Washington University in St. Louis
School of Medicine

Children's Hospital • St. Louis

Patient Name _____

DOB _____ DOV _____

MRN _____

Provider _____

Staff _____

Department of Pediatrics
Division of Genetics & Genomic Medicine

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) _____

PHYSICIAN INFORMATION

Referring Physician _____

Address _____

City/State/ZIP _____

Primary Care Physician _____

Address _____

City/State/ZIP _____

Other Physician _____

Address _____

City/State/ZIP _____

Other Physician _____

Address _____

City/State/ZIP _____

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.

_____

_____

_____

_____

_____

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_____

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_____

_____

_____

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

Did the mother have any of the listed complications during the pregnancy ***with this child?***

If yes, please list treatment: **Treatment**

Diabetes ☐ Yes ☐ No _____

High blood pressure ☐ Yes ☐ No _____

Infections, fevers, illnesses ☐ Yes ☐ No _____

Other problems/complications _____

Medications used during pregnancy _____

How much alcohol did the patient's mother consume during pregnancy? _____

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

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

Did the mother have:

Ultrasound ☐ Yes ☐ No Explain any abnormal results _____

1st trimester screen/triple/quad screen ☐ Yes ☐ No Explain any abnormal results _____

Amniocentesis or CVS ☐ Yes ☐ No Explain any abnormal results _____

The child was born: ☐ Full-term ☐ Prematurely– Weeks premature _____

If premature, please list the reason _____

The child was born: ☐ Vaginally ☒ by C-section– Reason _____

Birth Hospital _____ City and State _____

Birth weight _____ pounds _____ ounces 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 the child pass: 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? ☐ Yes ☐ No

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, check 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 and 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	_____	☐ Build a tower with 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 without help	_____
☐ Counting	_____	☐ Copy a line with crayon	_____	☐ Ride a tricycle	_____
☐ Sight words	_____	☐ Copy a circle with crayon	_____	☐ Ride 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**	
_____		_____		Not a fan of tummy time.	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

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 _____

DEVELOPMENTAL HISTORY continued

Check 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+)

Is your child school-aged? ☐ Yes ☐ No If yes, 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 describe the classroom setting and any assistance/accommodations.

_____

_____

_____

Does your child do any **extracurricular activities** (i.e., sports, music, dance, etc.)? ☐ Yes ☐ No

If yes, please list type and frequency.

Activity	Frequency	Activity	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 physician/primary and emergency room visits).

Doctor's Specialty	Physician Name and Hospital	Date Last Seen	Diagnosis or Reason Child was Seen
Genetics (prior to today's appointment)			
Cardiology (Heart doctor)			
Developmental pediatrics			
Endocrinology (Hormone doctor)			
ENT/Otolaryngology (Ear, Nose and 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 _____

SURGERIES AND HOSPITALIZATIONS

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

Month/Year	Physician Name/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** (examples: 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).

Medication Name	**Reaction**	**Medication Name**	**Reaction**
_____	_____	_____	_____
_____	_____	_____	_____

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 age(s) _____

Patient Name _____

PREVIOUS TESTS OR STUDIES

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

Test/Study	Date Performed	Hospital and City	Results (if known)
Brain MRI or Head CT			
Electroencephalogram (EEG)			
Hearing test/Audiology			
Echocardiogram			
Radiographs/X-rays *reason:*			
Ultrasound (liver, kidneys, etc.)			
Genetic Testing *type:*			
Metabolic Testing *type:*			
Other *list:*			

SOCIAL AND FAMILY HISTORY

Who does your child live with? _____

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

BIOLOGICAL MOTHER

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 _____

Mother's ethnic background _____ Mother's occupation _____

BIOLOGICAL FATHER

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 _____

Father's ethnic background _____ Father's occupation _____

Patient Name _____

REVIEW OF SYSTEMS – THIS SECTION 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, and 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
  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

General Appearance: Dysmorphic / Non-dysmorphic

Fontanel: AF _____ / PF_____ / Suture _____

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

Forehead: NL / Tall / Bossing / Broad _____

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

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

Age _____
Height_____
Weight _____
OFC_____
BP _____

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

Sclera: NL / Blue / Gray / Other _____

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

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

Ear Position: NL / Low / Post.-rotated

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 / Number_____

Palate: NL / High-arched / Cleft / Narrow

Chin: NL / Micrognathia / Retrognathia / Prognathia

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

IC_____
OC_____
PF _____
IP _____
Pinna _____

Chest

Pectus: Excavatum / Carinatum

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

Heart Sounds: NL / MVP Click / Murmur _____

Lungs: NL / Abnormal _____

IN_____
Upper _____
Lower _____
Arm Span_____

Abdomen

Umbilicus: NL / Hernia

Liver: NL / Below costal margin _____

Spleen: NL / Other _____

Back

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

Patient Name _____

GU

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

Extremities

Joints: Laxity of _____ Contractures_____

Creases: NL / Sydney / Single / Bridged / Hypoplastic / Deep _____

Fingers: NL / Brachy _____ Broad _____ Clino _____ Campto _____

Syn_____ Poly_____

Thumbs: NL / Triphalangeal_____ Broad_____ Hypoplastic_____ Absent_____

Nails: NL / Hypoplastic / Absent / Fused / Other _____

Feet: *Arch:* NL / Low / Flat *Protonation:* +/–

Toes: NL / Broad / Over-riding _____ Clino _____ Campto_____

Syn_____ Poly_____

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

Palm _____

Middle Finger _____

Total Hand _____

Foot_____

Skin

Pigmentation: CAL_____

Telangiectasias _____

Nevi _____

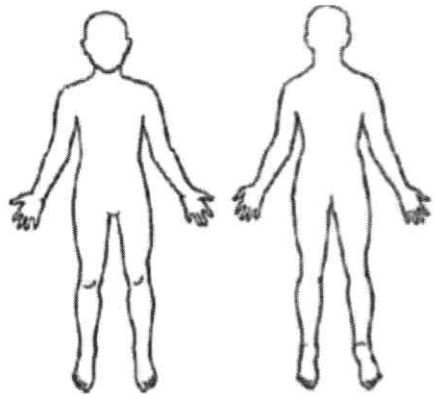
Other _____

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

Other: Striae_____

Eczema _____

Abnormal scarring _____



Neurological

Muscle tone: Normal / Hypotonia / Hypertonia

DTRs: Normal / Decreased / Increased / Clonus / _____

Cranial nerves: Intact / Abnormal _____

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

IMPRESSION

PLAN

FOLLOW UP

Resident/Fellow Signature _____

Genetic Counselor Signature _____

Attending Signature _____