GENETICS CENTER
211 South Main Street, Orange, California 92868
Tel 714.288.3500 & 888.4.GENETIC  Fax 714.288.3510
www.geneticscenter.com

# Pediatric Genetics Patient Questionnaire

**Please complete this form and mail or fax it back to our office (address and fax number are listed above). Once we receive this information, we can then proceed to schedule your/your child's appointment.**

Patient's name: _____ DOB: _____

Mother's name: _____ DOB: _____

Father's name: _____ DOB: _____

Address: _____

Home phone: _____

Mother's work phone: _____ Mother's cell phone: _____

Father's work phone: _____ Father's cell phone: _____

Name of person completing this form: _____

Relationship to the patient: _____

## *Referral Information*

Who referred you to see us? _____

What is the reason you have been referred? _____

Do you have any specific questions that you would like the doctor to address? Please use the space below.

## *Pregnancy History*

How many times has the mother of the patient been pregnant? _____

How many children does the mother have (please list by age, sex, and name)?_____

_____

Do all of the children have the same mother and father? (if "No," please explain) _____

Has the mother had any of the following (please indicate number):

- ☐ Miscarriages (please specify: _____)
- ☐ Still births (please specify: _____)
- ☐ Ectopic (tubal) pregnancies (please specify: _____)
- ☐ Elective abortions (please specify: _____)

How old was the patient's mother when the patient was born? _____

How old was the patient's father when the patient was born? _____

### *Regarding the mother's pregnancy with the patient:*

Duration of the pregnancy: _____ (Due Date: _____)

Was the mother under a doctor's care during the pregnancy? (ex. 40 weeks) _____

During the pregnancy, did you have any of the following? (If "yes," please describe)

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Vaginal bleeding or leakage of fluid? (please specify: _____) |
| ☐ | ☐ | Infections, rashes, or other illnesses? (please specify: _____) |
| ☐ | ☐ | Fever over 101ºF? (please specify: _____) |
| ☐ | ☐ | X-rays, hospitalizations, or surgeries? (please specify: _____) |
| ☐ | ☐ | Cigarettes or alcoholic beverages, exposure to second-hand smoke? (please specify: _____) |
| ☐ | ☐ | Drugs or other medications (other than prenatal vitamins or iron) (please specify: _____) |
| ☐ | ☐ | Ultrasound (sonogram) (If "Yes," were any abnormalities seen?_____) |
| ☐ | ☐ | Occupational, chemical, or other exposures (please specify: _____) |
| ☐ | ☐ | Maternal serum screening/Cell-free Fetal DNA Testing (please specify: _____) |
| ☐ | ☐ | Amniocentesis or CVS (please specify results:_____) |

When did you first notice the baby moving? _____ months

Did the movement seem "normal" to you? (If "No," please describe): _____

### *Birth history of the patient:*

Place of birth (Hospital): _____

Method of delivery: ☐ vaginal ☐ C-section (if C-section, please specify reason:_____)

Were there any problems with the delivery? If so, please specify: _____

Birth weight: _____

Birth length: _____

Birth head circumference (if known): _____

APGAR scores (if known): _____

Hearing screen passed at birth? _____

Any problems noted in the newborn period (examples: difficulty breathing, jaundice, unusual birth mark or other physical feature): _____

How long did the baby remain in the hospital after birth? _____

Any difficulties with feeding (examples: sucking or swallowing problems, liquids coming through nose)?
(If "Yes," please describe): _____

Was patient ☐ breastfed? ☐ bottlefed? ☐ both?

## *Patient's Developmental History*

How old was the patient when he/she first:

_____ smiled
_____ held head up
_____ rolled over
_____ reached for objects
_____ sat without support
_____ crawled
_____ stood with support
_____ pulled to stand
_____ walked
_____ said first word

Patient's current language consists of how many words? _____

Does the patient talk in sentences? If so how many words does the patient put together in a sentence? _____

Is his/her speech understandable? _____

Is the patient currently enrolled in any type of:

☐ school program (where and how often does he/she attend)
  ☐ regular classes? _____
  ☐ special education? _____
☐ therapy program (type of therapy, where and how often does he/she attend: _____)
☐ early intervention program (where and how often does he/she attend: _____)

## *Patient's Past Medical History*

Has the patient had any significant diseases or illnesses? (If "Yes," please describe): _____

_____

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Hospitalizations? (If "Yes," please indicate date, length of stay, hospital, and reason for admission): _____ |
| ☐ | ☐ | Surgeries? (If "Yes," please specify): _____ |
| ☐ | ☐ | Seizures? (If "Yes," please specify): _____ |
| ☐ | ☐ | Previous evaluations/tests? (If "Yes," please describe):_____ |
| ☐ | ☐ | Prior genetic testing? (If "Yes," please specify): _____ |
| ☐ | ☐ | Imaging (Such as X-Rays, MRIs, CT Scans, etc.; if "Yes," please specify): _____ _____ |
| ☐ | ☐ | Does the patient see any other specialists? (If "Yes," please specify):_____ _____ |

## *Social History*

Who lives in the home? _____

Mother's occupation: _____

Father's occupation: _____

Parents: ☐ married ☐ separated ☐ divorced ☐ single ☐ other _____
Are both parents above the biological parents? (if not, please explain) _____

Have there been any important changes in the family (e.g., frequent changes of address, sharing the home with other relatives, prolonged illness or death in the family)? _____

## *Family History*

Is there a history of any of the following conditions in either parent's family (living or not)? Please include all relatives: both parents, your children, grandparents, aunts, uncles and cousins. If you answer "yes" to any of the following, please describe in the space below.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Any physical birth defects (e.g. cleft lip, spina bifida, heart defects, etc.)? (If "Yes," please specify.) _____ |
| ☐ | ☐ | Stillbirth or childhood death? (please specify: _____) |
| ☐ | ☐ | Chromosome disorder (e.g., Down syndrome, Turner syndrome, etc.)? (please specify: _____) |
| ☐ | ☐ | Hemophilia or other bleeding disorder? (please specify: _____) |
| ☐ | ☐ | Multiple miscarriages? (please specify: _____) |
| ☐ | ☐ | Cystic fibrosis or other genetic syndrome? (please specify: _____) |
| ☐ | ☐ | Mental retardation, learning problems, or autism? (please specify: _____) |
| ☐ | ☐ | Blindness or deafness? (please specify: _____) |
| ☐ | ☐ | Nerve or muscle disorder? (please specify: _____) |
| ☐ | ☐ | Cancer? (If "Yes," what type? _____) |
| ☐ | ☐ | Anything else that seems "to run in the family?" (please specify: _____) |

What are the ethnic backgrounds of the patient's biological parents?

Mother: _____ Father: _____

Background of Patient

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Specify

Is there any other information that would be helpful or important in our evaluation of your child?