EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

Department of Human Genetics
Division of Medical Genetics
www.genetics.emory.edu

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

A Special Questionnaire Regarding Your Child's Genetics Clinic Visit

In order to help us develop an appropriate evaluation plan for your child BEFORE you arrive for your appointment, it is essential that you complete this questionnaire to the best of your ability.

Part of a genetics evaluation involves looking at a person's physical features. These physical features may suggest certain genetic conditions and rule out others. We ask that you provide a CLEAR, RECENT photograph of your child so that we may begin to evaluate for these things ahead of time. Feel free to include any pictures that are relevant to the reason your child has been referred. We will be able to return these photos to you if you need them at your clinic visit.

If English is not your first language and you are having trouble filling out this form, please contact us at 404-778-8570 and we will be happy to assist you.

Attach Photograph Here

What are the main reasons why your child's doctor has requested this genetic evaluation? What questions/concerns do you have about your child?

_____
_____
_____
_____
_____

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.*

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

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

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

When did the mother begin prenatal care? (**circle one)**
1^{st} Trimester *2^{nd} Trimester* *3^{rd} Trimester* *No prenatal care*

Please answer the following Yes/No questions about the pregnancy, providing detail where appropriate. Use the back of the page if necessary.

	Yes	**No**	**Detail**
Prenatal vitamins?			
Medications (perscription)?			
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?			
Hospitalization (do not count the delivery/birth)?			
Abnormal growth of baby?			
Other concerns?			

Please answer the following Yes/No 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 measurement plus blood work)			
Second Trimester Screen (Triple Screen, Quad Screen, AFP Test)			
Chorionic Villus Sampling (CVS)			
Amniocentesis			
Routine Ultrasound			
Specialized Ultrasound			
Other (please explain)			

Were any of these tests ABNORMAL? If YES, please explain:

_____
_____
_____
_____

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

Were the baby's movements normal during the pregnancy? Yes No (**please circle**)

Mother's total weight gain during pregnancy: _____ pounds

Birth History (for the birth of the child with the appointment)

Mother's age at delivery: _____years Father's age at delivery: _____ years

Due Date: _____ Date delivered: _____

The child was born: Early On Time Late (**please circle**)

If early or late, by how many weeks? _____ weeks

Birth Hospital (if not in GA, please include the state): _____

Was the labor (**please circle**) spontaneous (happened on its own) or induced?
If **induced**, please explain the reason why and the method used (ex: doctor broke your water, pitocin, etc.) if known:

_____
_____

How was the child delivered? Vaginal C-Section (**please circle**)

If **C-Section**, please explain the reason why (ex: previous child born that way, failure to progress, etc.):

_____

_____

Was the baby born head first? Yes No I don't know (**please circle**)

If **No**, please explain:

_____

Baby's weight: _____ Baby's length: _____ Baby's head size: _____

Were there any problems right after birth (for example: need to go to the NICU, feeding problems, breathing problems, jaundice, etc? Yes No (**please circle**)

If **Yes**, please explain:

_____

_____

_____

_____

_____

Was your child born with any birth defects (for example: club foot, cleft lip and/or palate, heart defects, extra fingers, etc.)? Yes No (**please circle**)

If **Yes**, please explain:

_____

_____

After the baby was born, how did he/she feed? Breast Bottle Other (**please circle**)

If **Other**, please explain:

_____

_____

Your baby was discharged home at _____ days/weeks (**please circle**)

<u>Early Development</u>

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

_____

_____

_____

_____

_____

_____

How old was your child when he/she began:

Rolling over? _____ Sitting alone? _____
Crawling? _____ Pulling to stand? _____
Cruising? _____ Walking alone? _____
First word?_____ Sentences?_____
Toilet trained?_____

Has your child lost any skills that he/she previously mastered (regression)? Yes No (**please circle**)

If **yes**, please explain:

_____
_____

School Information

Does your child currently attend school or daycare? Yes No (**please circle**)

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 (**please circle**)

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? **If possible, please send us a copy of your most recent IEP.**

_____
_____
_____
_____

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 (**please circle**)

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 **(please circle)**

If **yes**, when? And what were the results? **Please send us a copy if possible.**

_____

_____

_____

Past Medical History

Please answer the following yes/no questions about possible tests/procedures/etc. that your child may have had. If your child has had one of these things, please provide more detail in the far right box. Use the back of the page for extra space if you need it.

Has your child:

	Yes	No	Comments (When? Why? Results?)
Had a formal eye examination?			
Had a formal hearing examination?			
Been hospitalized overnight?			
Had surgery?			
Currently taking any medications?			
Had an MRI?			
Had a CT scan?			
Had an ultrasound (including echocardiogram)?			
Had an X-ray?			
Had any other special procedures (ex: EEG, swallow study, etc.)?			
Had any genetic tests (ex: chromosomes)?			
Have any allergies?			

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 your child is seen	How often you see this doctor (ex: once a year, every 3 months, etc.)

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)			

Family History

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

Are the patient's biological parents still together? 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**?
No Yes Don't Know

Has the patient been known by any other names in the past?
No Yes _____

This form helps us to get an idea of the patient's family history. Please answer the questions below. Include any miscarriages and/or people that are no longer living, including children. List any health or developmental problems that these individuals have. Use the back of the page for more space if you need it.

Patient's parents

	Mother	**Father**
Full Name		
Date of Birth		
Occupation		
Highest grade completed		
Special classes? Repeated grades?		
Health/developmental problems (please explain)?		

Patient's brothers and sisters

*Please list all of the patient's **mother's** children. Please note whether or not these children have the same father as the patient.*

Name	**Boy or Girl?**	**Age**	**Living (Yes or No)**	**Same father as patient (yes or no)?**	**Health/Developmental Problems?**

*Please list all of the patient's **father's** children**, if different from above**.*

Name	**Boy or Girl?**	**Age**	**Living (Yes or No)**	**Same mother as patient (yes or no)?**	**Health/Developmental Problems?**

*Please indicate whether any of the patient's relatives (on the mother's side OR on the father's side) have had any of the following problems. If **yes**, please tell us WHO has had this problem (example: maternal grandmother, paternal aunt, cousin, etc.) and provide as many details as you can about the problem. Try to specify how this person is related to the patient, and on which side of the family. Note: "Maternal" means related on the mother's side, and "paternal" means related on the father's side. Use the back of the page if you need more space.*

	Yes	No	Who?	Comments
Three or more miscarriages				
Stillbirths				
Birth defects requiring surgery (ex: cleft lip/palate, heart defects, spina bifida, etc.)				
Seizures				
Learning problems/mental retardation				
Hearing or vision loss in childhood				
Muscle disorders (ex: muscular dystrophy)				
Down syndrome or other chromosome problems				
Autism or other autism spectrum disorders				
Significant gastrointestinal (stomach/bowel) problems				
Significant kidney/bladder/genital problems				
Significant heart problems				
Significant bone/joint problems				
Significant skin problems (ex: unusual number or coloring of marks, etc.)				
Significant blood problems (ex: Hemophilia, Sickle Cell disease, etc.)				
Significant immune system problems				
Significant psychological problems (ex: schizophrenia)				
Cancer (please specify type and age at diagnosis)				
Other known genetic conditions				
Other health concerns (please specify)				

Do any of the child's family members have the same or similar problems as the child? For example, if the child is coming in for developmental delay, are there any other family members with developmental delay? Yes No (**please circle**)

If **Yes**, please explain WHO has the problem, HOW they are related to the child, and WHAT their health issues/diagnoses are:

_____
_____
_____
_____
_____

Please list the names, addresses, and phone/fax numbers if available for doctors who you would like to receive a copy of your child's genetics clinic note.

Doctor	**Address**	**Phone/Fax**

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.

Emory Genetics