VMP, llc
Expanding Genetic Horizons

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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 supply us and is designed to provide important information in a consistent manner. We need this form filled out even if you supply some other narrative of the history. 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. 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, but we understand if you cannot answer all
- answer as fully as possible
- **return to us as soon as possible and we prefer 2 weeks prior** to your scheduled appointment.

What do you hope to accomplish with this appointment?

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

Have you been vaccinated against COVID, and if so which one? _____

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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:

   _____

   _____

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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).

_____

_____

_____

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

	Yes	No	Time in Pregnancy
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? _____

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DELIVERY:

Due Date: _____ Birth date: _____ Birth Hospital: _____

1. Born biologically as: ☐ female ☐ male ☐ unknown Currently identify as:_____
2. Born at full-term? ☐ yes ☐ no
   If not, how premature was the birth? _____
3. How long was your mother's labor? _____ hours
4. What type of delivery ? (Check one):
   a)_____Vaginal _____C-section _____ Repeat C-section because of previous delivery was 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?

   _____

   _____

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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.

   _____

   _____

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): _____

   _____

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

   _____

   _____

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

   _____

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

   _____

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

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TOP PROBLEMS/DIAGNOSES:

(1) _____

(2) _____

(3) _____

(4) _____

GENETIC TESTING TO DATE: (List all genetic testing and which lab performed them)

_____

_____

HOSPITALIZATIONS/SURGERIES: (List length of stay/procedures/reason)

Please use back of this sheet if additional space is needed.

_____

_____

_____

_____

Date of last MRI: _____ **Result of MRI:** _____

MEDICATIONS/Supplements:

Please use back of this sheet if additional space is needed

Name of Medication Dosage Time

_____

_____

_____

_____

ALLERGIES: Does the child have any allergies? ☐ yes ☐ no

_____

If so, to what medications? _____

FAMILY HISTORY

1. What is the ethnicity of your parents' families (i.e. are you Scottish, Spanish, African American, etc.)?

   Your mother's family: _____

   Your father's family: _____

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

Notes: _____

Parents

Parent Names	Date of Birth	Medical Issues (indicate if deceased, age, & cause)

Grandparents

Grandparent	Date of Birth	Medical Issues (indicate if deceased, age, & cause)
Mother's Mother		
Mother's Father		
Father's Mother		
Father's Father		

Siblings (brothers or sisters related to the patient)

Siblings	Gender	Date of Birth	Full or Half	Medical Issues (indicate if deceased, age, & cause)
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	

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Maternal Family (brothers or sisters related to the patient's mother)

Aunts/Uncles	Gender	Date of Birth	Full or Half	Medical Issues (indicate if deceased, age, & cause)
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	

Paternal Family (brothers or sisters related to the patient's father)

Aunts/Uncles	Gender	Date of Birth	Full or Half	Medical Issues (indicate if deceased, age, & cause)
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	
	☐ M ☐ F		☐ Full (both) ☐ Half - Dad ☐ Half - Mom	

REVIEW OF SYSTEMS: circle/underline/highlight those issues you are experiencing

Constitutional: fatigue, fever, weight loss, weight gain, altered taste/smell, unable to sleep, excessive sleepiness, abnormal growth, lost interest in activities, Birthmark

Cardiovascular: sensation of chest pain/pressure/squeezing, shortness of breath on exertion, lower extremity swelling, chest pressure, fainting, heart failure, high blood pressure, shortness of breath, coronary disease, heat/cold intolerance, fainting

Endocrine: diabetes, thyroid disease, growth disorders, sexual dysfunction, excessive thirst or hunger, frequent urination, nausea

Eyes: double vision, blurred vision, floaters, glaucoma, cataracts, loss of peripheral vision, macular degeneration, drooping eye lids

Gastrointestinal: vomiting, diarrhea, reflux, constipation, abdominal pain, gastritis, hepatitis, hiatal hernia, rectal bleeding, ulcer, indigestion, nausea

Genitourinary: urine incontinence, stool incontinence, sexual dysfunction, constipation

Heme-Lymph: lymph node enlargement or tenderness, blood disorder, diabetes, sickle cell disease, thyroid disease, HIV, AIDS

HENT: loss of hearing, balance problems, nasal congestion, postnasal drip, neck pain, sore throat, tinnitus, allergies/hayfever, trouble breathing through nose, sinus disease, mouth sores, trouble swallowing, snoring

Respiratory: cough, bronchitis, emphysema, pneumonia, tuberculosis, asthma

Integument: rash, breast disease, melanoma, basal cell cancer, abnormal scars, easy bruising

Immunologic: frequent illnesses, recurrent infections

Musculoskeletal: joint pain, joint swelling, back pain, neck pain, hypermobile joints, muscle weakness, loss of muscle mass, lack of endurance

Neurologic: speech difficulties, incoordination, aggressive, trouble learning, trouble hearing, memory difficulties, seizures, tremors, head injuries, dizziness, hallucination, personality change, weakness, pain, facial numbness/tingling, numbness-arms, numbness-legs, nausea, stiffness, difficulty chewing, stares off into space, choking, difficulty tasting, drooling, trouble walking, vertigo, difficulty concentrating, fainting or passing out, difficulty sleeping, swallowing problems, trouble with smell, spells/fits, confusion, hostile/angry

Psychiatric: anxiety, depression, hallucinations, trouble concentrating, schizophrenia, in trouble at school, shy, panic attacks

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