Stanford Children's Health | Lucile Packard Children's Hospital Stanford
Sutter Health CPMC We Plus You

Clinical Genetics
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L15495-Genetics New Questionnaire

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)

Has there been any history of the following?

☐ Poor eye contact
☐ Delay in speech
☐ Head banging
☐ Repetitive movements (hand flapping, turning)
☐ Fascination with certain objects or parts of objects
☐ Lack of interest in interacting with peers
☐ Repetition of words or phrases
☐ Difficulty transitioning from one activity to another
☐ Food or texture avoidance
☐ Regression in development

Academic School Performance

☐ Excellent
☐ Average
☐ Poor

School Name: _____
Grade: _____
Class type: ☐ Advanced ☐ Regular ☐ Special Education

Learning disability? ☐ Yes ☐ No
Which areas are difficult?

Medical History

☐ **Hospital admissions**
When and why:

☐ **Surgeries**
When and why: _____

☐ Seizures ☐ with fever or ☐ without fever
☐ Breath-holding spells
☐ Hearing loss
☐ Vision loss/blindness
☐ Acidosis
☐ Ketosis
☐ Hypoglycemia or low blood sugar

☐ Other specialist evaluations (Endocrine, Neurology, Cardiology, etc)
When and why:

Any previous evaluations by a geneticist? ☐ Yes ☐ No

When and why:

Any previous genetic testing? ☐ Yes ☐ No

Please summarize any known results:

Any previous imaging (echocardiogram, ultrasound, X-ray, MRI, CT scan, endoscopy, etc)?
☐Yes ☐ No
When and why:

_____

Results:

_____

Medications

Name	Date Prescribed	Reason for Taking

Allergies: _____

Family History

Has any other relative had any of the following conditions?

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

Please briefly explain any checked boxes above:

_____

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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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
Father			
Mother			
Brother 1.			
Brother 2.			
Brother 3.			
Brother 4.			
Brother Others			
Sister 1.			
Sister 2.			
Sister 3.			
Sister 4.			
Sister Others:			
Child 1.			
Child 2.			
Child 3.			
Child 4.			
Child Others:			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
More Distant Relatives 1.			
More Distant Relatives 2.			
More Distant Relatives 3.			
More Distant Relatives 4.			

Review of Systems

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

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

Please briefly explain any checked boxes above:

_____

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:

_____

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

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