PHOENIX CHILDREN'S Medical Group®

Division of Genetics

NEW PATIENT QUESTIONNAIRE

Apply Patient Label

Date of Clinic Visit:_____(for office use only)

Patient Name _____ Date of Birth _____

Mailing Address _____

Phone (home) _____ (work) _____ (cell) _____

Mother's Name _____ Date of Birth _____

Father's Name _____ Date of Birth _____

Parent email address _____Date completed _____

Patient's Primary Care Physician _____

Address _____

Phone _____ Fax _____

Other physicians (Name and Address) who should receive a copy of our report

_____

_____

_____

Are there sensitive issues you do not want us to discuss in front of your child? Please explain.

_____

_____

_____

What is your understanding of the reason for this appointment?

_____

_____

_____

What questions would you like to have answered at this appointment?

_____

_____

_____

Have any other family members been evaluated by Genetics and/or had genetic testing? Please provide details.

_____

_____

_____

BIRTH/PREGNANCY HISTORY

What number pregnancy for mom? _____

Mother's age when patient was born _____ Father's age _____

Did mom have any complications or illnesses during the pregnancy? Y ☐ N ☐ If yes, please explain_____

_____

Was there any exposure to medications, tobacco, alcohol, and recreational drugs? Y ☐ N ☐ If so, please list _____

_____

Was there any exposure to chemicals or radiation, etc.: Y ☐ N ☐ If so, please list_____

Abnormal ultrasound findings: Y ☐ N ☐ If yes, please describe: _____

_____

_____

Any genetic testing during the pregnancy (CVS, amniocentesis, Non-invasive prenatal testing)?: Y ☐ N ☐

Results: _____

Hospital/Place of Birth _____Length of pregnancy (weeks)_____

Method of delivery _____Vaginal _____C-Section

Birth Weight_____ Birth Length _____ Head Circumference _____

How long was the child in the hospital after birth? _____ Time in NICU_____

Health problems or complications at birth_____

_____

_____

MEDICAL HISTORY

Please describe your child's current diet (type of food/formula, amount, frequency, aversions).

_____

_____

Please list any medications the patient is currently taking.

_____ _____ _____ _____

_____ _____ _____ _____

Does your child use any Durable Medical Equipment? Y ☐ N ☐ If yes, please list: _____

_____

_____

Please list surgeries your child has had (include approximate age/date).

1) _____ 3) _____

2) _____ 4) _____

Please list any overnight hospitalizations (include approx. date, reason, length of stay and what was done).

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any special genetic testing (ex. chromosome studies, metabolic studies, DNA studies, etc.) and include name of physician who ordered the test, why the test was done and result of the test.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any imaging studies that have been done (ex. MRI, CT, Ultrasound, X-Rays, etc.) and include name of physician who ordered the test, why the test was done and result of the test.

_____

_____

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Please check any medical problems your child has AND indicate age when diagnosed

Systemic: **Age**
- ❑ Fever _____
- ❑ Weight Loss _____
- ❑ Weight Gain _____
- ❑ Fatigue _____
- ❑ Other _____ _____

Ears/Nose/Throat:
- ❑ Frequent ear infections _____
- ❑ Hearing loss _____
- ❑ Congestion _____
- ❑ Snoring _____
- ❑ Other _____ _____

Eyes:
- ❑ Wears glasses _____
- ❑ Astigmatism _____
- ❑ Lazy Eye/Strabismus _____
- ❑ Clogged Tear Ducts _____
- ❑ Other _____ _____

Skin:
- ❑ Rashes _____
- ❑ Birthmarks _____
- ❑ Eczema _____
- ❑ Jaundice _____
- ❑ Problems with Wound Healing _____
- ❑ Other _____ _____

Heart:
- ❑ Murmur _____
- ❑ Fainting _____
- ❑ Chest Pain _____
- ❑ Turning Blue _____
- ❑ Other _____ _____

Lung:
- ❑ Cough _____
- ❑ Asthma _____
- ❑ Shortness of Breath _____
- ❑ Other _____ _____

Gastrointestinal:
- ❑ Poor Appetite _____
- ❑ Picky Eater _____
- ❑ Eats Too Much _____
- ❑ Esophageal Reflux _____
- ❑ Other _____ _____

FREQUENT:
- ❑ Vomiting _____
- ❑ Diarrhea _____
- ❑ Constipation _____
- ❑ Abdominal Pain _____

Genitourinary: **Age**
- ❑ Bed-wetting _____
- ❑ Urinary Tract Infections _____
- ❑ Blood in Urine _____
- ❑ Undescended Testicle(s) _____
- ❑ Other _____ _____

Neurologic:
- ❑ Headaches _____
- ❑ Migraines _____
- ❑ Seizures _____
- ❑ Sleep Problems _____
- ❑ Balance Problems _____
- ❑ Weakness _____
- ❑ Low Muscle Tone _____
- ❑ High Muscle Tone _____
- ❑ Other _____ _____

Musculoskeletal:
- ❑ Bone Fracture(s) _____
- ❑ Too Flexible _____
- ❑ Too Stiff _____
- ❑ Muscle Pain _____
- ❑ Joint Pain _____
- ❑ Joint Swelling _____
- ❑ Scoliosis _____
- ❑ Joint Dislocations _____
- ❑ Other _____ _____

Heme/Lymph:
- ❑ Nosebleeds _____
- ❑ Easy Bruiser _____
- ❑ Bleeds Too Long _____
- ❑ Swollen Glands/Nodes _____
- ❑ Other _____ _____

Psychiatric:
- ❑ Behavioral Concerns _____
- ❑ Tantrums _____
- ❑ Depression _____
- ❑ Anxiety _____
- ❑ Hyperactive _____
- ❑ Psychotic _____
- ❑ Other _____ _____

Endocrine:
- ❑ Temperature Regulation Problem _____
- ❑ Low Blood Sugar _____
- ❑ High Blood Sugar _____
- ❑ Hormone Problem _____
- ❑ Drinking/Urinating Too Much _____
- ❑ Other _____ _____

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Allergy/Immunology: **Age**

- ❑ Frequent Infections _____
- ❑ Food Allergies _____
- ❑ Environmental Allergies _____
- ❑ Other _____ _____

Please list specialists the patient has seen (cardiologist, endocrinologist, neurologist, etc.) and include name of physician, when they were seen and any diagnoses that were given.

1._____

2._____

3._____

4._____

5._____

6._____

DEVELOPMENTAL HISTORY

At what age did the patient develop these skills:

Rolling over_____ Sitting alone_____ Crawling_____
Walking alone_____ Able to speak one word_____ Two words together _____
Sentences _____ Toilet trained _____

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

_____

_____

Do you have any concerns about your child's behavior?

_____

_____

Does your child receive any therapies? Y ☐ N ☐ If yes, please circle the therapies that your child receives:
Speech / Physical / Occupational / Developmental / Feeding / Music / Vision / Equine

Name of the child's school _____ Grade level _____

Regular classes? Y ☐ N ☐ Special education classes? Y ☐ N ☐ Resource classes? Y ☐ N ☐

If he/she is not in school, what was the highest level of education obtained? _____

SOCIAL HISTORY

Who does your child live with? _____

Who is your child's primary caretaker? _____

Mother's occupation _____Father's occupation _____

Current Services (circle all that apply): DDD, CRS, AHCCCS, WIC, Private Insurance,
Other:_____

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FAMILY HISTORY

A detailed family history is a key tool used in genetic evaluations. Please indicate family members with the following conditions and write their relationship to the patient beside/below the appropriate condition.

Example: Hearing problems or deafness – patient's father and brother

Birth Defects	Hearing /Deafness
Pregnancy Losses (Miscarriage)	Eyesight/Blindness
Stillborn Babies/Childhood Death	Kidney
Stomach/Intestinal	Liver
Seizures/Epilepsy	Gland (Thyroid, Hormones)
Learning Disability/Special Education	Bones
Intellectual Disability	Spine
Mental Illness	Very Tall/Very Short Stature
Diabetes or sugar problems	Blood Abnormalities
Heart	Muscle
Cancers/Tumors	Known Genetic Conditions
Sudden/Unexplained Deaths	
Mother's Height _____	Father's Height _____

Additional family history/things that run in the family (use separate sheet if necessary)

_____

_____

_____

_____

Patient's siblings' names and birthdates:

_____

_____

_____

_____ _____ _____
Signature of Patient/ Legally Authorized Representative Date Time

_____ _____
Printed Name of Patient/ Legally Authorized Representative Relationship to Patient

_____ _____ _____
Practitioner Signature Date Time

_____
Printed Name