GENETICS NEW PATIENT QUESTIONNAIRE

Form completed by: Relationship to patient: Date:

Patient Information

Name: Date of Birth:

Reason for Genetics appointment:

Main question(s) you want to have addressed:

Main concern(s) about the patient:

Pregnancy History

How many pregnancies did patient's mother have before having the patient?

Indicate number of miscarriages, if any: Indicate number of terminations, if any:

Please check if the patient's mother had any of the following during the pregnancy:

Illnesses	☐No	☐Yes	☐Unknown
Fever	☐No	☐Yes	☐Unknown
Bleeding	☐No	☐Yes	☐Unknown

Was the patient's mother exposed to any of the following? (If yes, describe amount and approximate time during the pregnancy):

Alcohol	☐No	☐Yes
Cigarettes	☐No	☐Yes
Illicit Drugs	☐No	☐Yes
Medications	☐No	☐Yes

Please check if the patient's mother had any of the following during the pregnancy:

Blood tests to screen for Down syndrome	☐No	☐Yes	☐Unknown
Nuchal translucency	☐No	☐Yes	☐Unknown
Non-invasive prenatal testing (NIPT)	☐No	☐Yes	☐Unknown

Ultrasound	☐No	☐Yes	☐Unknown
Amniocentesis or Chorionic Villus Sampling (CVS)	☐No	☐Yes	☐Unknown

Birth History

Was patient full term? ☐Yes ☐No (If no, how many weeks/days):

Delivery Mode: ☐Vaginal ☐ C-Section (Reason):

Birth Hospital:

Birth Weight:

Birth Length:

Birth Head Circumference:

Were there any complications with the patient immediately after birth? ☐No ☐Yes (Please explain):

Did the patient go home from the hospital at the same time as mom did? ☐No ☐Yes (Please explain):

Medical History

Please check if the patient has had any of the following. If "yes" please provide more information and the name of the doctor who has seen the patient for the issue.

	No	Yes	Unknown
Previous genetics evaluation	☐	☐	☐
Previous genetic testing	☐	☐	☐
Imaging (X-Ray, MRI, CT, ultrasound)	☐	☐	☐
Eyes/vision	☐	☐	☐
Ears/hearing, Nose, Mouth, Throat	☐	☐	☐
Cardiovascular/Heart	☐	☐	☐
Gastrointestinal/Stomach	☐	☐	☐
Genital or kidney problems	☐	☐	☐
Muscles/Bones/Joints	☐	☐	☐
Neurological/Brain/Development	☐	☐	☐
Endocrine/Hormones/Puberty	☐	☐	☐
Immunologic/Lymphatic	☐	☐	☐
Respiratory/Lungs/Breathing	☐	☐	☐
Skin/Hair/Nails	☐	☐	☐

	No	Yes	Unknown
Psychiatric/Mental Health	☐	☐	☐
Hematologic/Blood/Cancer	☐	☐	☐
Unusual growth (weight/height/head size)	☐	☐	☐

Other:

Other Medical History

	No	Yes (please explain):
Has the patient had hospitalizations?	☐	☐
Has the patient had surgeries?	☐	☐
Is the patient taking medications?	☐	☐

Development

Please list approximate age when patient first did the following:

Rolled over:
Sat:
Walked:
First words:
Toilet trained:

How is present speech? ☐Normal for age ☐Delayed

Has patient lost any milestones? ☐No ☐Yes (please explain):

Has patient had a developmental assessment? ☐No ☐Yes (If yes, when and where):

Has patient IQ testing? ☐No ☐Yes (If yes, when, where, results):

Behavior: ☐Typical ☐Atypical (Describe concerning behaviors):

Therapies

Check if patient is receiving therapy (please include how long the patient has been receiving the therapy and where the therapy services occur):

Speech therapy ☐No ☐Yes:
Physical therapy ☐No ☐Yes:
Occupational therapy ☐No ☐Yes:

Other:	☐	☐		☐
Is the patient a client of the Regional Center?	☐	☐	☐No ☐Yes	☐
	☐	☐		☐

Is the patient in an Early Start program now ? ☐No ☐Yes
Is the patient a client of the California Children's Services (CCS)? ☐No ☐Yes

School Performance

If your child is in school, please complete the following:
School name:
Grade:
Class type: ☐Advanced ☐Regular ☐Special Education
Performance: ☐Excellent ☐Average ☐Poor
Areas of difficulty:

Family History

How old are the patient's parents: Mother_____ Father:_____
What are the ethnic backgrounds of the patient's parents? Mother_____ Father_____
Are the patient's parents related by blood (share common ancestors)? ☐No ☐Yes (If yes, how are they related?)

List number of brothers and sisters of the patient and their ages:

Has any relative had any of the following conditions? (If yes, please explain relationship to patient)

Intellectual disability/Mental retardation	☐No	☐Yes:
Birth defects	☐No	☐Yes:
Epilepsy/Seizures	☐No	☐Yes:
Autism	☐No	☐Yes:
Learning disabilities	☐No	☐Yes:
Psychiatric illness	☐No	☐Yes:
Childhood deaths	☐No	☐Yes:
History of 3 or more miscarriages	☐No	☐Yes:
Stillbirths	☐No	☐Yes:
Any inherited disorders	☐No	☐Yes:

Social History

Who lives at home with the patient?

Occupations of parents: Mother_____ Father _____

DATE TIME Provider Signature: Credentials ☐MD ☐PA ☐NP

PRINT Name: Dictation Number: