Children's Hospital of Pittsburgh of UPMC

DIVISION OF MEDICAL GENETICS
CONFIDENTIAL QUESTIONAIRE
FOR NEW 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)			

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

Pregnancy History:

Age of mother at delivery of patient: _____ Number of prior pregnancies prior to the patient's birth: _____

Did mother receive regular prenatal care? ☐ Yes ☐ No If yes, beginning at what month of pregnancy: _____

Were any of the below a concern during pregnancy?

Please check as appropriate. If the answer is yes, provide additional details in the provided space.

Febrile illness/fevers	☐ Yes _____	☐ No
High blood pressure	☐ Yes _____	☐ No
Diabetes	☐ Yes _____	☐ No
Beer, wine or liquor use (if yes, how much)	☐ Yes _____	☐ No
Cigarette use (if yes, how many packs/day)	☐ Yes _____	☐ No
Abnormal bleeding	☐ Yes _____	☐ No
Early labor	☐ Yes _____	☐ No
Trauma or accidents	☐ Yes _____	☐ No
Infections (CMV, toxoplasmosis, chicken pox	☐ Yes _____	☐ No
Were there concerns about baby's movements in the womb	☐ Yes _____	☐ No
Any special tests done	☐ Yes _____	☐ No

List any medications or drugs taken during pregnancy:

1. _____
2. _____
3. _____

Birth:

Where was the patient born? City and State: _____ Hospital: _____

Birth Weight _____ Birth Length _____ Birth Head Circumferance _____ Method of Delivery: ☐ Vaginal ☐ Cesarean

If by Cesarean section, why? _____

Head or bottom first? _____ Was there use of ☐ forceps ☐ vacuum ☐ neither

Was infant born prematurely? (If so, how early) ☐ Yes _____ ☐ No

Apgar scores: _____ at 1 minute _____ at 5 minutes _____ ☐ don't know

Did infant need any of the following? (Add details as needed)

CPR or resuscitation after birth ☐ Yes _____ ☐ No

Special Care or Intensive care nursery ☐ Yes _____ ☐ No

If yes, when and how long _____

Antibiotics ☐ Yes _____ ☐ No

Ventilator use ☐ Yes _____ ☐ No

Bilirubin lights for yellow jaundice ☐ Yes _____ ☐ No

Blood transfusions ☐ Yes _____ ☐ No

Were any of the following a problem in the nursery? (Add details as needed)

Breathing problems ☐ Yes _____ ☐ No

Infections ☐ Yes _____ ☐ No

Seizures ☐ Yes _____ ☐ No

Feeding problems ☐ Yes _____ ☐ No

Birth marks ☐ Yes _____ ☐ No

Deformities or birth defects ☐ Yes _____ ☐ No

Paralysis ☐ Yes _____ ☐ No

How old was the patient when sent home from the nursery? _____

Do you have any other concerns regarding pregnancy or birth? _____

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

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

(cont.)

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REVIEW OF SYSTEMS (cont.) Date of Visit:

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

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_____

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Family History:

Please list name and age of all brothers and sisters, note if they have a different mother or father.

Other than the child seen today, does anyone in the family have any of these conditions? Please state **who** has the condition

Epilepsy/seizures without fever	☐ Yes	☐ No	Learning disabilities	☐ Yes	☐ No
Seizures with fever	☐ Yes	☐ No	Attention deficit disorder	☐ Yes	☐ No
Severe headaches	☐ Yes	☐ No	Fainting spells	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Nerve or muscle diseases	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Early or sudden death	☐ Yes	☐ No
Tics or Tourette's syndrome	☐ Yes	☐ No	Deafness	☐ Yes	☐ No
Birth defects	☐ Yes	☐ No	Paralysis/palsies, in a wheelchair	☐ Yes	☐ No
Slow Development	☐ Yes	☐ No	Psychiatric problems	☐ Yes	☐ No
Breath-holding spells	☐ Yes	☐ No	Mental retardation	☐ Yes	☐ No

Details regarding family history: _____

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: _____