London Health Sciences Centre

Medical Genetics Program of Southwestern Ontario
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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 _____

Continue on back →

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?

_____

_____