Genetics and Genomics Institute
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GENETICS CLINIC INTAKE FORM - 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

Child's Name: Date of birth:

Primary care provider:

Specialists your child has seen:

Has your child or anyone else in the family seen a geneticist before, or had genetic testing?
☐ No ☐ Yes ____

Reason for Referral

Why was your child referred to Genetics Clinic?

____

____

____

How and when did this problem present?

____

____

____

____

Patient Identification - Write in or attach patient label

Name

MRN#

CSN #

Age /Sex and Gender

GENETICS CLINIC INTAKE FORM - CHILD

Mary Bridge Children's

88-5650-5 (7/19)

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:

____

____

Medical History

Has your child ever been hospitalized overnight?

☐ No ☐ Yes ____

Please list all overnight hospitalizations not at a Mary Bridge / MultiCare Hospital

Approximate date	Hospital/Location	Reason for hospital stay

Has your child ever had surgery?

☐ No ☐ Yes ____

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

☐ No ☐ Yes ____

Does your child have any allergies?

☐ No ☐ Yes ____

Which studies has your child had done? *(Check all that apply)*

☐ Developmental assessment ☐ Eye/vision exam ☐ Hearing evaluation
☐ Neuropsychology assessment ☐ X-rays/MRI/US ☐ Genetic tests
☐ Other studies: ____

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

Are the patient's mother and father related? *(For example: cousins)* ☐ No ☐ Yes ☐ Possibly

Is there a history in patient's family of …? *(Check all that apply)*

☐ Miscarriages ☐ Stillbirths ☐ Newborn/childhood deaths
☐ Infertility ☐ Birth defects ☐ Unusual features
☐ Developmental problems ☐ Learning disorders ☐ Cancer
☐ Other disease (please list):

If yes, please explain: ____

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

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

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

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

Please indicate if your child has any of the following symptoms or health concerns. If yes, please add details.

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________________________________

Completed by: ____ Date: ______________

Relationship to patient: ____