EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

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

Patient's Name:______________________
Date of Birth:__________________

A Special Questionnaire Regarding Your Child's Genetics Clinic Visit

This questionnaire concerns important information that you can provide to help us evaluate your child. By looking through your child's "baby book" or medical records you may have on your child, you will frequently find the answers to many of the following questions. Our evaluation includes not only a review of the family and medical history, but also a review of the pregnancy, labor, and delivery history. We know that it will take time to complete and send in this questionnaire, but valuable time will be saved during your visit with us if you can answer as many of these questions as possible. For those questions that you find difficult or impossible to answer before the visit, we will discuss them with you during the visit. In addition, please attach a recent photograph of your child that we can keep in his/her file. If additional space is needed in answering any of the questions, please feel free to use the back of the form. Thank you for helping us to better understand your child's growth, development and medical history, and your concerns about your child.

Please remember that this entire questionnaire should be mailed to us at least two weeks prior to your child's appointment, or the appointment may be rescheduled.

Attach Photograph Here

Patient's Name:*________________________ *Date of Birth:

What are the main reasons that you or your child's doctor requested this genetic evaluation? What concerns do you or your child's doctor have about your child?

____

____

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____

Pregnancy History

1. The pregnancy with this child was confirmed by **blood test/urine test** (circle one) at about ______**weeks/months** (circle one).

2. Who provided the prenatal care? ___________________

3. About how many ultrasounds were performed during the pregnancy? ________

   When (weeks or months) during the pregnancy were they performed?

   #1__________ #4__________
   #2__________ #5__________
   #3__________ #6__________

4. Were any of the ultrasounds abnormal? Yes____ No____ Don't know/Other______

   If **yes**, please explain:

____

____

____

____

5. Were any other special studies done during this pregnancy?

Yes____ No ____ Don't know/Other______

If **yes**, please explain (include maternal serum "triple" or "quad" screens, CVS, amniocentesis, glucose tolerance test, etc.):

____

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____

____

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6. List all of the over-the-counter and prescription medications, vitamins, health preparations, cigarettes, drugs, etc. used during this pregnancy (include the name/brand, amount, and when taken during the pregnancy).

Medication/Vitamins etc.	Amount or dose	When during pregnancy (example: 3 to 5 months)
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
Cigarettes or tobacco		
______________	______________	______________
Alcohol (wine, beer, etc)		
______________	______________	______________
______________	______________	______________
______________	______________	______________
Drugs (marijuana, cocaine, etc.)		
______________	______________	______________
______________	______________	______________

7. The pregnancy was complicated by:

	Yes	No	When during pregnancy
Bleeding/spotting	_______	_______	______________
Cold or flu-like illness	_______	_______	______________
Bladder infection	_______	_______	______________
Fever	_______	_______	______________
Yeast infection	_______	_______	______________
Other vaginal infection	_______	_______	______________
Skin rash	_______	_______	______________
Dehydration from vomiting	_______	_______	______________
Abnormal growth of baby	_______	_______	______________
Premature labor	_______	_______	______________
High blood pressure	_______	_______	______________
Blood sugar problems	_______	_______	______________
Exposure to x-rays/chemicals	_______	_______	______________
Other: ______________	_______	_______	______________
______________	_______	_______	______________

8. How would you describe your baby's activity in the womb during the pregnancy?

______Very active ______ Moderately active
______ Occasionally active ______ Rarely active

9. About how many pounds did you gain during the pregnancy? _______

Delivery History

1. Due date:_________ Date Delivered: ________Birth Hospital:_____________

2. Was your child born at full term (9 months or 40 weeks)?
Yes____ No____ Don't know/remember_____

If not born at term, how premature was your child? _____________________________

3. How long was your labor? ___________ hours

4. How was your child delivered?

a. ______ Vaginal ______ C-section ______ Repeat C-section because a previous child was delivered this way

b. ______ Head first ______ Shoulder first
______ Bottom first ______ Feet first

Birth History

1. Weight: ______ Length:_______ Head size: ______ Chest circumference:______

2. Did your child have any major problems after birth such as low blood sugar, need for intensive care, oxygen or breathing tubes, jaundice needing "bililytes", transfusions, etc.?

Yes_____ No_____ Don't know/remember_______

If **yes**, please describe:
____
____
____
____

3. Babies are given special scores at birth called "Apgar" scores. The scores are based on the baby's color, breathing, heartbeat, muscle tone, and cry. If you remember your child's Apgar scores, please record them here: Don't remember______

______ at 1 minute ______ at 5 minutes

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4. After your baby was born, how did he/she feed?

Breast ______ Bottle ______ Other _______

If **other**, please explain: ____
____

5. Were there any feeding problems? Yes ____ No____ Don't know/remember_____

If **yes**, please explain:
____
____
____

6. Your baby was discharged to home at _________ **days/weeks** (circle one) of age.

First Year of Life

Did your child have any medical, growth, or developmental problems during the first year of life? Yes____ No____ Don't know/remember_____

If **yes**, please explain:
____
____
____
____
____

One to Three Years of Life

Did your child have any medical, growth, or developmental problems from one to three years of age? Yes____ No____ Not applicable_____ Don't know/remember_____

If **yes**, please explain:
____
____
____
____
____

Three to Six Years of Life (Preschool)

Did your child have any medical, growth, developmental or behavioral problems from three to six years of age? Yes____ No____
Not applicable_____ Don't know/remember _____

If **yes,** please explain:

____
____
____
____
____
____

Six to 12 Years of Life (Grammar and Middle School)

Did your child have any medical, growth, developmental, or behavioral problems from six to 12 years of age? Yes____ No____
Not applicable_____ Don't know/remember_____

If **yes**, please explain:

____
____
____
____
____
____

12 to 18 Years of Life (Adolescence)

Did your child have any medical, growth, developmental or behavioral problems from 12 to 18 years of age? Yes____No____
Not applicable_____ Don't know/remember_____

If **yes,** please explain:

____
____
____
____
____
____

Developmental/Educational History

1. To the best of your memory, please record your child's age beside those milestones that your child has reached, and circle the months or years as appropriate:

Rolled over: ________ months/years
Sat alone: _________ months/years
Crawled: __________ months/years

Walked holding onto furniture: ___________ months/years
Walked alone: ____________ months/years
Used first word: __________ months/years
Began to combine words: __________ months/years
Began to use sentences: __________ months/years

2. Does your child currently have any age appropriate problems understanding or using language? Yes: ____ No: _____ Don't know/Other:_____

If **yes,** please explain:
____
____
____

3. Does your child receive any special services (occupational, physical, or speech/language therapies) through the "Babies Can't Wait" program, other public, or private organization? Yes______ No____ Don't know/Other________

If **yes,** list type and amount of services (ex. PT 3 times a week for one hour):
____
____
____

4. Is or was your child enrolled in any special education program?
Yes____ No____ Don't know/Other_____

If **yes**, please explain. What age level is he/she functioning at? **Please send us a copy of any recent development evaluations.**
____
____
____
____

5. Has your child lost any of the developmental skills that he/she had previously learned?
Yes _____ No _____ Don't know/Other ______

If **yes,** please explain:
____
____
____

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Review of Systems

Does your child currently have any problems in any of the areas listed below? If **yes**, please explain at the end of the list.

Area of Concern	Yes	No	Don't know/Other
Unusual weight gain or loss	❐	❐	❐
Vision or eyesight	❐	❐	❐
Hearing	❐	❐	❐
Teething	❐	❐	❐
Recurrent ear or throat infections	❐	❐	❐
Asthma or lung problems	❐	❐	❐
Heart or circulation problems	❐	❐	❐
Stomach or bowel problems	❐	❐	❐
Recent changes in appetite	❐	❐	❐
Kidney or bladder problems	❐	❐	❐
Muscle pains, weakness, etc.	❐	❐	❐
Joint pains, swelling, stiffness	❐	❐	❐
Skin, hair or nail problems	❐	❐	❐
Poor wound healing	❐	❐	❐
Easy bruising or bleeding	❐	❐	❐
Headaches/Seizures	❐	❐	❐
Loss of balance or coordination	❐	❐	❐
Loss of developmental skills	❐	❐	❐
Sleep disturbances or problems	❐	❐	❐
Behavior or educational problems	❐	❐	❐
Growth problems	❐	❐	❐
Area of Concern	**Yes**	**No**	**Don't know/Other**
Heat or cold intolerance	❐	❐	❐
Delays or problems with puberty	❐	❐	❐
Hormonal problems	❐	❐	❐
Other problems	❐	❐	❐

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If **YES** to any of the above, please explain. Use the reverse side for more space.

____
____
____
____
____
____
____
____

Immunizations

Are your child's immunizations up to date? Yes____ No____ Don't Know/Other_____

Medications

1. Is your child allergic to any medications? Yes___ No____ Don't know/Other ___

If **yes**, please list the medications:

____
____

2. Please list any medications that your child is currently taking:

Name	Dosage	Time
_____________	_____________	_____________
_____________	_____________	_____________
_____________	_____________	_____________
_____________	_____________	_____________
_____________	_____________	_____________

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Hospitalizations

Name of hospital	**Approximate date of hospitalization**	**Reason**
____________________	_____________	____________________
		____________________
____________________	_____________	____________________
		____________________
____________________	_____________	____________________
		____________________

Surgeries

Type of surgery	**Approximate date of surgery**	**Reason**
____________________	_____________	____________________
		____________________
____________________	_____________	____________________
		____________________

Specialist Physicians

Please provide the names and specialty of any doctors that your child has seen along with the reason for the visits.

Name	**Specialty**	**Reason**
____________________	_____________	____________________
		____________________
____________________	_____________	____________________
		____________________
____________________	_____________	____________________
		____________________

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Physicians to receive a copy of our report

Please provide the name and full mailing address of any physicians or health care providers that you wish to receive a copy of our summary letter(s):

Name	**Full Address**	**Phone Number**
____________________	____________________________	____________________
	____________________________	
	____________________________	
	____________________________	
____________________	____________________________	____________________
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