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	__________________________________