

**DIVISION OF MEDICAL GENETICS  
CONFIDENTIAL QUESTIONNAIRE  
FOR FOLLOW-UP PATIENTS**

CHP-2252 Rev 02/16

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In order to help us get to know the patient and concerns better, please answer the following questions to the best of your abilities. Please note there is a front and back to each sheet. This information will be held confidential and will not be released without your permission. Thank you.

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

Parent/Guardian Name(s): \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

Name of any family member(s) evaluated in Genetics (if applicable): \_\_\_\_\_

**Please describe briefly the problem(s) for which we are seeing the patient and when you first noticed these problems:**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**Please list the main questions you would like us to attempt to answer:**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**Please list any non-CHP doctor or other health care professional the patient has seen for these problem(s):**

Name	City	Dates
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1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**Past Medical History:**

Has the patient ever been **hospitalized overnight** or had any **operations**? Please provide all details: for example, how old was the patient, where was he/she hospitalized, what was the length of the stay, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list all current medications and doses the patient is taking, including over-the-counter medications: (attach separate sheet if necessary)**

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

**Please list all medication allergies and provide details about what happened when medication was given.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Immunizations up to date?  Yes  No



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**REVIEW OF SYSTEMS**

Date of Visit: \_\_\_\_\_

Does your child currently have problems with (please indicate past problems with "P")

<b>GENERAL</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Growth		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Weight Gain/Loss		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>CARDIAC SYMPTOMS</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Chest Pain		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Palpitations		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
High Blood Pressure		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Loss of Consciousness		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Dizziness/lightheadedness		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>RESPIRATORY SYMPTOMS</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Shortness of Breath		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Asthma		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Wheezing		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Snoring		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>GI SYMPTOMS</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Diarrhea		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Constipation		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Reflux		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Abdominal Pain		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>NEUROLOGICAL SYMPTOMS</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Headaches/Migraines		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Seizures		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>SKIN</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Birthmarks/Moles		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Poor wound healing or abnormal scarring		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Prolonged bleeding		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Easy bruising		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Stretch marks		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Hyperelastic Skin		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>KIDNEY/LIVER</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Kidney problem		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Liver problem		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>GENITAL/URINARY</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>
Abnormal smell/color of urine		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Early signs of puberty		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P

<b>VISION/EYES</b>	<input type="checkbox"/> <b>NO CHANGE SINCE LAST VISIT</b>	<b>PLEASE CHECK</b>	
Vision Problems		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P	
Nearsighted		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P	
Farsighted		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P	
Astigmatism		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P	
Glasses/Contacts		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P	
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> P	RX: _____



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**Social History:**

Where does the patient currently go to school or daycare? \_\_\_\_\_

What is the current grade level? \_\_\_\_\_ Has the patient ever repeated a grade, if so, which? \_\_\_\_\_

Does the patient require a special classroom?  Yes  No If yes, what type: SLD, EH, EMH, TMH, or other: \_\_\_\_\_

Do they receive special services, physical, speech or occupational therapies?  Yes  No

If Yes, please list service and how often received:

Physical \_\_\_\_\_ Speech \_\_\_\_\_ Occupational Therapies \_\_\_\_\_

Developmental \_\_\_\_\_ Vision \_\_\_\_\_

Has the patient's intelligence or development ever been tested?  Yes  No

If yes, by whom, where and when: \_\_\_\_\_

Who does the patient live with? Please list all adults and children who live in the same house and their relationship to the patient?  
\_\_\_\_\_  
\_\_\_\_\_

Please note if the patient is adopted or in foster care. \_\_\_\_\_

Please provide the following information about the parents

Age	Highest level of school completed	Current employment/occupation
Mother: _____	_____	_____
Father: _____	_____	_____

Parents are (check correct choice)  Married  Never Married  Separated  Divorced

**This form was completed by:**

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This form was reviewed by:**

Name: \_\_\_\_\_ Credential: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_