NEW PATIENT QUESTIONNAIRE - GENETICS DEPARTMENT

Name: ______________________________ Medical Record #: _______________
DOB: ______________________ Age: ___________ Male/Female: _________

REASON FOR VISIT:
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PREGNANCY HISTORY:
Mother's age at delivery ___________ What number pregnancy was this baby? ___________
Complications during pregnancy ☐ YES ☐ NO
If yes, please describe:____
Any maternal conditions (diabetes, etc.)? ☐ YES ☐ NO
If yes, please describe: ____

Any exposures to the below? ☐ YES ☐ NO If yes, please indicate how much and when:

- ☐ Alcohol ____
- ☐ Cigarettes ____
- ☐ Drugs ____
- ☐ Medications ____
- ☐ X-rays ____
- ☐ Chemicals/Other exposures ____

Testing performed? ☐ YES ☐ NO If yes, please indicate below:
☐ Ultrasound _________________ ☐ Blood tests/serum screening ___________________
☐ CVS/Amniocentesis ____________________________________

BIRTH HISTORY:
Delivered at Kaiser Hospital ☐ YES ☐ NO
Full term delivery? ☐ YES ☐ NO If no, how many weeks early? __________________
Birth weight: ___________ Birth length: __________ Head circumference: ________
APGAR scores (if known): _____________________
Any complications after birth? ☐ YES ☐ NO If yes, please describe:
____
____
How long did the baby stay in the hospital after birth? ☐ 2 days ☐ 4 days ☐ >1 week _______

DEVELOPMENTAL HISTORY:
Does your child have developmental delay? ☐ YES ☐ NO
Please indicate how old your child was when he/she:

Smiled socially		Walked along furniture	
Reached for objects		Walked alone	
Rolled over		Said his/her first word	
Sat alone		Combined two words together	
Crawled		Was toilet trained	
Pulled to stand			

Is your child in any therapy program? ☐ YES ☐ NO
- ☐ Physical therapy: ☐ KAISER ☐ REG CTR ☐ SCHOOL
- ☐ Occupational therapy: ☐ KAISER ☐ REG CTR ☐ SCHOOL
- ☐ Speech/language therapy: ☐ KAISER ☐ REG CTR ☐ SCHOOL
- ☐ Other therapy: ☐ KAISER ☐ REG CTR ☐ SCHOOL

Is your child in special education? ☐ YES ☐ NO

MEDICAL HISTORY:

Does your child have any significant medical concerns that you want us to be aware of?

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Does your child have any issues with the following?: ☐ YES ☐ NO

If yes, please describe:
- ☐ Sleeping ____
- ☐ Urination ____
- ☐ Bowel movements ____
- ☐ Appetite ____
- ☐ Hearing ____
- ☐ Vision ____
- ☐ Any other ____

FAMILY HISTORY:

How many children do you have?____ Please list with ages and if there are any developmental or medical concerns.

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Are there any individuals in your family with the following?: ☐ YES ☐ NO

If yes, please describe:
- ☐ Developmental delay/speech delay ______________________________
- ☐ Birth defects (cleft lip/palate, heart defect, etc.) ___________________________
- ☐ Autism _____________________________
- ☐ Hearing loss ______________________________
- ☐ Similar medical issues to your child _____________________________
- ☐ Known genetic condition ______________________________