Genetics

Genetics Clinic New Pediatric Patient History

Date:_____

Please complete the following questionnaire as well as you can. Don't be concerned if you don't know some of the answers.

Child's name: _____ DOB:_____

Main reason for referral to Genetics: _____

Your main concerns: _____

Who is attending visit today: _____

Who lives at home with the child? _____

Birth history (of the child being seen today):

Mother's age at delivery? _____

Was the child born (circle one): Early On Time Late If Early or Late, how many weeks? _____

What hospital was the baby born at (name, city, state): _____

What was the birth weight? _____

What was the length at birth? _____

What was the head size (circumference) at birth? _____

When did the baby go home from the hospital? _____

Vaginal delivery?	□ Yes	□ No	□ don't know
Labor induced?	□ Yes	□ No	Reason?
Caesarian section delivery?	□ Yes	□ No	Reason?
Was the baby born head first?	□ Yes	□ No	□ don't know
Any problems after delivery?	□ Yes	□ No	Describe:

Pregnancy history:
Please give information about the mother while she was pregnant with the child being seen today.

	Yes	No	Specify
Medications			
Over the counter drugs			
Street drugs			
Alcohol/beer/wine			
Smoking			
Infections or illness			
Fever			
Bleeding			
Rashes			

Pregnancy history (cont'd)

	Yes	No	Specify
X-rays/radiation			
Diabetes in pregnancy?			
High blood pressure?			
Other concerns: 1. 2.			

First movements of the baby were felt at: _____ weeks / months (please circle)

Were the baby's movements normal during the pregnancy? Yes No

Mother's total weight gain during pregnancy: _____ pounds

Testing during pregnancy of the child being seen today:

	Yes	No	Results
Routine Ultrasound			
Specialized Ultrasound Amniocentesis Other tests:			

Early development:

If there are concerns regarding the child's development, how and when were they first noticed?

_____

Has your child ever lost any skills (developmental regression)? □ Yes □ No

How old was the child when he / she began:

Smiling _____ Walking _____

Rolling over _____ First words _____

Sitting _____ Toilet Trained _____

Any skills you believe the child started late?_____

School information:

Child's school or Daycare: _____ Grade: _____

Does your child attend special classes or receive special help? □ Yes □ No

Describe_____

Are there any behavior problems? □ Yes □ No

Describe _____

Does the child receive:

School information (cont'd)

Physical therapy services? □ Yes □ No Occupational therapy services? □ Yes □ No

Speech therapy services? □ Yes □ No

What are the child's current language skills?_____

Has the child ever had IQ testing, or developmental evaluation? □ Yes □ No

When, and what were the results? _____

Past medical history:

Has your child:

	Yes	No	When?	Results or Reason?
Had an eye examination?				
Had a hearing test?				
Been in the hospital overnight?				
Had surgery?				
Been diagnosed with a major medical condition?				
Has your child ever had genetic tests? (ex: chromosomes, DNA)				
Had other special tests or evaluations?				
Currently taking medicines?				
Been on any medicines in the past?				

Please list information about any specialists who have evaluated your child.

Doctor's name	Specialty (i.e. neurology, GI, ENT, eye doctor, etc)	Reason for evaluation:	Date of last visit:	Next Appointment:

Does your child have any problems regarding:

	Yes	No	Describe
Eating, sleeping, growth			
Eyes			
Ears, nose, mouth, throat			
Lungs			
Heart			
Stomach, intestines, bowels			
Kidneys, bladder, genitals			
Muscles, bones, spine, chest			
Skin			
Neurological system			
Psychological/behavior problems			
Hormones, diabetes			
Blood, sickle cell disease			
Allergies, immune system			

Family history:

Parents of Child:	Mother	Father
Full Name		
DOB		
Ethnic background (i.e. German, Irish, Dutch etc.)		
Occupation		
Highest grade completed		
Repeated grades? Special Classes?		
How many pregnancies	----------	

Are the mother and father blood relatives? □ Yes □ No

Are you currently pregnant or planning to have more children? _____

Names & ages of mother's children:

Child's name	Birthdate	Dad's name

Names & ages of father's children, **if different from above**:

Child's name	Birthdate	Mother's name

Check all medical problems for family members of BOTH of the child's parents and tell how the family member is related to the child (aunt, cousin, etc).

	Yes	No	Who?	Problem
Multiple miscarriages, stillbirths				
Early newborn/childhood deaths				
Birth defects				
Learning problems				
Mental retardation				
Spina bifida (open spine)				
Down syndrome or other chromosome problems				
Bone, joint problems				
Heart defects				
Anemia, sickle cell, hemophilia				
Cystic fibrosis				
Stomach, kidney, liver problems				
Diabetes				
Infertility				
Seizures, hydrocephalus (water on the brain), or cerebral palsy				
Mental health problems				
Vision, cataracts, glaucoma				
Early hearing loss				
Birthmarks or skin problems				
Cancer				
Other health concerns:				