Children's Hospital of Pittsburgh of UPMC

DIVISION OF MEDICAL GENETICS
CONFIDENTIAL QUETIONAIRE
FOR FOLLOW-UP PATIENTS

In order to help us get to know the patient and concerns better, please answer the following questions to the best of your abilities. Please note there is a front and back to each sheet. This information will be held confidential and will not be released without your permission. Thank you.

Patient's Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____

Date of Appointment: _____

Name of any family member(s) evaluated in Genetics (if applicable): _____

Please describe briefly the problem(s) for which we are seeing the patient and when you first noticed these problems:

1) _____

2) _____

3) _____

Please list the main questions you would like us to attempt to answer:

1) _____

2) _____

3) _____

Please list any non-CHP doctor or other health care professional the patient has seen for these problem(s):

	Name	**City**	**Dates**
1)			
2)			
3)			

Past Medical History:

Has the patient ever been **hospitalized overnight** or had any **operations**? Please provide all details: for example, how old was the patient, where was he/she hospitalized, what was the length of the stay, etc.

_____

_____

_____

Please list all current medications and doses the patient is taking, including over-the-counter medications: (attach separate sheet if necessary)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list all **medication allergies** and provide details about what happened when medication was given.

_____

_____

_____

_____

Immunizations up to date? ☐ Yes ☐ No

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CONFIDENTIAL QUESTIONAIRE
FOR FOLLOW-UP PATIENTS

REVIEW OF SYSTEMS Date of Visit:

Does you child currently have problems with (please indicate past problems with "P")

GENERAL	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Growth		☐ Yes ☐ No ☐ P
Weight Gane/Loss		☐ Yes ☐ No ☐ P

CARDIAC SYMPTOMS	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Chest Pain		☐ Yes ☐ No ☐ P
Palpitations		☐ Yes ☐ No ☐ P
High Blood Pressure		☐ Yes ☐ No ☐ P
Loss of Consciousness		☐ Yes ☐ No ☐ P
Diziness/lightheadedness		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

RESPIRATORY SYMPTOMS	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Shortness of Breath		☐ Yes ☐ No ☐ P
Asthma		☐ Yes ☐ No ☐ P
Wheezing		☐ Yes ☐ No ☐ P
Snoring		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

GI SYMPTOMS	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Diarrhea		☐ Yes ☐ No ☐ P
Constipation		☐ Yes ☐ No ☐ P
Reflux		☐ Yes ☐ No ☐ P
Abdominal Pain		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

NEUROLOGICAL SYMPTOMS	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Headaches/Migraines		☐ Yes ☐ No ☐ P
Seizures		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

SKIN	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Birthmarks/Moles		☐ Yes ☐ No ☐ P
Poor wound healing or abnormal scarring		☐ Yes ☐ No ☐ P
Prolonged bleeding		☐ Yes ☐ No ☐ P
Easy bruising		☐ Yes ☐ No ☐ P
Stretch marks		☐ Yes ☐ No ☐ P
Hyperelastic Skin		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

KIDNEY/LIVER	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Kidney problem		☐ Yes ☐ No ☐ P
Liver problem		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

GENITAL/URINARY	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Abnormal smell/color of urine		☐ Yes ☐ No ☐ P
Early signs of puberty		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

VISION/EYES	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**	
Vision Problems		☐ Yes ☐ No ☐ P	
Nearsighted		☐ Yes ☐ No ☐ P	
Farsighted		☐ Yes ☐ No ☐ P	
Astigmatism		☐ Yes ☐ No ☐ P	
Glasses/Contacts		☐ Yes ☐ No ☐ P	RX: _____
Other		☐ Yes ☐ No ☐ P	

(cont.)

REVIEW OF SYSTEMS (cont.) Date of Visit:

Does you child currently have problems with (please indicate past problems with "P")

HEARING/EARS	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Hearing problems		☐ Yes ☐ No ☐ P
Frequent ear infections		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

DENTAL	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Problems with teeth		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

MUSCULOSKELETAL	☐ **NO CHANGE SINCE LAST VISIT**	**PLEASE CHECK**
Joint Pain		☐ Yes ☐ No ☐ P
Joint dislocation		☐ Yes ☐ No ☐ P
Frequent fractures		☐ Yes ☐ No ☐ P
Joint hyperflexibility		☐ Yes ☐ No ☐ P
Scoliosis		☐ Yes ☐ No ☐ P
Numbness or tingling in arms or legs		☐ Yes ☐ No ☐ P
Other		☐ Yes ☐ No ☐ P

OTHER _____

If you are an adult patient, please skip to Social History.

Development:

Do you think the patient has developed normally? ☐ Yes ☐ No ☐ Unsure

As best as you can recall, at what age did the patient achieve these milestones? **Please specify months versus years**

Rolled over_____ Sat alone_____ Crawled_____ Walked_____ Said First Words_____ Toilet Trained_____

Social History:

Where does the patient currently go to school or daycare? _____

What is the current grade level? _____ Has the patient ever repeated a grade, if so, which? _____

Does the patient require a special classroom? ☐ Yes ☐ No If yes, what type: SLD, EH, EMH, TMH, or other: _____

Do they receive special services, physical, speech or occupational therapies? ☐ Yes ☐ No

If Yes, please list service and how often received:

Physical _____ Speech _____ Occupational Therapies _____

Developmental _____ Vision _____

Has the patient's intelligence or development ever been tested? ☐ Yes ☐ No

If yes, by whom, where and when: _____

Who does the patient live with? Please list all adults and children who live in the same house and their relationship to the patient?

_____

_____

Please note if the patient is adopted or in foster care. _____

Please provide the following information about the parents

	Age	**Highest level of school completed**	**Current employment/occupation**
Mother:	_____	_____	_____
Father:	_____	_____	_____

Parents are (check correct choice) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced

This form was completed by:

Name: _____ Relationship to the patient: _____

Signature: _____ Date: _____

This form was reviewed by:

Name: _____ Credential: _____

Signature: _____ Date: _____ Time: _____