



**GENETICS NEW PATIENT QUESTIONNAIRE**

**INSTRUCTIONS:** Please complete this form as completely as possible and fax or mail, using the information at the top of the page, prior to scheduling your appointment. **You can type in the fields on this form and save this document.** Delays in sending this form may result in scheduling your appointment for a later date.

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PRIMARY DOCTOR: \_\_\_\_\_

REFERRING DOCTOR (if different): \_\_\_\_\_

PROBLEM OR CONCERN REQUIRING A GENETICIST: \_\_\_\_\_

**Birth History**

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Head circumference: \_\_\_\_\_

Full term  yes  no (If no: \_\_\_\_\_ weeks/days). APGAR scores \_\_\_\_\_

Delivery:  Vaginal or  C-section Reason: \_\_\_\_\_

Procedures: CVS, Amniocentesis: \_\_\_\_\_

Medications, illnesses, exposures during pregnancy: \_\_\_\_\_

**Mom's Pregnancy:**

Uncomplicated

Complications: \_\_\_\_\_

**Postnatal (After birth) Complications**

None

Complications: \_\_\_\_\_

Other notes: \_\_\_\_\_

**Developmental History**

Rolled over at: \_\_\_\_\_ Sat at: \_\_\_\_\_ Crawled at: \_\_\_\_\_

Pulled to stand: \_\_\_\_\_ Walked at: \_\_\_\_\_ Spoke first words: \_\_\_\_\_

Any regression of speech? \_\_\_\_\_

Physical, speech, occupational or other therapy services? \_\_\_\_\_

**Behavior / Socialization**

Average/Typical

Abnormal (if yes, continue below)

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## Has there been any history of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Poor eye contact                                     | <input type="checkbox"/> Lack of interest in interacting with peers            |
| <input type="checkbox"/> Delay in speech                                      | <input type="checkbox"/> Repetition of words or phrases                        |
| <input type="checkbox"/> Head banging   | <input type="checkbox"/> Difficulty transitioning from one activity to another |
| <input type="checkbox"/> Repetitive movements (hand flapping, turning)        | <input type="checkbox"/> Food or texture avoidance                             |
| <input type="checkbox"/> Fascination with certain objects or parts of objects | <input type="checkbox"/> Regression in development                             |

## Academic School Performance

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Excellent | <b>School Name:</b> _____  |
| <input type="checkbox"/> Average   | <b>Grade:</b> _____  |
| <input type="checkbox"/> Poor      | <b>Class type:</b> <input type="checkbox"/> Advanced <input type="checkbox"/> Regular <input type="checkbox"/> Special Education |

Learning disability?  Yes       No

Which areas are difficult?

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## Medical History

Hospital admissions

When and why:

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Surgeries

When and why: \_\_\_\_\_

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- |   |  |
|---|--|
| <input type="checkbox"/> Seizures <input type="checkbox"/> with fever or <input type="checkbox"/> without fever | <input type="checkbox"/> Acidosis                        |
| <input type="checkbox"/> Breath-holding spells  | <input type="checkbox"/> Ketosis                         |
| <input type="checkbox"/> Hearing loss   | <input type="checkbox"/> Hypoglycemia or low blood sugar |
| <input type="checkbox"/> Vision loss/blindness  |  |

Other specialist evaluations (Endocrine, Neurology, Cardiology, etc)

When and why:

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Any previous evaluations by a geneticist?  Yes       No

When and why:

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Any previous genetic testing?       Yes       No

Please summarize any known results:

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Any previous imaging (echocardiogram, ultrasound, X-ray, MRI, CT scan, endoscopy, etc)?

Yes       No

When and why:

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Results:

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### Medications

Name	Date Prescribed	Reason for Taking

Allergies: \_\_\_\_\_

### Family History

Has any other relative had any of the following conditions?

- |  |  |
|--|--|
| <input type="checkbox"/> Epilepsy/Seizures                             | <input type="checkbox"/> Headaches/ Migraines                  |
| <input type="checkbox"/> Cerebral palsy                                | <input type="checkbox"/> Muscle disorders or diseases          |
| <input type="checkbox"/> Learning disabilities                         | <input type="checkbox"/> Psychiatric illnesses                 |
| <input type="checkbox"/> Autism  | <input type="checkbox"/> Intellectual impairment/disability    |
| <input type="checkbox"/> Early onset of cancer, or any unusual cancers | <input type="checkbox"/> Strokes at younger than 40 years      |
| <input type="checkbox"/> Aneurysms                                     | <input type="checkbox"/> History of 3 or more miscarriages     |
| <input type="checkbox"/> Early childhood deaths                        | <input type="checkbox"/> Stillbirth(s)                         |
| <input type="checkbox"/> Blindness                                     | <input type="checkbox"/> Deafness or hearing loss              |
| <input type="checkbox"/> Autoimmune disease(s)                         | <input type="checkbox"/> Birth defects (including internal)    |
| <input type="checkbox"/> Known genetic or inherited disorder           | <input type="checkbox"/> Other, unlisted condition to consider |

Please briefly explain any checked boxes above:

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### Social History

Where does patient live (home, care facility, etc): \_\_\_\_\_

Who else lives with patient? \_\_\_\_\_

Patient's profession: \_\_\_\_\_

Parent/caregiver professions: \_\_\_\_\_

Any recent moves or major life events in the family which may impact health?

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## GENETICS NEW PATIENT QUESTIONNAIRE

Are the patient's mother and father are related to one another by blood (share common ancestors)?  Yes  No

If so, how are they related? \_\_\_\_\_

Family Member	Age	Relevant Health Condition	Ethnicity
<b>Father</b>			
<b>Mother</b>			
<b>Brother 1.</b>			
<b>Brother 2.</b>			
<b>Brother 3.</b>			
<b>Brother 4.</b>			
<b>Brother Others</b>			
<b>Sister 1.</b>			
<b>Sister 2.</b>			
<b>Sister 3.</b>			
<b>Sister 4.</b>			
<b>Sister Others:</b>			
<b>Child 1.</b>			
<b>Child 2.</b>			
<b>Child 3.</b>			
<b>Child 4.</b>			
<b>Child Others:</b>			
<b>Paternal Grandfather</b>			
<b>Paternal Grandmother</b>			
<b>Maternal Grandfather</b>			
<b>Maternal Grandmother</b>			
<b>More Distant Relatives 1.</b>			
<b>More Distant Relatives 2.</b>			
<b>More Distant Relatives 3.</b>			
<b>More Distant Relatives 4.</b>			

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## Review of Systems

Please indicate any patient health issues, concerns or problems in any of the following areas:

- |   |   |
|---|---|
| <input type="checkbox"/> General health, well being, height or weight | <input type="checkbox"/> Cardiovascular / Heart                   |
| <input type="checkbox"/> Ears/Hearing, Nose, Mouth, Throat            | <input type="checkbox"/> Gastrointestinal / GI / Stomach / Bowels |
| <input type="checkbox"/> Respiratory / Lungs / Breathing              | <input type="checkbox"/> Skin / Hair / Nails                      |
| <input type="checkbox"/> Muscles / Skeleton / Bones / Joints          | <input type="checkbox"/> Psychiatric / Mental Health              |
| <input type="checkbox"/> Neurological / Brain / Development           | <input type="checkbox"/> Hematologic / Blood / Cancer             |
| <input type="checkbox"/> Endocrine / Hormones / Puberty               | <input type="checkbox"/> Immunologic / Infections / Allergies     |
| <input type="checkbox"/> Lymphatic/ Body or tissue fluid retention    | <input type="checkbox"/> Genital / Bladder / Kidney / Urinary     |
| <input type="checkbox"/> Eyes or vision                               | <input type="checkbox"/> Other                                    |

**Please briefly explain any checked boxes above:**

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**Form completed by:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

In case we have questions regarding this form, please indicate the best time for our genetic counselor to reach you, as indicated below:

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Best phone number to reach you: \_\_\_\_\_

- Home     Work     Cell

**Thank you for taking the time to complete this questionnaire. Your responses will help us focus your upcoming appointment specifically to your needs.**

**Jacqueline Chui, MS, LCGC**  
**Genetic Counselor**

**Eric A. Muller II, MD, PhD**  
**Clinical Geneticist**



Lucile Packard  
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