/ tobacco, asthma)	yes/no	_____	
Bronchiectasis	yes/no		
Infertility/subfertility	yes/no	if yes, describe _____	
Ectopic pregnancy	yes/no		

Situs abnormalities:

Kartagener syndrome yes/no
Situs inversus totalis yes/no
Dextrocardia yes/no
Other situs abnormalities yes/no if yes, describe _____
(e.g. polysplenia, asplenia, congenital heart disease) _____

Family history (provide pedigree if possible)

Primary ciliary dyskinesia yes/no
Kartagener syndrome yes/no
Situs abnormalities yes/no
Consanguinity yes/no

Diagnostic testing

Genetic testing for PCD in family yes/no date _____ Results _____

Respiratory cultures yes/no date _____ Results _____

Sweat Chloride test yes/no date _____ Results _____

Genotyping for CF yes/no date _____ Results _____

Nasal cilia scrape or biopsy yes/no date _____ Results _____

Nasal nitric oxide (NO) yes/no date _____ Results _____

Radiology studies yes/no date _____ Results _____