SIU HealthCare

*Exceptional Medicine. Partners in Care.*

Patient name: _____

DOB: _____ DOV: _____

MRN: _____

Provider: _____

## GENETICS CLINIC PATIENT QUESTIONNAIRE (PEDIATRIC)

Child's Name: _____ Date of Birth: _____ Current Age: _____

Person completing form: _____ Relationship to Child: _____

Parents/Guardians' Names: _____

Contact Phone Number(s): _____

**This form is confidential and will become part of the patient's medical record.**

Referring physician: _____
Address: _____
_____
_____

Primary Care Physician: _____
Address: _____
_____
_____

Other Physician: _____
Address: _____
_____
_____

Other Physician: _____
Address: _____
_____
_____

**By signing below, you give us permission to send a copy of the clinic note from the clinic visit to the healthcare providers you listed above.**

_____ _____

Patient's Signature/Signature of Parent or Guardian Date

**Your Questions for the Doctor**

Please list the reason why your child was referred to Genetics and specific questions or concerns you would like to discuss during the clinic visit.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____

**Pregnancy and Birth History**

Mother's age at delivery: _____ What number pregnancy was this child for the mother? _____

Method of conception: ☐ Natural ☐ Artificial reproductive technology (IVF, Clomid)

Is the mother currently pregnant? ☐ Yes ☐ No

Thinking of *all* of the mother's pregnancies to date, including this one, how many resulted in each of the following:

| | Number |
|---|---|
| Miscarriage in the first trimester (up to 14th week of pregnancy) | _____ |
| Miscarriage later in pregnancy | _____ |
| Stillbirth | _____ |
| Elective abortion | _____ |
| Preterm birth (prior to 37 weeks) | _____ |
| Full term birth (37 weeks or more) | _____ |

Did the mother have any of the following complication during ***this child's*** pregnancy? If yes, please list treatment.

| | YES | NO | |
|---|---|---|---|
| Diabetes | ☐ | ☐ | _____ |
| High blood pressure | ☐ | ☐ | _____ |
| Infections, fevers, illnesses | ☐ | ☐ | _____ |

Other problems/complications: _____

Medications used during pregnancy: _____

How much alcohol did the mother consume during pregnancy? _____

How many packs per day of cigarettes did the mother smoke during pregnancy? _____

Please list any street drugs (marijuana, cocaine, etc) used during pregnancy: _____

Did the mother have an ☐ ultrasound ☐ 1st trimester screen/triple/quad screen ☐ amniocentesis or CVS

Were any results from this testing abnormal? If yes, please explain: _____

_____

The child was born: ☐ at full-term ☐ prematurely (weeks premature: _____)

If premature, please list the reason: _____

The child was born: ☐ Vaginally ☐ by C-section; if so, why: _____

Birth Hospital: _____ City & State: _____

Birth weight: _____ Birth Length: _____ Birth head circumference: _____

Did your child have any problems after delivery or require admission to the Neonatal Intensive Care Unit (NICU)?

Yes / No If yes, please explain: _____

_____

Did he/she pass the: Newborn metabolic screen Yes No Unsure Newborn hearing screen Yes No Unsure

How many days old was the child when he/she went home from the hospital? _____

Did the child have any other problems in the first month of life? If yes, please explain: _____

_____

Patient Name: _____

**Developmental History**

Are you concerned about your child's developmental milestones? Yes / No If yes, since what age:_____

If yes, circle the developmental concerns that you or your child's doctor(s) have about your child:

| | | |
|---|---|---|
| Hyperactivity | Delay in motor development | Autism/Asperger/PDD-NOS |
| Short attention span | Delay in language development | Learning difficulties |

List any other developmental or behavioral problems that your child has or may have: _____

_____

_____

What do you think is the developmental age of your child? _____

Please check what skills your child currently has and *list the age* when achieved if known:

| **Language Skills** | ✓ | **Age** | **Fine Motor Skills** | ✓ | **Age** | **Gross Motor Skills** | ✓ | **Age** |
|---|---|---|---|---|---|---|---|---|
| Smile | | | Reach out & grasp | | | Head control | | |
| Coo | | | Transfer objects | | | Roll over | | |
| Laugh | | | Use pincer grasp | | | Sit without support | | |
| Babble | | | Finger feed | | | Crawl | | |
| First word (not dada/ mama) | | | Use utensils | | | Pull to stand | | |
| Responds to name | | | Builds a tower w/ blocks | | | Cruise | | |
| Signing | | | Scribble with crayon | | | Walk | | |
| Points to 5 body parts | | | Dress and Undress | | | Toilet train | | |
| Sentences | | | Button or Zip clothing | | | Go up steps w/o help | | |
| Counting | | | Copy a line with crayon | | | Riding a tricycle | | |
| Sight words | | | Copy a circle w/ crayon | | | Riding a bicycle | | |
| Reading | | | Print first and last name | | | | | |
| **List current language skills:** *(i.e. number of words/signs, sentence length [2-3, 3-4, 5+], reading level)* | | | **List current fine motor skills:** | | | **List current gross motor skills:** | | |

Has your child ever **lost a skill** that he or she was previously able to do (regressed)? Yes / No
If yes, please explain:_____

_____

_____

_____

_____

Patient Name: _____

Circle all of the following **behaviors** that your child does frequently:

| | | |
|---|---|---|
| Rocking back and forth | Involuntary movements or vocalizations | Poor socialization |
| Head banging | Injuring self or others | Hand wringing |

Other: _____

Is your child currently enrolled in:

☐ MO First Steps/ IL Child & Family Connections (age 0-3)

☐ Early Childhood School (age 3-5)

☐ Elementary, Middle, or High School (age 5+)

If your child is school-aged: Current Grade _____
Grades on last report card, if applicable _____

Has your child ever had an **evaluation** by therapists, an IEP, or formal IQ testing? Yes / No
If yes, at what age(s)? _____ What were the results? _____

For each **therapeutic service** that your child receives, list the frequency or length of time each *week*:

Physical therapy _____ Occupational therapy _____ Speech therapy _____

Developmental therapy _____ Other: _____

Is your child receiving special education or resource room assistance? ☐ Yes ☐ No
If yes, please explain the type and amount of assistance your child receives: _____

Does your child do any **extracurricular activities** (i.e. sports, music, dance, etc)? ☐ Yes ☐ No
If yes, please list type and frequency: _____

Are you currently satisfied with the services your child is receiving? ☐ Yes ☐ No
If not, please explain your current concerns: _____

Patient Name: _____

## Past Medical History

List all physicians that your child has seen (except general pediatrician and emergency room visits):

| Doctor's Specialty | Physician Name & Hospital | Date Last Seen | Diagnosis or Surgery |
|---|---|---|---|
| Genetics (prior to today's appointment) | | | |
| Cardiology (Heart doctor) | | | |
| Developmental pediatrics | | | |
| Endocrinology (Hormone doctor) | | | |
| ENT/otolaryngology (Ear, Nose & Throat) | | | |
| Gastroenterology (GI doctor) | | | |
| Neurology Neurosurgery | | | |
| Urology | | | |
| Nephrology / Renal (Kidney doctor) | | | |
| Ophthalmology or Optometry (Eyes) | | | |
| Orthopedic surgery (Bone doctor) | | | |
| Pulmonology (Lung doctor) | | | |
| Psychology/Psychiatry | | | |
| Other specialist(s): | | | |

Patient Name: _____

Please list any **surgeries or overnight admissions to the hospital:**

| **Date (Month/Year)** | **Physician/Hospital** | ***Briefly* Describe Admission or Surgery** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Does your child have any other medical problems not addressed above? ☐ Yes ☐ No

If yes, please explain: _____

_____

**Medications** ☐ No medications

| **Medication Name** | **Reason** (example: allergies or seizures) | **Dose** (examples: 25 mg tablet or 100 mg/5 ml suspension) | **Frequency Taken** (examples: 1 tablet twice daily or 2 teaspoons 3 times a day) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Does your child have any **allergies to medications**: Yes / No

If yes, please list medication name(s) and describe allergic reaction(s): _____

_____

**Diet History**

Please describe your child's current diet: _____

_____

Does your child have any food aversions, food allergies, or require a special diet? Yes / No

If yes, please explain: _____

_____

Has you child ever had a G-button or nasogastric (NG) tube? Yes / No If yes, what ages: _____

Patient Name: _____

**Previous Tests or Studies**

Please list if your child has had any of the following tests:

| Test/Study | Date Performed | Hospital / City | Results (if known) |
|---|---|---|---|
| Brain MRI or Head CT | | | |
| Electroencephalogram (EEG) | | | |
| Hearing test/Audiology | | | |
| Echocardiogram | | | |
| Radiographs/X-rays (Indicate of what) | | | |
| Ultrasound (liver, kidneys, etc) | | | |
| Genetic Testing (indicate type) | | | |
| Metabolic Testing (indicate type) | | | |
| Other: | | | |

**Social and Family History**

Who does your child live with? _____

Does the child smoke or use other tobacco products? Yes / No _____

List the **biological mother's** health problems or concerns: _____

_____

Did the biological mother have any learning difficulties in school, require special education, or have resource room assistance? Yes / No If yes, please explain: _____

Highest level of education completed by child's biological mother: _____

What is the mother's ethnic background? _____

What is the mother's occupation? _____

List the **biological father's** health problems or concerns: _____

_____

Did the biological father have any learning difficulties in school, require special education, or have resource room assistance? Yes / No If yes, please explain: _____

Highest level of education completed by child's biological father: _____

What is the biological father's ethnic background? _____

What is the father's occupation? _____

Patient Name: _____

**Review of Systems** – ***This page is for use by the Genetics faculty and staff***

**Neurological**
Headaches
Seizures
Clumsiness
Unusual movements
Hypertonia
Hypotonia
Tingling

**Eyes and Vision**
Wears glasses/contacts
Nearsighted
Farsighted
Strabismus
Nystagmus

**Ear, Nose, & Throat**
Hearing loss
Recurrent ear infections
Nasal speech

**Dental**
Abnormal number or shape of teeth
Dental cavities

**Cardiovascular**
Chest pain
High blood pressure
Fainting
Rapid heartbeat
Palpitations

**Pulmonary**
Snoring
Apnea
Wheezing
Persistent cough

**Gastrointestinal**
Constipation
Diarrhea
Reflux/GERD
Abdominal pain
Vomiting
Jaundice
Blood in stool

**Genitourinary**
Pain with urination
Frequent urination
Blood in urine
Undescended testicle(s)
Genital malformation

**Dermatology**
Birthmarks (please list)
Stretch marks
Eczema
Unusual lumps/bumps
Rashes
Coarse, fine, or excess hair

**Infectious Disease**
Frequent infections (type)
Recent fever

**Hematology**
Anemia
Easy bruising
History of transfusion

**Physician's Notes:** _____

Patient Name: _____

**Physical Examination** - ***This page is for use by the Genetics faculty and staff***

**Age:**_____

**General Appearance:** Dysmorphic / Non-dysmorphic

**Ht:**_____

**Fontanel:** AF _____ / PF_____ / Suture _____

**Wt:** _____

**Head Shape:** NL / Plagio / Brachy / Scapho / Trigon / Dolico

**OFC:** _____

**Forehead:** NL / Tall / Bossing / Broad

**BP:** _____

**Face:** NL / Myopathic / Coarse / Round / Long / Other _____

**Hair:** NL / Sparse / Hirsuit / Low hairline / Whorls / Coarse / Alopecia

---

**Eyes:** Hypertel / Hypotel / Synophrys / Epicanthal folds / Iridodenesis

**IC:**_____

**Sclera:** NL / Blue / Gray / Other _____

**OC:**_____

**PF:** NL / Up-slanting / Down-slanting / Narrow / Long / Short

**PF:**_____

**IP:**_____

**Ears:** NL / Simple / Cupped / Folded / Pits / Tags / Creases

**Ear Position:** NL / Low / Post.-rotated

**Pinna:**_____

**Nasal bridge:** NL / Low / Prominent / Broad / Flat

**Nares:** Anteverted / Narrow / Bulbous tip

**Philtrum:** NL / Smooth / Short / Long / Narrow

**Lips:** NL / Thin vermillion border / Full / Cupid's bow /Small mouth / Tented upper lip / Pits

**Teeth:** NL / Crowded / Abnormal shape / Hypo/hyperdontia / Discolored / Wide-spaced / Overbite / # _____

**Palate:** NL / High-arched / Cleft / Narrow

**Chin:** NL / Micrognathia / Retrognathia / Prognathia

**Neck:** NL / Webbed / Short / Redundant skin / Branchial defects

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**Chest**

**Pectus:** Excavatum / Carinatum

**IN:**_____

**Nipples:** NL / Inverted / Supernumary / Wide-spaced / Hypoplastic

**Heart Sounds:** NL / MVP Click / Murmur _____

**Upper:**_____

**Lungs:** NL/ Abnormal_____

**Lower:**_____

**Arm span:**_____

**Abdomen**

**Umbilicus:** NL / Hernia

**Liver:** NL / Below costal margin: _____

**Spleen:** NL / Other _____

**Back**

Spine: NL / Scoliosis / Lordosis / Kyphosis / Sacral dimple / Other _____

**G/U**

**Tanner Stage:** _____

**Penis**: NL / Hypospadias/ Micropenis

**Testes:** NL/ Undescended

**Scrotum:** NL / Shawl / Hypoplastic

**Labia majora**: NL / Hypoplastic

**Labia minora:** NL / Hypoplastic

**Clitoris:** NL / Other

**Inguinal Hernia:** + / - Unilateral / Bilateral

**Anus:** NL / Patent / Anterior placement

Patient Name: _____

**Extremities**

**Joints:** Laxity of _____; Contractures: _____ **Palm:**_____

**Creases:** NL / Sydney / Single / Bridged / Hypoplastic / Deep **Middle finger:**_____

**Total hand:**_____

**Fingers:** NL / Brachy _____Broad _____Clino _____Campto_____Syn_____Poly_____

**Thumbs:** NL / Triphalengeal_____Broad_____Hypoplastic_____Absent_____

**Fingernails:** NL / Hypoplastic / Absent / Fused / Other _____

**Feet:** **Arch:** NL / Low / Flat **Protonation:** +/- **Foot:**_____

**Toes:** NL / Broad / Over-riding _____Clino _____Campto_____Syn_____Poly_____

**Toenails:** NL / Hypoplastic / Absent / Fused / Other _____

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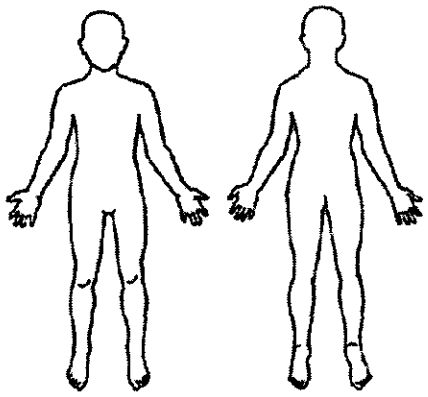
**Skin**

**Pigmentation:** CAL _____

Telangectasias_____

Nevi_____

Other _____



**Texture:** Soft / Dry / Thick / Thin / Doughy / Elastic

**Other:** Striae_____

Eczema_____

Abnormal scarring_____

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**Neurological**

**Muscle tone:** Normal / Hypotonia / Hypertonia

**DTRs:** Normal / Decreased / Increased / Clonus / _____

**Cranial nerves:** Intact / Abnormal _____

**Other:** Focal signs / Cerebellar / Abnormal gait / Other _____

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**Impression:**_____

_____

_____

**Plan:**_____

_____

_____

_____

_____

**Follow-Up:** _____

_____ _____

Genetic Counselor Signature Attending Signature