

**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 1<sup>st</sup> 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:

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

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

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