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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	
Neonatal respiratory distress (in full term infants)	yes/no	Age of onset:
Chronic otitis media	yes/no	_____
Chronic nasal congestion	yes/no	_____
Chronic sinusitis	yes/no	_____
Chronic cough (not seasonal)	yes/no	_____
Chronic bronchitis (not assoc w/ tobacco, asthma)	yes/no	_____
Bronchiectasis	yes/no	
Infertility/subfertility	yes/no	if yes, describe _____
Ectopic pregnancy	yes/no	

Ethnic Background
- □ Caucasian
- □ Hispanic
- □ African American
- □ Asian
- □ Other

Situs abnormalities:

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

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_____