

Medical Genetics Program of Southwestern Ontario
Tel: 519-685-8140 Fax: 519-685-8214

PREGNANCY AND CHILD DEVELOPMENT QUESTIONNAIRE

Name of Child: _____ Date of Birth: _____

Name of person completing this form: _____

Relationship to child: _____

Please complete the following information regarding the child being referred to the genetics clinic. This information will aid us in the assessment of your child and allow us to provide the best possible service to you and your family.

If you do not know an answer, please write “don’t know” or “DK” in the space provided. If necessary, please add a page with additional information.

Thank you

Pregnancy History

Age of biological mother at the time of the pregnancy: _____

During the pregnancy, did the child’s biological mother have any exposure to:

- Recreational Drugs No Yes, please specify _____
- Alcohol No Yes, please specify _____
- Medications No Yes, please specify _____
- Cigarettes No Yes, please specify _____
- X-rays No Yes, please specify _____
- Chemicals No Yes, please specify _____

During the pregnancy, did the child’s biological mother have any:

- Infections/Rashes No Yes, please specify _____
- High Fever No Yes, please specify _____
- Bleeding No Yes, please specify _____

Duration of Pregnancy: _____ weeks

Were there any complications during the pregnancy? No Yes, please specify _____

Was the pregnancy the result of infertility treatment? No Yes, please specify _____

Birth/Neonatal History

Type of Delivery: Vaginal C-section

Was the delivery induced: No Yes

Was vacuum or forceps required: No Yes, please specify _____

Birth weight of child: _____

Apgar Scores: 1 minute _____ 5 minutes _____ 10 minutes _____

Did the child require any oxygen or special treatment following the birth: No Yes

If yes, please specify _____

Were there any complications following the birth: No Yes

If yes, please specify _____

Development History

Please fill in the age at which the child reached the following developmental milestones:

Sitting _____

Drank from a cup _____

Crawling _____

Spoke 1st words _____

Walking _____

Toilet trained _____

What is the child's present school grade or highest grade completed if no longer in school? _____

Is the child in a modified program? No Yes

Please indicate in the space provided if the child has had any hospitalizations or surgeries:

Please indicate in the space provided if the child is taking any medications:

Do you have any additional concerns regarding your child's development?
