

Infant/child family history questionnaire

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Today's date: _____
 Person completing questionnaire: _____

Patient	
Name	_____
Date of birth	_____
Height	_____
Weight	_____
Adopted	<input type="radio"/> Yes <input type="radio"/> No

	Mother*	Father*
Name	_____	_____
Date of birth	_____	_____
Occupation	_____	_____
Marital status (married, divorced, widowed, single)	_____	_____
Last grade completed	_____	_____
Height	_____	_____
Weight	_____	_____
Adopted	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

* biological parents

Child's Past medical history *Check all that apply*

Explain checked items, include year or age

Surgeries	<input type="checkbox"/>	_____
Hospitalizations	<input type="checkbox"/>	_____
Major illnesses	<input type="checkbox"/>	_____
Chronic medical problems	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	_____
Learning problems	<input type="checkbox"/>	_____
Behavior problems	<input type="checkbox"/>	_____
Mental illness	<input type="checkbox"/>	_____

Birth history

Gestational age at time of delivery (e.g., 40 weeks)	_____
Delivery type	<input type="radio"/> vaginal <input type="radio"/> c-section
reason for c-section	_____
Complications during delivery	<input type="radio"/> Yes <input type="radio"/> No
If yes, please explain:	_____
Weight	_____ Length _____ Head circumference _____
APGAR scores	_____
Medical problems at birth	<input type="radio"/> Yes <input type="radio"/> No
If yes, please explain:	_____
Physical differences or unusual features noted at birth	<input type="radio"/> Yes <input type="radio"/> No
If yes, please explain:	_____

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Maternal pregnancy and reproductive history

Mother's age at time of delivery _____
Father's age at time of delivery _____

During the pregnancy, did the mother:

- | | Yes | No |
|--|-----------------------|-----------------------|
| Take any medications (prescription or non-prescription)? | <input type="radio"/> | <input type="radio"/> |
| Drink alcohol (beer, wine, hard liquor)? | <input type="radio"/> | <input type="radio"/> |
| Smoke cigarettes? | <input type="radio"/> | <input type="radio"/> |
| Use any recreational drugs (cocaine, marijuana, heroin)? | <input type="radio"/> | <input type="radio"/> |

For any **"yes"** answers, describe below, including amounts and dates, if known.

During the pregnancy, did the mother have any of the following infections or exposures?

- | | Yes | No |
|-------------------------|-----------------------|-----------------------|
| Chicken pox (varicella) | <input type="radio"/> | <input type="radio"/> |
| Fifth disease | <input type="radio"/> | <input type="radio"/> |
| Toxoplasmosis | <input type="radio"/> | <input type="radio"/> |
| Cytomegalovirus | <input type="radio"/> | <input type="radio"/> |
| Radiation (x-rays) | <input type="radio"/> | <input type="radio"/> |
| Chemicals | <input type="radio"/> | <input type="radio"/> |
| Immunizations | <input type="radio"/> | <input type="radio"/> |

For any **"yes"** answers, describe below, including amounts and dates, if known.

Did the child's mother have a history of: Yes No

- | | | |
|-----------------------------------|-----------------------|-----------------------|
| Thyroid disease | <input type="radio"/> | <input type="radio"/> |
| Diabetes | <input type="radio"/> | <input type="radio"/> |
| Seizures | <input type="radio"/> | <input type="radio"/> |
| Hyperphe or phenylketonuria (PKU) | <input type="radio"/> | <input type="radio"/> |
| Deep vein thrombosis | <input type="radio"/> | <input type="radio"/> |
| Lupus | <input type="radio"/> | <input type="radio"/> |
| Other chronic conditions: | <input type="radio"/> | <input type="radio"/> |

For biological mother, please list number of:

- | | |
|--------------------------|-------|
| Pregnancies | _____ |
| Full-term births | _____ |
| Preterm births (<37 wks) | _____ |
| Stillbirths | _____ |
| Miscarriages (<24 wks) | _____ |
| Elective abortions | _____ |
| Living children | _____ |

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Parents' past medical history *Check all that apply for each parent*

	Mother	Father	Explain checked items, include year or age
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major illnesses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic medical	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____

Ethnic Background

Where did the child's ancestors come from before the United States? *Check all that apply*

	Mother	Father
Mediterranean (e.g., Italian, Greek)	<input type="checkbox"/>	<input type="checkbox"/>
European Caucasian (e.g., Irish, English, German)	<input type="checkbox"/>	<input type="checkbox"/>
African or African-American	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenazi Jewish	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic (e.g., Puerto Rican, Dominican, Mexican)	<input type="checkbox"/>	<input type="checkbox"/>
Cajun or French Canadian	<input type="checkbox"/>	<input type="checkbox"/>
Southeast Asian (e.g., Laotian, Chinese, Vietnamese)	<input type="checkbox"/>	<input type="checkbox"/>
Indian (from India)	<input type="checkbox"/>	<input type="checkbox"/>
Middle Eastern (e.g., Lebanese, Iranian, Egyptian)	<input type="checkbox"/>	<input type="checkbox"/>
Native American	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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For the questions below, please check the boxes for those conditions that have occurred in the families of the (biological) parents of this child. Include the mother and the father of this child, as well as their respective: siblings (full and half), parents, children, grandparents, aunts, uncles, nieces, nephews and first cousins if possible.

	Mother's Family	Father's Family	Who has the condition? (you, parent, sib, etc.)
Anencephaly or spina bifida (openings in the skull or spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hydrocephalus (water on the brain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
A large, small or unusually shaped head	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness or other vision problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deafness or significant hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusual shape, size or position of ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cleft lip and/or cleft palate (opening in lip and/or roof of the mouth)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental problems (missing, extra or abnormally formed teeth)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital heart defect (e.g., "hole" in the heart)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack or coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory disease or chronic lung condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alpha-1-antitrypsin deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pyloric stenosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth defects of the bowels or intestines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polycystic kidneys, missing or extra kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital or urinary tract defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital hip dislocation (born with dislocated hips)	<input type="checkbox"/>	<input type="checkbox"/>	_____
A birth defect of an arm or a leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusually formed bones or many broken bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis (curved spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	Mother's Family	Father's Family	Who has the condition? (you, parent, sib, etc.)
Unusually formed hands or feet (including club foot)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Very short or tall stature	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marfan syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle weakness or poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental retardation or developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning disabilities or a slow learner	<input type="checkbox"/>	<input type="checkbox"/>	_____
Attention deficit or hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures, epilepsy or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Down syndrome or other chromosome syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fragile X syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tay-Sachs disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Canavan disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phenylketonuria (PKU)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gaucher disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer disease or other form of dementia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Huntington disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia or other mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Manic depression (bipolar)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unipolar disorder (severe depression)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birthmarks or unusual growths on skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
A chronic skin condition (e.g., eczema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patches of different colored hair	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patches of different colored skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding or clotting disorder (e.g., Hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hereditary anemia (e.g., thalassemia, sickle cell, other)	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	Mother's Family	Father's Family	Who has the condition? (you, parent, sib, etc.)
Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Factor V Leiden	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemochromatosis (iron storage condition)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure or hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other cancers or tumors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stillbirths	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infant or childhood deaths	<input type="checkbox"/>	<input type="checkbox"/>	_____
Two or more miscarriages or pregnancy losses (in the same person)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infertility or sterility (unable to get pregnant or have children)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Premature ovarian failure (early menopause)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Primary amenorrhea (never had a period)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has anyone in the child's family had genetic testing? Yes No

If yes, please explain:

Are the parents of this child related as first cousins or in any other way as blood relatives? Yes No

If yes, please explain:

Has this child attended an Early Intervention Program (EIP) or special education classes? Yes No

If yes, please explain:

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Do you have any concerns about:

- Your child's overall growth or size?
- The size, shape, or appearance of any of his or her body parts?
- Your child's ability to learn?
- Your child's development or "milestones"?
- Whether your child may have a problem that is genetic/inherited?

- | | |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No |

Please explain any "yes" answers to the above questions.

For office use only

Significant findings

Recommendations

Date discussed with patient/family _____

HCP name/initials _____

Patient/parent/guardian signature

X
