Pediatric Clinical Genetics Questionnaire

This form may be printed out and given to your physician at your appointment. It may be helpful to fill out the following sections before seeing your doctor:
Patient information, Pregnancy History, Birth History, Developmental History, Educational/Therapy Programs
Growth History

Patient's name____ Date_________________

Address____

Referred by and reason for referral____

____

Pregnancy History
Duration of Pregnancy ________ Wks.

THEN: G______ P______ Sab______ Tab______ ST.BTH______

NOW: G______ P______ Sab______ Tab______ ST.BTH______

Mother's age________ Father's age________

Complications____

____

Exposures____

Prenatal Testing ____

Fetal Movement Noted At_________ Mos. Gest.

Normal?________________ Reduced?________________

Birth History
Place of Birth____

Mode of Delivery____

BW________________ Length________________ APGARS________________ HC______________

Complications in Newborn Period____

____

____

Discharged in_____________ Days

Feeding
Perinatal____

Currently____

Developmental History

Smiled ________________ Head up ________________

Rolled over ________________ Reached for objects ________________

Sat without support________________ Crawled ________________

Stood w/support ________________ Walked ________________

First word ________________ Current Language ________________

Educational/Therapy Programs____

____

____

____

Growth History
Significant past medical hisotry (eg seizures, surgeries, hospitalizations, meds.)

____

____

____

Review of Systems

____

____

____

Previous Evaluations (eg imaging studies, EEG, Labs, etc.)

____

____

____

Physical Examination

HT _______ (_____%) WT _______ (_____%) HC _______ (_____%)

US/LS ________ SPAN ________ RESP _______ BP ________

TEMP _______ CC _______ IN _______ (_____%) IC _______ (_____%)

OC _______ (_____%) IP _______ (_____%) PF _______ (_____%)

Ocular Measurements

________ WNL

________ Hypotelorism

________ Hypertelorism

HAND ______ (_____% OF HT) MF ______ (_____% OF HAND LENGTH)
FOOT ______ (_____% OF HT)

Head
Shape ________________________________ AF _______________

Forehead ____

Hair ____

Ant. Hairline ___________________ Post. Hairline _______________

Eyes

Palperbral angle ____

Red Reflex _______________________ PERRL _________________

Range of
Movement ____

Irises ____

Lashes ______________________ Brows ______________________

Nose

Bridge _____________________________ Tip___________________

Nares ____

Ears

Size (R)____________________________ (L)_________________

Positi____

Shap____

Tags ____

Mouth

Lips ____________________________ Philtrum________________

Corners (check one) UP______ DOWN ______

Palate____

Teeth ____

Neck
Comments

Chest/Lungs
Comments

Heart
Comments

Abdomen
Comments

____

____

____

____

Spine/Back
Comments

____

____

____

____

Genitalia
Comments

____

____

____

____

Neurological

DTR's ____

Tone _______________ Mass_______________ Strength_____________

Development____

Extremities

Palmar crease ____

Digits ____

Skin
Comments

____

____

Impression

Assessment

Recommendations/Plans

Signature/Date