GENOMIC MEDICINE CLINIC
New Patient Questionnaire

UCDAVIS HEALTH | MIND INSTITUTE

Thank you for choosing the UC Davis Genomic Medicine Clinic for your / your child's care. Please fill out and return this questionnaire at least 1 week prior to your appointment by either fax or mail. This will allow us to spend more time during the appointment addressing your questions. Fill out this questionnaire as completely as you can. Feel free to call with any questions.

IMPORTANT: IF YOU HAVE COPIES OF GENETIC TEST RESULTS FOR YOU / YOUR CHILD / YOUR FAMILY MEMBERS, PLEASE MAIL/ FAX A COPY TO US, OR BRING THEM TO THE APPOINTMENT

Mailing address:
UC Davis MIND Institute
Attention: Genomic Medicine
2825 50th Street
Sacramento, CA 95817

Fax:
(916) 703-0350, Attention: Elizabeth

Scheduling Phone Number:
(916) 703-0317

Appointment date and time: _____

Provider you will be seeing: _____

GENERAL PATIENT INFORMATION

Please list reason for referral: _____

Please list your main concerns: _____

Form Competed By/Date: _____

Patient's Name: _____

Date of Birth: _____

Gender: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Patient lives with:

_____

Primary Care Physician Information

Name: _____
Phone: _____
Address: _____
_____

Referring Physician Information (if not same as primary)

Name: _____
Phone: _____
Address: _____
_____

If the patient is an adult:
Spouse/Partner's Name:
_____

If the patient is adopted or in foster care, please explain: _____
_____

If the patient is a child/minor:
Mother's name: _____
Occupation: _____
Date of birth: _____
Father's name: _____
Occupation: _____
Date of birth: _____

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PREGNANCY HISTORY

Age of Mother at delivery: _____ Age of Father at delivery: _____
Total pregnancies: ____ Total deliveries: ____ Total miscarriages: ____ Total terminations: ___
How many weeks or months into the pregnancy did prenatal care begin? _____
Describe fertility medication or in vitro fertilization (IVF) used to assist conception, if applicable?
_____

During the pregnancy, did the mother of the patient use or take any of the following?

Vitamins?	No	Yes	List: _____
Alcohol?	No	Yes	How much and how often? _____
Cigarettes?	No	Yes	How many cigarettes (or packs) per day? _____
Prescriptions?	No	Yes	List medication and dosage (if known): _____
Recreational or street drugs?	No	Yes	List type and frequency: _____

Did the mother of the patient have health problems during the pregnancy, such as diabetes, hypertension, etc. ? Please list: _____
_____

Did the mother of the patient have any of the following prenatal tests?

Ultrasound	No	Yes	Results: _____
Screening via mother's blood	No	Yes	Name of screen/Results: _____
Chorionic villus sampling (CVS) or Amniocentesis	No	Yes	Results: _____

Please list any other concerns during the pregnancy:_____

_____

BIRTH and NEWBORN HISTORY

Name and location of hospital where you/your child was delivered: _____

Gestational age at delivery (circle one): Term Born early Born late

Delivery (circle one): Vaginal Planned C-section Emergency C-section Other

Birth weight: _____ **Birth length:** _____ **Birth head circumference:**_____

At birth, were there any concerns about your/your child's health? Yes No

If yes, please describe: _____

Were you/your child treated for any health concerns in the nursery/NICU? Yes No

Please list:_____

DEVELOPMENTAL HISTORY

****Please skip for **ADULTS** with normal childhood development****

Cognitive Development

Do you have concerns about your/ your child's ability to think or learn? Yes No
Please explain:_____

Motor Development

Age sat without support: _____
Age walked without aid: _____
Age picked up small objects: _____
Age drew shapes: _____

Speech and Language Development

Age spoke single words: _____
Age spoke in 3-word phrases: _____
Number of words child currently uses: _____
Date of last hearing exam and results: _____

Previous treatment/evaluation/diagnostic tests (select all that apply and describe reason)

Developmental Pediatrician	No	Yes	Reason:
Psychologist	No	Yes	Reason:
Psychiatrist	No	Yes	Reason:
Neurologist	No	Yes	Reason:
Physical Therapy	No	Yes	Reason:
Occupational Therapy	No	Yes	Reason:
Speech-Language Therapy	No	Yes	Reason:
Behavioral/ABA Therapy	No	Yes	Reason:

Has your child been given any of the following diagnosis (select all that apply)

Learning Disability	No	Yes	ADHD	No	Yes
Developmental Delay	No	Yes	Speech/Language Disorder	No	Yes
Intellectual Disability	No	Yes	Behavioral/Emotional Disorder	No	Yes
Autism Spectrum Disorder	No	Yes	Sensory Processing Disorder	No	Yes
Epilepsy/Seizures	No	Yes	Other:		

Current grade level and school: _____

Special education: No Yes If yes, how many hours per day?_____
Past or current client of the Regional Center: No Yes Explain:_____

HEALTH HISTORY

Have you/your child had impairment /problems with any of the following? Select "No", "Yes, in the past", or "Yes, currently" for all that apply and explain.

	NO	YES in the past	YES currently	EXPLAIN
Feeding				
Vision				
Hearing				
Teeth/Mouth				
Breathing				
Heart				
Stomach				
Kidneys				
Urinary tract				
Fertility				
Muscles				
Bones				
Joints				
Skin				
Seizures				
Nervous system				
Endocrine system				
Blood				
Immune system				
Other				

Please list SPECIALISTS you/your child has been seen by (i.e. cardiology, neurology, endocrinology)

Specialist	Reason for seeing and date of last visit

(Please use back of questionnaire, if needed, to list other specialists)

Please list SURGERIES you/your child has had

Surgery	Reason for surgery and date of surgery

(Please use back of questionnaire, if needed, to list other surgeries)

Have you/your child had any of the following studies?

	NO	YES	DATE	DESCRIPTION & RESULTS
X-rays				
Ultrasounds				
MRI or CT				
Biopsy				
Genetic testing				
Other				

Current medications:

_____

Medication allergies:

_____

FAMILY HISTORY

Is there anyone else in the family with the same or a similar condition as you/your child? If so, please describe the symptoms or condition and how that person is related to the patient being seen in the Genomic Medicine Clinic.

Is there anyone in your family with the following conditions? If yes, please provide any details you know and describe how that person is related to the patient being seen in the Genomic Medicine Clinic.

Birth defects	No	Yes	Explain:_____
Developmental delay, learning disabilities or intellectual disability	No	Yes	Explain:_____
Multiple miscarriages	No	Yes	Explain:_____
Cancer	No	Yes	Explain:_____

Other conditions that run in the family and who they affect?

Please use space below for additional information or questions: