Genetics and Genomics Institute
311 S L Street • Tacoma, WA, 98405
Phone: 253-403-3476 • Fax: 253-403-8674

GENETICS CLINIC INTAKE FORM – HYPERMOBILE CHILD

Welcome

To help us prepare for your child's upcoming visit to the Mary Bridge Genetics Clinic, please take a few minutes to fill out this health information survey prior to your visit.

Patient Information

Patient Name: Today's date:

Age: Date of birth:

Primary care provider:
Specialists your child has seen:
Eye specialist (ophthalmologist, optometrist):
Heart specialist (cardiologist):
Other specialists:
Have you or anyone else in the family seen a geneticist before, or had genetic testing?
☐ No ☐ Yes _____

Medical History

Please tell us why your child is coming to genetics clinic. What are your main concerns?

Patient Identification - Write in or attach patient label

Name

MRN#

CSN #

Age /Sex and Gender

GENETICS CLINIC INTAKE FORM
HYPERMOBILE CHILD

Mary Bridge Children's

88-5652-7 (5/19)

Does your child have any health issues?

☐ No ☐ Yes_____

Has your child ever been hospitalized overnight?

☐ No ☐ Yes_____

Has your child ever had surgery?

☐ No ☐ Yes_____

Does your child take any medication regularly? (Include over the counter medications, vitamins, herbal, homeopathic and other remedies.)

☐ No ☐ Yes_____

Does your child have any allergies?

☐ No ☐ Yes_____

Does your child have a history of any of the following? If you answer yes, please describe.

Joints that seem unusually flexible

☐ No ☐ Yes_____

Joints that feel like they pop out of place

☐ No ☐ Yes_____

Joints that dislocated and required medical treatment

☐ No ☐ Yes_____

Unusual scars

☐ No ☐ Yes_____

Vision problems

☐ No ☐ Yes_____

Heart problems

☐ No ☐ Yes_____

Birth and prenatal history

Prenatal History ☐ Prenatal Information not known (check box and proceed to birth history)
Location of prenatal care: _____
What prenatal testing did patient's mother have? *(Check all that apply)*
☐ Blood test for Down syndrome and other conditions (for example, AFP, Triple / Quad / Sequential / Integrated screen / NIPT) ☐ Glucose (sugar) Test ☐ Ultrasound
☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other: _____
☐ Fetal echocardiogram
☐ Had testing, but not sure which test
Describe any abnormal results: _____

Which of these applied to patient's mother's pregnancy? *(Check all that apply)*
☐ Information not known
☐ Chronic illness ☐ Diabetes ☐ Medicine use_____
☐ Infection ☐ Fever ☐ Bleeding
☐ Tobacco use ☐ Alcohol use ☐ Drug use
☐ Prenatal vitamin use
☐ Other pregnancy complications: _____

_____

Birth History ☐ Birth information not known (check box and proceed to medical history)
Mother's age at birth: _____ Father's age at birth: _____
Length of pregnancy: _____ Delivery type: ☐ Vaginal ☐ C-section
Birth weight: _____ Birth length: _____ Head circumference: _____
Hospital: _____ Apgar score: _____ Length of hospital stay: _____
Birth complications, if any:
_____

_____

Developmental History

When did your child first…? *(If you cannot remember when, but your child can perform the task, check the box)*

Roll over		Smile	
Sit unsupported		Say first word	
Walk alone		Point to objects	
Use a spoon		Use two-word combinations	
Complete toilet training		Dress his/her self	

Education
Your child is in: *(check all that apply)*
☐ _____ Grade ☐ Regular Classes ☐ Special Education
☐ IEP ☐ 504 ☐ Physical Therapy
☐ Occupational Therapy ☐ Speech Therapy ☐ Other Therapy: _____

Do you have any concerns about your child's development or school performance?

☐ No ☐ Yes_____

Family History

Is there a history of any of the following in the family? If you answer yes, please add details.

Very flexible joints

☐ No ☐ Yes_____

Aneurysm

☐ No ☐ Yes_____

Intestine rupture

☐ No ☐ Yes_____

Uterine rupture

☐ No ☐ Yes_____

Pneumothorax (collapsed lung)

☐ No ☐ Yes_____

Sudden or unexpected death (not related to an accident or homicide)

☐ No ☐ Yes_____

Brothers and sisters of the patient (if half-siblings, please note maternal or paternal)

Name (first and last)	Date of Birth or approx. age	Sex	Medical problems past or present	If deceased, age at death and cause	# of children
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			

Mother's History

Date of birth _____ Height _____

# of Pregnancies _____ # of Live births _____

# of Miscarriages _____ # of Stillbirths _____

Medical Problems _____

Mother's brothers and sisters (if half-siblings, please note maternal or paternal):

Name (first and last)	Date of Birth or approx. age	Sex	Medical problems past or present	If deceased, age at death and cause	# of children
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			

Mother's parents:

Name (first and last)	Date of Birth or approx. age	Medical problems past or present	If deceased, age at death and cause
Patient's grandmother:			
Patient's grandfather:			

Father's History

Date of birth _____ Height _____

Medical Problems _____

Father's brothers and sisters (if half-siblings, please note maternal or paternal):

Name (first and last)	Date of Birth or approx. age	Sex	Medical problems past or present	If deceased, age at death and cause	# of children
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			
		n/a			

Father's parents:

Name (first and last)	Date of Birth or approx. age	Medical problems past or present	If deceased, age at death and cause
Patient's grandmother:			
Patient's grandfather:			

Health Review

Does your child have any of the following symptoms or health concerns? If yes, please add details.

If not applicable due to age, write NA or leave blank.

Sleep problems? ☐ No ☐ Yes_____

Trouble falling asleep? ☐ No ☐ Yes Fatigue? ☐ No ☐ Yes

Trouble staying asleep? ☐ No ☐ Yes Takes naps? ☐ No ☐ Yes

Poor sleep? ☐ No ☐ Yes

Appetite problems? ☐ No ☐ Yes_____

Special diet? ☐ No ☐ Yes G-tube/feeding tube? ☐ No ☐ Yes

Growth concerns? ☐ No ☐ Yes _____

Vision problems? ☐ No ☐ Yes _____

Prescribed glasses or contacts? ☐ No ☐ Yes

Hearing Problems? ☐ No ☐ Yes _____

Snoring? ☐ No ☐ Yes _____

Nasal congestion? ☐ No ☐ Yes _____

Dental problems? ☐ No ☐ Yes _____

Breathing problems? ☐ No ☐ Yes _____

Frequent cough? ☐ No ☐ Yes Frequent wheeze? ☐ No ☐ Yes

Heart problems? ☐ No ☐ Yes _____

Heart murmur? ☐ No ☐ Yes

Chest pain? ☐ No ☐ Yes

Fainting? ☐ No ☐ Yes

Ever had an echocardiogram? ☐ No ☐ Yes: Where/when: _____

Ever saw a heart doctor? ☐ No ☐ Yes: Where/when: _____

Abdominal problems? ☐ No ☐ Yes _____

Constipation? ☐ No ☐ Yes Vomiting? ☐ No ☐ Yes

Diarrhea? ☐ No ☐ Yes Reflux? ☐ No ☐ Yes

Urinary problems? ☐ No ☐ Yes _____

Joint problems? ☐ No ☐ Yes _____

Back problems? ☐ No ☐ Yes _____

Broken bones? ☐ No ☐ Yes _____

Rashes? ☐ No ☐ Yes _____

Birth marks or spots? ☐ No ☐ Yes _____

Neurologic problems? ☐ No ☐ Yes_____

Frequent headache? ☐ No ☐ Yes

Seizures? ☐ No ☐ Yes Attention problems? ☐ No ☐ Yes

Weakness? ☐ No ☐ Yes Anxiety? ☐ No ☐ Yes

Balance problems? ☐ No ☐ Yes Sadness? ☐ No ☐ Yes

Blood problems? ☐ No ☐ Yes _____

Easy bruising? ☐ No ☐ Yes Nosebleeds? ☐ No ☐ Yes

Easy bleeding? ☐ No ☐ Yes Anemia? ☐ No ☐ Yes

Frequent colds/infections? ☐ No ☐ Yes_____

Additional Information

Please share any additional information that you feel may be important.