PROVINCIAL MEDICAL GENETICS PROGRAM
Department of Medical Genetics
Telephone 604-875-2157
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Children's and Women's Health Centre
Room C234, 4500 Oak Street
Vancouver, BC V6H 3N1

QUESTIONNAIRE - PEDIATRIC

Patient's Name: _____ (Last Name) _____ (First Name) _____ (Date of Birth) _____ (Our Reference No.)

Address: _____ (Street) _____ (City) _____ (Postal Code)

Telephone: _____ (Home) _____ (Work) _____ (Cell) _____ (Other)

_____ (Name of person completing form) _____ (Relationship to Patient) _____ (Date)

Who does the patient live with?

Birth parents ☐Mother ☐Father *Adoptive parents* ☐Mother ☐ Father *Other* ☐_____
Step parents ☐Mother ☐Father *Foster parents* ☐Mother ☐Father _____

What are you hoping will be accomplished at this appointment?

_____

_____

Following this appointment, a letter summarizing the consult will be sent to the referring physician and any other care providers of your choice. Please list these other care providers:

_____

_____

PREGNANCY DETAILS

Were any assisted reproductive techniques used to help conceive this pregnancy? e.g. egg donation, sperm donation, IVF, ICSI
☐No ☐Yes ☐Unsure If yes, please explain _____

Were there any complications during the pregnancy? e.g. illness, bleeding, injury, reduced fetal movement, or ultrasound findings
☐No ☐ Yes, please list _____

_____

Were any of the following medications or substances used?

Prescription medications ☐No ☐ Yes, please list _____
Cigarettes ☐No ☐Yes
Alcoholic beverages ☐No ☐Yes
Drug exposure ☐No ☐Yes, please list (e.g. marijuana, cocaine)_____
Herbal remedies ☐No ☐Yes

Do you have any other concerns about your pregnancy? ☐No ☐Yes If yes, please list _____

_____

Was the delivery on time? ☐Yes ☐No If no, how many weeks early? _____ or how many weeks late? _____

Method of Delivery: ☐ Vaginal delivery ☐Forceps or vacuum used in delivery ☐ Caesarean Section

Birthweight: _____

Were there any problems immediately after birth? e.g. baby turned blue; jaundice; feeding problems
☐No ☐Yes, please list _____

_____

FOR OFFICE USE ONLY
Referral Date: _____
MG#: _____
Wait List Time: _____
Date Received: _____

Our Reference Number

YOUR CHILD'S HEALTH

Are there any concerns about your child's:

SKIN e.g. light or dark birth marks; unusual hair or nails; bumps; rashes; absent sweating
☐No ☐ Yes _____

EYES e.g. near-sighted; far-sighted; colour blindness; night blindness; cataracts; lazy eye
☐No ☐ Yes _____

EARS e.g. hearing loss; more than 2 infections per year; ringing
☐No ☐Yes _____

NOSE e.g. poor sense of smell; frequent colds; nosebleeds
☐No ☐ Yes _____

MOUTH / TEETH e.g. cleft lip or palate; early or late eruption of teeth; unusually formed teeth; problems with teeth, gums, or tongue
☐No ☐ Yes _____

THROAT / NECK e.g. difficulty swallowing, hoarse voice
☐No ☐ Yes _____

HEAD / BRAIN e.g. headaches; dizziness; seizures; large or small-sized head
☐No ☐Yes _____

HEART e.g. structural defect; murmur; irregular heartbeat; chest pain; high blood pressure
☐No ☐Yes _____

BLOOD e.g. easy bruising; easy bleeding; blood clots; stroke; low blood count
☐No ☐Yes _____

LUNGS e.g. asthma; chronic wheezing or cough; pneumonia
☐No ☐Yes _____

STOMACH / INTESTINES e.g. avoiding specific foods; frequent vomiting; reflux disease; constipation; diarrhea; bad diaper rash
☐No ☐Yes _____

URINARY TRACT / GENITALIA e.g. kidney problems; bladder infections; bed wetting; blood in urine; abnormal genitalia
☐No ☐Yes _____

MUSCLES e.g. weakness; coordination difficulties; paralysis; tight muscles
☐No ☐ Yes _____

ENDOCRINE SYSTEM e.g. diabetes; thyroid problems; concerns with weight or growth
☐No ☐Yes _____

BONES / EXTREMITIES e.g. fractures; abnormal number or shape of fingers or toes; disproportion; tight joints
☐No ☐ Yes _____

Has your child had any surgeries, injuries or prolonged hospitalizations?
☐No ☐Yes, please list _____

_____

_____

_____

Is your child taking any medication or has your child taken any medication for extended periods in the past:
☐No ☐Yes, please list _____

_____

Please list any investigations your child has had that might be useful for our assessment: e.g. MRIs, muscle biopsies, blood tests

_____

_____

_____

Our Reference Number

YOUR CHILD'S DEVELOPMENT

At about what age did your child do the following (if applicable):

Walk without support _____

Use single, meaningful words _____

Put two or three words together _____

Scribble _____

Feed self using spoon _____

Toilet trained during daytime _____

What are your child's strengths and favourite activities?

_____

_____

_____

_____

What does your child have most difficulty with?

_____

_____

_____

_____

Does your child have any behavioural difficulties?

☐No ☐Yes, please describe _____

_____

_____

Is English the main language spoken at home? ☐Yes ☐No

Please list what other languages are spoken at home _____

Is your child receiving any developmental services or has your child had such aid in the past? e.g. IDP, physio, speech therapy

☐No ☐Yes, please describe _____

_____

_____

_____

Are there any other special considerations about your child that we should be aware of?

☐No ☐Yes, please describe _____

_____

_____

_____

_____

_____

_____

_____

SIBLING DETAILS

Please list all of the patient's brothers/sisters, and any pregnancy losses experienced by the patient's biological parents.

	Name *or* pregnancy outcome (miscarriage, stillbirth, etc.)	Age *or* Date of Birth	Sex (M/F)	Medical or learning problems (if yes, please provide details)
1				☐No ☐Yes
2				☐No ☐Yes
3				☐No ☐ Yes
4				☐No ☐Yes
5				☐No ☐Yes

Were any of these children adopted?

☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of the patient's brothers/sisters share the same 2 parents?

☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

BIOLOGICAL PARENT DETAILS

Are the patient's biological parents related by blood? e.g. first cousins

☐No ☐Yes If yes, please explain relationship

BIOLOGICAL MOTHER DETAILS

Please provide the following details about the patient's biological mother and her family:

Last Name | First Name | Date of Birth | PHN/Care Card #

Does she have any medical or learning problems? ☐Yes ☐No If yes, please provide details:

What is her race/ethnic ancestry? *(Please list all that apply)*
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

BIOLOGICAL MOTHER'S SIBLINGS: Please list the patient's mother's brothers/sisters (the patient's aunts and uncles).

	Name	Sex (M/F)	Still living?	Age or Age at death	Does he/she have children?	If yes, how many?
1			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
2			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
3			☐No ☐Yes		☐No ☐Yes	Male:
						Female:
4			☐No ☐Yes		☐No ☐Yes	Male:
						Female:

Were any of these children adopted?

☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of these aunts/uncles share the same 2 parents?

☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

Our Reference Number

BIOLOGICAL FATHER DETAILS

Please provide the following details about the patient's father and his family:

Last Name _____ First Name _____ Date of Birth _____ PHN/Care Card # _____

Does he have any medical or learning problems? ☐Yes ☐No If yes, please provide details: _____

What is his race/ethnic ancestry? *(Please list all that apply)* _____
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

BIOLOGICAL FATHER'S SIBLINGS: Please list the patient's father's brothers/sisters (the patient's aunts and uncles).

	Name	Sex (M/F)	Still living?	Age or Age at death	Does he/she have children?	If yes, how many?
1			☐No ☐Yes		☐No ☐Yes	Male: Female:
2			☐No ☐Yes		☐No ☐Yes	Male: Female:
3			☐No ☐Yes		☐No ☐Yes	Male: Female:
4			☐No ☐Yes		☐No ☐Yes	Male: Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family:

Do all of these aunts/uncles share the same 2 parents?
☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

EXTENDED FAMILY DETAILS

Does anyone in your biological family currently have or have a history of any of the following conditions?
Please consider your nieces, nephews, aunts, uncles, first cousins, and grandparents.

Yes	No	Unsure	Condition	Name and relationship to patient	Details:
☐	☐	☐	Medical problems similar to the patient		
☐	☐	☐	Birth defects		
☐	☐	☐	Intellectual disability/special needs/learning disability		
☐	☐	☐	Chromosome condition (eg. Down syndrome)		
☐	☐	☐	Two or more miscarriages		
☐	☐	☐	Stillbirth or early childhood death		
☐	☐	☐	Cancer under the age of 50		
☐	☐	☐	Any health condition being passed down in the family		

Are there any other family history concerns that you would like us to address?

Any questions about this form? Please contact us at 604-875-2157.