The Children's Hospital of San Antonio™
CHRISTUS Health

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Baylor College of Medicine

Genetics Clinic Pediatric Patient Questionnaire

To help us understand your child's medical situation, please answer the questions below. Select yes or no for each question as indicated, but you can use the space provided to add an explanation in your own words.

Your Information:

Name of the person filling out this form: _____

Relationship to patient: _____

Phone Number: _____ Email: _____

Patient Information:

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

Primary Care Physician (PCP) Name: _____

Name of Practice: _____

PCP Address: _____

PCP Phone Number: _____ PCP Fax Number: _____

Did another health care provider refer your child to our clinic? ☐ Yes ☐ No

If yes, referring health care provider: _____

Specialty: _____

What concerns do you have for your child, and what questions can the Genetics Team try to help answer?

Medical History

Surgery	Date	Comments

Has your child been hospitalized overnight? ☐ Yes ☐ No If Yes, when (date/age) and for what reason?

Does your child take a daily vitamin, any supplements, or any alternative treatments? ☐ Yes ☐ No If Yes, please describe:

Pregnancy History (for the pregnancy of the child with appointment)

Mother's age at delivery: _____ years Father's age at delivery: _____ years

What number pregnancy was this for the mother (1st, 2nd, 3rd, etc.)? _____

Number of living children when baby was born: _____ Pregnancy losses before this pregnancy: _____

The pregnancy was confirmed at about _____ ☐ weeks or ☐ months.

How far into the mother's pregnancy did she begin prenatal care? _____ ☐ weeks or ☐ months

How far into the mother's pregnancy did she begin prenatal vitamins? _____ ☐ weeks or ☐ months

Were reproductive technologies used to achieve this pregnancy? ☐ Yes ☐ No If Yes, please describe:

First movements of your child were felt at _____ months.

Describe your child's movements during the pregnancy (please check one): ☐ Normal ☐ Poor ☐ Very active

Mother's total weight gain during pregnancy: _____ pounds

Please provide information about testing that may have been done during the pregnancy.

Yes	No	Not sure	Test	Results (normal/abnormal and when occurred — 1st , 2nd, 3rd trimester)
☐	☐	☐	1st and/or 2nd trimester screen checking for chromosome conditions	
☐	☐	☐	Glucose Tolerance Test	
☐	☐	☐	Amniocentesis or Chorionic Villus Sample	
☐	☐	☐	Prenatal ultrasound	
☐	☐	☐	Carrier testing of parents	
☐	☐	☐	Other (please explain)	

Did the mother have any of the following during the pregnancy?

Yes	No		Provide details and when occurred — 1st , 2nd, 3rd trimester
☐	☐	Medications (List name(s) and when taken)	
☐	☐	Smoking (List amount/day and when)	
☐	☐	Alcohol (Beer, wine, or liquor? List type/amount/when)	
☐	☐	Street drugs (List type/amount/when)	
☐	☐	X-rays	
☐	☐	Bleeding	
☐	☐	Illness/Infection	
☐	☐	Fever	
☐	☐	Rash	
☐	☐	Diabetes	
☐	☐	Thyroid Problems	
☐	☐	High blood pressure	
☐	☐	Preeclampsia	
☐	☐	Premature Labor	
☐	☐	Hospitalization during pregnancy (besides delivery)	
☐	☐	Abnormal growth of baby	
☐	☐	Abnormal amount or leaking of amniotic fluid	
☐	☐	Specialist - list name of provider	
☐	☐	Other concerns	

Birth History (for the birth of the child with the appointment)

Birth Hospital: _____ City: _____ State: _____

At how many weeks was your child born? _____ (i.e., 37 weeks, full term, premature)

Was the labor: ☐ Spontaneous ☐ Induced How was you child delivered? ☐ Vaginal ☐ C-section

If C-section, please explain reason why (i.e. previous child born that way, failure to progress, breech, etc.):

Child's birth weigh? _____ pounds _____ ounces/_____ kg

Child's birth length: _____ Child's birth head size: _____

Were there any problems right after birth such as need to go to the NICU, feeding problems, breathing problems, jaundice, etc.?

☐ Yes ☐ No If yes, please explain:

Was your child transferred after birth? ☐ Yes ☐ No If yes, which hospital? _____

Did the mother experience any problems following delivery? ☐ Yes ☐ No If yes, please describe:

Was your child born with any birth defects such as clubfoot, cleft lip or palate, heart defect, extra fingers or toes?

☐ Yes ☐ No If yes, please describe:

Did your child need tube feeding? ? ☐ Yes ☐ No If yes, please explain:

Did your child pass the newborn screening test (heel prick)? ☐ Yes ☐ No If no, please explain:

Did your child pass the newborn hearing test? ☐ Yes ☐ No If no, please explain:

How old was your child at the time of discharge from the hospital? _____ days old/_____ weeks old/_____months old

Early Development:

How old was your child when he/she began to do each skill below?

Skill	Attained (months or years)
Smile	
Roll over	
Sit alone	
Crawl	
Stand alone	
Walk	

Skill	Attained (months or years)
Say first words	
Say 2 to 3 words together	
Use a spoon	
Bladder trained	
Bowel trained	
Dress self	

Please describe any concerns about your child's development and when this was first noticed?

Has your child lost any skills that he/she previously mastered? ☐ Yes ☐ No If yes, please explain:

School information:

Does your child currently attend school or day care? ☐ Yes ☐ No

If yes, what is the name of the school/day care? _____ Grade, if applicable: _____

Does your child attend special classes or need special help? ☐ Yes ☐ No If yes, please describe:

Has your child ever had IQ testing or a formal developmental assessment? ☐ Yes ☐ No If yes, results:

Does your child have any behavioral problems? ☐ Yes ☐ No If yes, please describe:

Does your child receive any of the following?

Yes	No		Frequency/Location/Name of Agency
☐	☐	Physical therapy	
☐	☐	Occupational therapy	
☐	☐	Speech therapy	
☐	☐	Other therapy (please describe)	

Past Medical History:

Has your child ever seen a doctor in these specialties?

Yes	No		Physician's Name/Reason/Date of Last Visit
☐	☐	Allery/Immunology	
☐	☐	Audiology (Hearing)	
☐	☐	Cardiology (Heart)	
☐	☐	Dermatology (Skin)	
☐	☐	Developmental	
☐	☐	Ear, Nose and Throat	
☐	☐	Endocrinology (Hormones)	
☐	☐	Gastroenterology (Stomach/Intestines)	
☐	☐	Hematology/Oncology (Blood/Cancer)	
☐	☐	Nephrology (Kidneys)	
☐	☐	Neurology (Brain)	
☐	☐	Neurosurgery	
☐	☐	Ophthalmology (Eyes)	
☐	☐	Orthopedics (Bones)	
☐	☐	Psychology/Psychiatry	
☐	☐	Pulmonology (Lungs)	
☐	☐	Rheumatology (Joints)	
☐	☐	Urology	

If your child has seen someone in genetics before, please answer the following questions:

Name of geneticist: _____

Location of clinic: _____ Date of appointment? _____

Do you have a copy of the evaluation? ☐ Yes ☐ No

Was any genetic testing done? ☐ Yes ☐ No ☐ Not Sure

If yes, please make sure to provide copies of all prior genetic test results before your child's new genetics appointment.

Has your child had any of the following?

Yes	No		List when, where, and result
☐	☐	Formal eye examination	
☐	☐	Formal hearing test	
☐	☐	MRI or CT scan	
☐	☐	X-rays	
☐	☐	Ultrasound	
☐	☐	Echocardiogram of the heart	
☐	☐	Other special procedures such as EEG, swallow study, etc.	
☐	☐	Biopsies	