



VIRTUALMEDICALPRACTICE, LLC  
*expanding genetics horizons...*

## HISTORY QUESTIONNAIRE - Child

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Name of Person Filling Out Form

\_\_\_\_\_  
Relationship to Patient

The attached questionnaire is important to your child's evaluation. Much of this information is regarding early childhood development, milestones, and family relationships & history. Many have found looking through your child's "baby book" or other records you may have will frequently generate answers. Our evaluation includes not only a review of the family and medical history, but also a review of the pregnancy, labor and delivery history. In addition, it is nice to have a recent photograph.

To take full advantage of the time you have with your physician in your appointment:

- please answer as many of the questions as possible,
- answer as fully as possible, and
- **return to us as soon as possible but at least 2 weeks prior** to your scheduled appointment.

We are honored that you have allowed us to participate in your child's care.

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*What do you hope to accomplish with this appointment?*

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*What are the most important questions that need to be addressed during your appointment?*

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**PREGNANCY:** Please answer to the best of your ability. If unknown, please indicate UKN.

1. The pregnancy with this child was confirmed by  blood test  urine test  
at \_\_\_\_\_  weeks  months
2. How old was the patient's mother when she became pregnant? \_\_\_\_\_
3. What number pregnancy was this pregnancy for the patient's mother? \_\_\_\_\_
3. If provided, who provided the prenatal care? \_\_\_\_\_
4. Was an ultrasound done as a part of the prenatal care?  yes  no
5. How many ultrasounds were done? \_\_\_\_\_  
When during the pregnancy were the ultrasounds completed?

- |           |           |
|-----------|-----------|
| #1. _____ | #4. _____ |
| #2. _____ | #5. _____ |
| #3. _____ | #6. _____ |

(Please list on back page any additional ultrasound studies completed.)

Where was each ultrasound completed? (i.e. OB's office, hospital, etc.)

- |           |           |
|-----------|-----------|
| #1. _____ | #4. _____ |
| #2. _____ | #5. _____ |
| #3. _____ | #6. _____ |

(Please list on back page any additional ultrasound studies completed.)

6. Were any of the ultrasounds abnormal?  yes  no  
If **yes**, explain in the space below:  
\_\_\_\_\_  
\_\_\_\_\_

7. Were other special studies done during this pregnancy?  yes  no  
Include alpha-fetoprotein, amniocentesis, glucose tolerance test, and other study results here. If **yes**, please explain in the space below:  
\_\_\_\_\_  
\_\_\_\_\_

8. List all over-the-counter and prescription medications, vitamins, health preparations, cigarettes, etc. used during this pregnancy (include name/brand, amount, and when taken during the pregnancy).

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9. Where any of the following present during pregnancy (answer yes or no):

	<u>Yes</u>	<u>No</u>	<u>Time in Pregnancy</u>
Bleeding/spotting	_____	_____	_____
Cold or Flu-like illness	_____	_____	_____
Bladder Infection	_____	_____	_____
Fever	_____	_____	_____
Yeast Infection	_____	_____	_____
Other Vaginal Infection	_____	_____	_____
Skin Rash	_____	_____	_____
Dehydration from Vomiting	_____	_____	_____
Abnormal growth of the baby	_____	_____	_____
Premature labor	_____	_____	_____
High blood pressure	_____	_____	_____
Blood sugar problems	_____	_____	_____
Exposure to x-rays or chemicals	_____	_____	_____
Other	_____	_____	_____

10. Would you describe the activity in the womb during the pregnancy as (check one):

\_\_\_\_\_ Very active                      \_\_\_\_\_ moderately active  
 \_\_\_\_\_ Occasionally active      \_\_\_\_\_ rarely moved

11. How much weight did you gain during pregnancy? \_\_\_\_\_

**DELIVERY:**

Due Date: \_\_\_\_\_ Birth date: \_\_\_\_\_ Birth Hospital: \_\_\_\_\_

1. Born at full-term?  yes  no  
If not, how premature was the birth? \_\_\_\_\_

2. How long was the labor? \_\_\_\_\_ hours

3. What type of delivery ? (Check one):

a) \_\_\_\_\_ Vaginal      \_\_\_\_\_ C-section      \_\_\_\_\_ Repeat C-section because there was a previous delivery this way

b) \_\_\_\_\_ Head first      \_\_\_\_\_ Shoulder(s) first      \_\_\_\_\_ Bottom first      \_\_\_\_\_ Feet first

**BIRTH:**

1. Weight? \_\_\_\_\_ Length? \_\_\_\_\_ Chest size? \_\_\_\_\_ Head size? \_\_\_\_\_

2. Did your child have any problems at birth? If so, please describe in the space below  
(You may use the attached blank sheet)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Babies are given special scores at birth called Apgar scores based on the baby's color, breathing, heartbeat, muscle tone, and cry. If you recall your child's Apgar scores, please record them here:

\_\_\_\_\_ at 1 minute      \_\_\_\_\_ at 5 minutes

4. After your baby was born, how did she/he feed? (check one)

\_\_\_\_\_ Breast      \_\_\_\_\_ Bottle      \_\_\_\_\_ Other

5. The baby was discharged to go home at \_\_\_\_\_ (days/weeks) of age.

**FIRST YEAR:**

1. Did the child have any complications during the first month of life?  yes  no  
If yes, please explain in the space below:

\_\_\_\_\_  
\_\_\_\_\_

2. Were there any complications in the first year of life?

\_\_\_\_\_  
\_\_\_\_\_

## DEVELOPMENTAL MILESTONES HISTORY:

1. Please record the child's age beside those milestones they have met and circle months or years appropriately:

Rolled over \_\_\_\_ months/years                      Sat alone \_\_\_\_ months/years

Crawled \_\_\_\_ months/years                      First word \_\_\_\_ months/years

Walked holding onto furniture \_\_\_\_ months/years

Walked alone \_\_\_\_ months/years

2. The child now says \_\_\_\_ words (record number).
3. Does the child receive any special services (OT, PT, speech)? If **yes**, list type and number of services (e.g. PT 3 times a week for one hour) each session.

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4. Is the child enrolled in a special education program?  yes  no  
If **yes**, what age level is he/she functioning at? \_\_\_\_\_

*(Please bring a copy of any developmental evaluation reports)*

Regular classroom:  yes  no

If so, what grade level? \_\_\_\_\_

Special educations (summarize program/services received): \_\_\_\_\_

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5. Has the child lost any previously gained skills?  yes  no  
If **yes**, please explain in the space below.

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6. Does the child have vision problems?  yes  no  
If **yes**, please explain in the space below.

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7. Does the child have hearing problems?  yes  no  
If **yes**, please explain in the space below.

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**IMMUNIZATIONS:**

Is the child's immunizations up-to-date:  yes  no

**MEDICATIONS:** The child is currently taking the following medications/supplements:

Name of Medication/Supplement

Dosage

Time

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**ALLERGIES:**

Does the child have any allergies?  yes  no

If so, to what medications? \_\_\_\_\_

Other allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITALIZATIONS:** (List all hospital admissions—name of hospital, length of stay and reason for admission) *Please use back of this sheet if additional space is needed.*

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**SURGERIES:** \_\_\_\_\_

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**PROCEDURES:** \_\_\_\_\_

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Date of last MRI: \_\_\_\_\_ what was the result? \_\_\_\_\_

# PHYSICIANS TO RECEIVE A COPY OF OUR LETTER (s):

*Please include fax number as this is how we send copies*

Name of Physician                      Practice Name                      Phone                      Fax (important)

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*Use another sheet or the back of this page if required*

**Skip - REVIEW OF SYMPTOMS/PROBLEMS:** (To be filled out by physician, please skip to next section for Family History)

- |  |   |
|--|---|
| <input type="checkbox"/> Appetite changes/problems | <input type="checkbox"/> Depression                           |
| <input type="checkbox"/> Growth difficulties       | <input type="checkbox"/> Behavior/learning problems           |
| <input type="checkbox"/> Visual problems           | <input type="checkbox"/> Skin changes/lesions                 |
| <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Bladder/Urinary tract problems       |
| <input type="checkbox"/> Vomiting                  | <input type="checkbox"/> Headaches                            |
| <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Menstrual difficulties               |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Sleep disturbances                   |
| <input type="checkbox"/> Cardiac problems          | <input type="checkbox"/> Sexual dysfunction                   |
| <input type="checkbox"/> Respiratory difficulties  | <input type="checkbox"/> Substance abuse (Alcohol, cigs, etc) |
| <input type="checkbox"/> Seizures/staring spells   | <input type="checkbox"/> Other psychiatric history            |

## FAMILY HISTORY

Please complete all sections on this form. If there is not sufficient space provided, use the back of the pages, indicating the section letter being supplemented.

### **Section A - Information about brothers and sisters of the child**

Please list these – include any miscarriages by the mother of the patient. Differentiate between sisters and brothers who have the same 2 parents from those who share only 1 parent. Indicate the parent in common. If any sisters or brothers have had children, include this information and note any problems these children may have/had.

**Name, birth date, sex, living or age at death, medical problems, if any**

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_
- (5) \_\_\_\_\_

**SECTION B – Information about the child’s parents and their aunts and uncles** (parents’ brothers and sisters) In this section, list the patient’s "Father" and the "Mother", their sisters and brothers, their children and any medical problems in these individuals.

**(Child's) Father & His Brothers & Sisters**

**Father:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**(Child's) Mother & Her Brothers & Sisters**

**Mother (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**SECTION C – Information about the Grandparents of the Child.**

In these next 2 sections, list the parents of the "Father" and the "Mother" from Section B (grandparents to the child), and each grandparent's sisters and brothers, their children and any medical problems in these individuals.

**Father's Family**

(His Parents, Aunts, Uncles, Cousins)

**Father's Father & His Brothers/Sisters**

**Father's Father:** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Father's Mother & Her Brothers/Sisters**

**Father's Mother (maiden):** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_

Age (if living): \_\_\_\_\_

Medical problems, if known: \_\_\_\_\_

If deceased, age at time of death: \_\_\_\_\_

Cause of death, if known: \_\_\_\_\_

Number of children: \_\_\_\_\_

**Mother's Family**  
(Her Parents, Aunts, Uncles, Cousins)

**Mother's Father & His Brothers/Sisters**

**Mother's Father:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Mother's Mother & Her Brothers/Sisters**

**Mother's Mother (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**Name (maiden):** \_\_\_\_\_  
Age (if living): \_\_\_\_\_  
Medical problems, if known: \_\_\_\_\_  
If deceased, age at time of death: \_\_\_\_\_  
Cause of death, if known: \_\_\_\_\_  
Number of children: \_\_\_\_\_

**GENERAL FAMILY INFORMATION:**

1. What is the ethnicity of the child’s parents’ families (i.e. are they Scottish, Irish, German, Polish, Mayan, Vietnamese, Spanish, Portuguese, African, etc.)?

Child’s mother’s family: \_\_\_\_\_

Child’s father’s family: \_\_\_\_\_

2. As far back as you can trace your ancestors, do you, the child’s parents’, have any common relatives? (i.e. do you share a grandparent, great grandparent, etc)  yes  no

**GENERAL NOTES:**