MEDICAL GENETICS REFERRAL- PLEASE CALL 914-304-5280 FOR APPOINTMENT

MEDICAL HISTORY INTAKE FORM

Patient Name: _____ Date: _____

DOB: _____ Age: _____ MRN: _____

Person completing form: _____ Relationship to patient: _____

Referred by: _____ Pediatrician: _____

Reason for Referral: _____

Medical History of Chief Concern: _____

_____

Birth History

Full Term: [ ] Yes [ ] No (If no: _____ weeks)
Birth Weight: _____ Birth Length: _____
Prenatal Problems: [ ] Yes [ ] No
Complications: [ ] Yes [ ] No
Age at discharge from hospital: _____

Medical Problems [ ] None

1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations and Surgical Procedures [ ] None

	Month/Year	Name of Hospital	Reason
1.			
2.			
3.			
4.			
5.			

Has the patient had any of the following procedures/tests? Where were they done?

[ ] Chromosome testing: _____
[ ] Metabolic testing: _____
[ ] MRI or CT scan: _____
[ ] X- Rays: _____
[ ] Ultrasound: _____
[ ] Other: _____

Previous Subspecialty Evaluations:

Specialty	Month/Year	Findings
Previous Genetics Evaluation [ ] Yes [ ] No		
Cardiology		
Neurology		
Endocrinology		
Gastroenterology		
Other: _____		

Developmental History:

Rolled over: _____ Sat independently: _____ Walked: _____
Single words: _____ Two word sentences: _____ Toilet trained: _____
History of regression (loss of milestones): [ ] Yes [ ] No

Education History:

Early intervention: [ ] Yes [ ] No
School setting: _____
Therapy: _____

Social & Family History:

Primary caregiver: _____
Day care: [ ] Yes [ ] No
Language(s) spoken at home: _____

Is there anyone in the family with similar medical problems: [ ] Yes [ ] No

Please use this space to specify any additional concerns you may have or additional relevant information:

_____

_____