O&O Alpan, LLC Today's Date: _____

Pediatric Genetics Patient Questionnaire

Patient's Name:_____
Date of Birth: _____Age: _____
Name of person filling out form/relationship to patient: _____

What is the reason your doctor has requested this genetic evaluation?

_____

What do you hope to learn from this visit with Genetics?

_____

What is your main health concern?

_____

Is your child adopted?	Yes	No
Is the child being seen today currently in foster care?	Yes	No

-*If **YES*** to either question above, please fill out this questionnaire to the best of your ability

Patient's Parents	Mother	Father
Full Name		
Date of Birth		
Occupation		
Highest Grade Completed		
Special Classes/Repeated Grades		
Health/Developmental Problems (please explain)		

Has your child:	Yes	No	Date/Results
Had a formal eye examination?			
Had a formal hearing examination?			
Had a formal heart examination?			
Had a formal neurology examination?			
Had an MRI?			
Had a CT scan?			
Had an ultrasound echocardiogram)?			
Had an X-Ray?			
Had an echocardiogram?			

Had an EKG?			
Had any other special procedures (ex: EEG, swallow study, etc.)?			
Had any genetic tests (Chromosomes)?			
Been hospitalized overnight?			
Had surgery?			

Pregnancy History (For the pregnancy of the child with the appointment)

-Was any reproductive assistance needed for this pregnancy? **(circle one**) YES NO

-If **YES** please list any reproductive services/procedures performed.

_____

_____

-The pregnancy was confirmed by **(circle one)** blood/urine test at about _____ weeks/months

-What number pregnancy was this for the mother (1^{st}, 2^{nd}, 3^{rd}, etc…)? _____

-Total number of pregnancies? _____

-Total number of abortions? _____

-Which trimester did the mother begin prenatal care? **(circle one)** 1^{st} 2^{nd} 3^{rd} None

Answer the following questions about the pregnancy, providing detail where appropriate. Use the back if necessary.

	Yes	No	Detail
Prenatal vitamins?			
Medications (prescription)?			
Medications (over-the-counter)?			
Smoking?			
Alcohol (beer, wine, liquor)?			
Street drugs?			
Illness/Infection?			
Bleeding?			
Rash?			
Fevers?			
Diabetes?			
High blood pressure?			
Thyroid problems?			
X-Rays/radiation?			
Premature labor?			
Hospitalizations?			
Abnormal growth of baby?			

Please answer these questions regarding testing that may have been done during the pregnancy

Test	Yes	No	Don't know
Glucose Tolerance Test			
First Trimester Screen (ultrasound of baby's neck/nuchal Translucency/NT measurements plus blood work.)			
Second Trimester Screen (Triple screen, quad screen, AFP test)			
Chronic Villus Sampling (CVS)			
Amniocentesis			
Routine Ultrasound			
Specialized Ultrasound			
Other (please explain)			

-Where any of these tests **ABNORMAL**? If yes, please explain: _____
_____
_____

-Firsts movements of the baby were felt at: _____ weeks/months (**circle one)**
-Were the baby's movements normal during the pregnancy? Yes No
-Mother's total weight gain during pregnancy: _____ pounds

Birth History (For the birth of the child with the appointment)
-Mother's age at delivery: _____
-Father's age at delivery:_____
-Due Date: _____
-The child was born **(circle one):** Early On Time Late
-If early or late, how many weeks? _____
-Birth Hospital (if not in the state of Virginia, please include the state): _____
-Was the labor **(circle one)** Spontaneous (happened on its own) Induced
-If **induced,** please explain the reason why and the method if known:_____
_____
_____
-How was the child delivered? Vaginal C-Section
-If **C-Section**, please explain the reason why (ex: previous C-section, failure to progress, etc.)
_____
_____
_____

-Was the baby born head first? Yes No I don't know
-If **No**, please explain:_____
_____
_____

Baby's Weight: _____ Baby's Length: _____
Baby's Head Size: _____

Were there any problems right after birth (ex: NICU, feeding problems, breathing problems, jaundice, etc.?) Yes No
If Yes, Please explain:_____
_____
_____

What were the Apgar Scores?

Was your child born with any birth defects (for example: cleft lip/palate, heart defects, extra fingers,

etc.)? Yes No
If Yes, please explain:

-After the baby was born, how did he/she feed? Breast Bottle Other
-If Other, please explain:_____
_____
_____

-Your baby was discharged home at _____ days/weeks **(Please Circle)**

Early Development
How old was your child when he/she began to :

Rolling over? _____ Sitting alone? _____

Crawling? _____ Pulling to stand? _____

Cruising? _____ Walking alone? _____

Using first word?_____ Using sentences?_____

Toilet training? _____

If there are any concerns about your child's development, how and when were they noticed?
_____
_____
_____

Has your child lost any skills that he/she preciously mastered (regression)? Yes No
If yes, please explain:_____
_____
_____

Does your child take any medications? Yes No
-If yes, please list:
1. _____
2._____
3._____

School Information

-Does your child currently attend school or daycare? Yes No
-If Yes, what is the name of the school/daycare?_____
-Grade (if applicable)? _____

-Does your child attend special classes or need special help? Yes No
-If yes, please explain. For example, which subjects does he/she need help in? Is he/she in an inclusion class or a self-contained class? _____
_____
_____

Does your child receive:	Yes	No	How Often
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Other therapy (please describe)			

-Does your child have any behavioral problems? Yes No
If yes, please explain: _____
_____
_____

-Do you feel that your child's language skills are where they should be for your child's age?
Yes No **(Please Circle)**
If no, please explain: _____
_____
_____

-Has your child ever had IQ testing or a formal developmental assessment? Yes No
-If yes, when? And what were the results? _____
_____
_____

Past Medical History

Does your child have any significant problems with:

	Yes	No	Describe
Unusual weight gain or loss			
Eyes/vision			
Hearing			

Ears/nose/mouth/throat			
Teeth			
Lungs/breathing			
Heart/veins/arteries/circulation			
Stomach/intestines/bowels			
Kidneys/bladder/genitals			
Bones/muscles (pain, weakness, abnormalities, etc.)			
Joint pains/swelling/stiffness			
Skin/hair/nails			
Easy bruising/bleeding or poor wound healing			
Headaches/Seizures			
Loss of balance or coordination			
Loss of developmental skills			
Sleep disturbances/problems			
Behavior/psychological problems			
Growth			
Heat or cold intolerance			
Delays or problems with puberty			
Hormones			
Other (please describe)			

Are the biological parents related to one another (blood relatives)? Yes No Don't Know

Are the biological parents thinking of having more children? Yes No Don't Know

Is the biological mother (or partner of the biological father, if applicable) currently pregnant?

Yes No Don't know

Has the patient been known by any other names in the past?
No Yes (please list):_____

Please list any special doctors your child sees aside from their pediatrician. Use the back of the page if you need extra space.

Name of Doctor	**Specialty** (ex: Neurology, Cardiology, GI, etc.)	**Reason for Visit**	**Frequency of Visits** (ex: once a year, once every 3 months)

Thank you for taking the time to fill out this form. You are providing us with valuable information that will allow us to better care for your child. -O&O Alpan, LLC.