

Intake Form For New Participants

Clinical Genetics Evaluation

Participant Name

Date of Birth

Study ID

Provided by:

Contact:

Referred By:

Reason for Referral / Enrollment:

Medical History

Hospitalizations

None Yes

Describe

Operations

None Yes

Describe

Medications

None Yes

Describe

Pregnancy History

Number of Pregnancies _____

Pregnancy Outcome: Full Term _____

Pregnancy Outcome: Premature Delivery _____

Pregnancy Outcome: Abortions _____

Pregnancy Outcome: Living Children _____

Mother's Age at Birth _____

Father's Age at Birth _____

Prenatal Exposures / Illnesses _____

Pregnancy Complications Yes No

Please Describe _____

Fetal Movement _____

Testing During Pregnancy Maternal serum screen
 Other

Please Describe _____

Prenatal Diagnosis Yes No

Please Describe _____

Fetal Ultrasound Yes No

Please Describe _____

Perinatal History

Gestational age:

Place of Delivery

How was the patient delivered?

- Vaginally, normal
- Vaginally, with forceps
- Vaginally, with vacuum extraction
- Vaginally, with a breech position
- C-section, due to size
- C-section, due to breech position
- Other

Please explain

Complications

- Yes No

Please Describe

Birth Weight:

Birth Length:

Head Circumference:

Apgar Scores:

NICU Stay

- Yes No

Please comment

Age at discharge:

Neonatal problems

Developmental History

Smiled (age):

Roll over (age):

Sit alone (age):

Crawl (age):

Walk (age):

Babble (age):

1st Word (age):

1 -2 Word phrases (age):

Sentences (age):

Additional comments:

Family History / Pedigree

Unremarkable

Yes No

Please Describe

Please draw a relevant pedigree below (Please print this page in order to draw a pedigree, please fax the completed for to 916-703-0460 or scan and email to hs-boydlab@ucdavis.edu)

Review of Systems

General Normal Abnormal

Please Describe

Vision Normal Abnormal

Please Describe

Head and Neck Normal Abnormal

Please Describe

Pulmonary Normal Abnormal

Please Describe

Cardiovascular

Normal Abnormal

Please Describe

Gastrointestinal

Normal Abnormal

Please Describe

Genito-Urinary

Normal Abnormal

Please Describe

Hematology/Oncology

Normal Abnormal

Please Describe

Ob/Gyn/Breast

Normal Abnormal

Please Describe

Neurological

Normal Abnormal

Please Describe

Endocrine

Normal Abnormal

Please Describe

Infectious Diseases

Normal Abnormal

Please Describe

Musculoskeletal

Normal Abnormal

Please Describe

Mental Health

Normal Abnormal

Please Describe

Skin and Hair

Normal Abnormal

Please Describe

Previous Testing and Evaluations

Genetic Tests:

Yes No

Please Describe

Imaging Studies:

Yes No

Please Describe

Place of Imaging Study

Other Tests and Evaluations

Yes No

Please Describe

Additional Information

Patient Diagnosis (Mark all that apply)

- Sagittal
- R. Coronal
- L. Coronal
- Bicoronal
- Metopic
- R. Lambdoidal
- L. Lambdoidal
- Multiple sutures
- Syndrome

Please describe

Please describe

Other Diagnoses

Additional Comments

Assessment and Plan

This form was completed by:

Date
