OU Children's Physicians - Genetics Questionnaire

Please complete this questionnaire and return it to the front desk. If you cannot answer a question, leave it blank.

Problem: HOW CAN WE HELP YOU OR YOUR CHILD TODAY? _____

_____

_____

Prenatal history

(only complete if patient is a child)

Mother's age at birth of child _____ Father's _____

Any abnormalities seen on prenatal ultrasound? _____

_____

Did the mother of the baby have illnesses such as diabetes, thyroid disease, bacterial infection, seizures, or mental health disorder? _____

_____

Did the mother of the baby smoke cigarettes, drink alcohol, or use drugs during the pregnancy? _____

Was your child born on time? _____

Birth weight _____ Length _____

Vaginal birth or c-section? _____

Problems for your child at delivery? _____

Problems for your child in the nursery? _____

_____

How old was your child when he/she went home from the hospital, as a baby? _____

Medical History

If yes, please explain:

Past illnesses	no	yes
Surgeries	no	yes
Specialists seen	no	yes
X-ray, MRI, or ultrasound	no	yes
Heart problems	no	yes

_____

_____

_____

_____

_____

Family Health History

Does anyone in the family have:

If yes, list relationship to patient:

A child who died	no	yes
A miscarriage or stillborn	no	yes
Developmental delay	no	yes
Birth defect (cleft palate, heart defect, etc)	no	yes
Very short or very tall	no	yes
Seizures	no	yes
Cancer	no	yes
Other health condition	no	yes

_____

_____

_____

_____

_____

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_____

_____

Developmental History

at what age (in months) did your child reach these milestones:

Rolling over _____ Sitting up unassisted _____

Crawling _____ Walking alone _____

Saying words _____ Sentences _____

School

Grade: _____

Performance: _____

Does your child have an IEP (individualized education plan)?

_____

Has your child ever received physical, occupational, or speech therapies?_____

Behavior concerns: _____

Social History

Who lives in the home with the patient? _____

_____

Other concerns

_____

_____

_____