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

RECALL QUESTIONNAIRE – PEDIATRIC

Date last seen in Medical Genetics: ______________________________

Please fill out this questionnaire in order that we may determine if a follow-up Medical Genetics appointment is indicated.

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	____________

YOUR CHILD'S HEALTH

Since your last visit, have there been any new 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. 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 ______________________________

FOR OFFICE USE ONLY
Date Received: ______________

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 since the last visit?
☐No ☐Yes, please list ______________________________

____

____

____

Is your child taking any new medications since the last visit?
☐No ☐Yes, please list ______________________________

____

Please list any investigations your child has had since the last visit: e.g. MRIs, muscle biopsies, blood tests

____

____

____

YOUR CHILD'S DEVELOPMENT

Please note any new skills your child has attained since the last visit:

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?

____

____

Our Reference Number_______________

Does your child have any new 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 ____________________________

Has your child received any developmental services since the last visit? e.g. IDP, physio, speech therapy
☐No ☐Yes, please describe ____

____

____

____

Are there any other new considerations about your child that we should be aware of?
☐No ☐Yes, please describe ____

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____

BIOLOGICAL PARENTS

Mother's Name:____

Still living? ☐Yes ☐No If no, age and cause of death (if known): ____________________________

New medical problems? ☐Yes ☐No If yes, please provide details: ____________________________

____

Father's Name:____

Still living? ☐Yes ☐No If no, age and cause of death (if known): ____________________________

Medical or learning problems? ☐Yes ☐No If yes, please provide details: ____________________________

____

NEW SIBLING DETAILS (if applicable)

Please list any new brothers/sisters of the patient, and any new 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

Our Reference Number_______________

Were any of these new 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 new 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.

____

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		

Has anyone in your family been seen in Medical Genetics (in BC or elsewhere) ? ☐ **No** ☐ **Yes**

If yes, please provide details (Name, clinic location, year seen): ______________________________

____

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

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Do you wish to be seen again in Medical Genetics? ☐ **No** ☐ **Yes**

If yes, what are you hoping will be accomplished at a follow-up appointment?

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