

Levine Children's Hospital
Clinical Genetics Center
Medical History

Please answer the following questions carefully. Your answers will help us in trying to identify problems that may affect you or your child's health. Completing this form before your visit with us will also help to speed the evaluation process. All information will be kept CONFIDENTIAL Please mail this form back to us in the enclosed envelope if there is time before your appointment; otherwise, bring it with you on the day of your appointment. Thank you!

PATIENT NAME: _____ DOB: _____

A. PREGNANCY HISTORY :

What was your age when your child was born? _____ years

How many pregnancies have you had? _____

What number pregnancy was this child? (eg. First, third, etc) _____

_____ How many liveborn?

_____ How many miscarried?

_____ How many elective terminations?

_____ How many premature births?

Who was the doctor that cared for you during your pregnancy? _____

How far along were you at your first prenatal visit to the doctor? _____

Was your child born at term, early, or overdue? _____ How many weeks? _____

How much weight did you gain during the pregnancy? _____ lbs.

How far along were you when you first felt the baby move? _____

Did the baby kick actively? YES NO

Did you smoke cigarettes during this pregnancy? YES NO

How many per day? _____

Did you drink any alcohol during this pregnancy? YES NO

How much per day? _____

Did you have any ultrasounds during this pregnancy YES NO

How many and how far along were you? _____

Were there any problems found? YES NO

What? _____

Did you have Triple Screen AFP test, CVS, or amniocentesis? YES NO

Results _____

Did you take any medications during the pregnancy? YES NO

Medications? _____

Do you recall any unusual illnesses or complications during the pregnancy? YES NO

Complications _____

Were you exposed to any x-rays, chemicals, or infectious diseases during the pregnancy? YES NO

What? _____

Name: _____

B. PERINATAL HISTORY

Where was your child born? (hospital, city, state) _____

Was your child delivered vaginally or by C-section _____
If C-section why? _____

Was the baby head first or breach _____

Were there any complications YES NO
Complications _____

What were the baby's APGAR scores? _____ 1 minute _____ 5 minutes

What was the birth weight? _____
The birth length? _____
The head circumference _____

How long was the baby in the hospital? _____

Was the baby ever in the intensive care nursery YES NO
Why? _____

Were there any problems in the nursery such as jaundice or cyanosis? YES NO
Problems? _____

Was the baby breast fed or formula fed? _____ What formula? _____

Were there any feeding difficulties? YES NO
Difficulties? _____

How is your child's appetite now? _____

C. DEVELOPMENTAL HISOTRY :

When did your child first show these skills (what age)?

_____ Smile	_____ First words
_____ Reach for objects	_____ Crawl
_____ Transfer objects from hand to hand	_____ Walk with help
_____ Roll over	_____ Walk alone
_____ Sit with help	_____ Put words together in a sentence
_____ Sit alone	_____ Toilet trained

Do you feel your child has progressed normally in his/her abilities or are they delayed?
NORMAL DELAYED

If delayed when did you first notice he/she was behind? _____

Is your child in a daycare or in school? YES NO
Where and what grade? _____

Is your child getting an special help at school (such as speech or resource)? YES NO
What are they receiving? _____

Name: _____

Has your child ever been evaluated at a developmental center (Watkins Center, Shelby or Concord DEC, Child & Family Development, etc.)? YES NO

Where? _____

What were the results of the testing? _____

_____ Child's age when testing was done?

_____ Overall age level

_____ Gross motor age level

_____ Fine motor age level

_____ Overall language level

_____ Expressive language level

_____ Receptive language level

Is your child receiving any therapies?

_____ Speech therapy

_____ Physical therapy

_____ Occupational therapy

_____ Other therapy

D. MEDICAL HISOTRY

Who is your child's pediatrician/Family doctor? _____

Are your child's immunizations up to date? YES NO

Is your child currently taking any medications? YES NO

Medications? _____

Does your child have any allergies? YES NO

Allergies? _____

Has your child had any major illnesses or been hospitalized? YES NO

Where/when/why? _____

Has your child seen any special doctors? YES NO

_____ Audiology

_____ Cardiology

_____ Endocrinology

_____ Ear,

_____ Nose & throat

_____ Genetics

_____ GI

_____ Nephrologist

_____ Neurology

_____ Ophthalmologist

_____ Orthopedist

_____ Plastic surgery

_____ Surgeon

_____ Urology

_____ Other

Who? _____

Name: _____

Has your child had any special tests done? YES NO

- _____ Blood tests
- _____ CT scan
- _____ EEG
- _____ Echocardiogram
- _____ MRI scan
- _____ Ultrasound
- _____ X-rays
- _____ Other

What were the results? _____

E. FAMILY HISOTRY

Has anyone in the mother's or the father's family ever had:

- _____ Down syndrome or other chromosome condition
- _____ Spina bifida (other spine) or anecephaly (open brain)
- _____ Hydrocephaly (water on brain)
- _____ Muscular Dystrophy
- _____ Hemophilia (free bleeder or problems with clotting)
- _____ Cystic fibrosis
- _____ Sickle cell anemia
- _____ Stillbirth (baby died prior to birth)
- _____ Epilepsy (seizures)
- _____ Blindness or deafness
- _____ Heart defect (hole in heart)
- _____ Kidney disease
- _____ Illness (depression, schizophrenia)
- _____ Cleft lip and/or palate
- _____ Phenylketonuria or history of metabolic condition
- _____ Infants who died after birth
- _____ Mental retardation

Has either parent or any relatives ever had a child born dead or alive with inherited disease, birth defect, or problem not listed above? YES NO

What? _____

Does either parent have any close relatives who have mental retardation? YES NO

Does either parent have any relatives with a metabolic condition or enzyme deficiency? YES NO

What? _____

Does the mother of father of the child have any blood relatives who are:

(circle all that apply)

- | | |
|--|-----------------|
| Caucasian | Jewish |
| African-American | French Canadian |
| Mediterranean descent (Italian, Greek) | Asian |

What are your main concerns regarding your child?