Epilepsy and Brain Development Genetics Clinics

Medical/Family History Form

Please complete this form to the best of your ability and return it to us in the enclosed envelope.

Date Completed ______________

Child's Name __________________________________ Date of Birth ___________________________

Parent #1 Name __________________________________ Date of Birth ___________________________

Parent #2 Name __________________________________ Date of Birth ___________________________

Home Address ____

Street City

____

State/Country Zip

Home Phone ___________________________ Cell Phone __________________________________

Email ____

Languages spoken at home ______________________________

Would you like a language interpreter present for your visit? ☐NO ☐YES

What is your understanding of your child's diagnosis and prognosis? ____

____

____

What have your child's doctors told you about his or her condition, what is their opinion and what have they offered in terms of treatment?

____

____

How did you hear about us? ____

2/19

Genetic Testing

Has your child ever had genetic testing? NO YES

If yes, please fill out below: Please include all testing that is currently pending.

Test Name	Hospital	Ordering Doctor	Lab Completed

PRENATAL / BIRTH HISTORY

How many times has the patient's mother been pregnant? __________

Which of mother's pregnancies was this (1st, 2nd, etc)? __________

Was this pregnancy achieved through the use of any assisted reproductive technologies? ☐NO ☐YES

If yes, please indicate all that apply:

☐ Artificial insemination ☐ IVF ☐ GIFT ☐ ZIFT ☐ ICSI

☐ Assisted hatching ☐ Blastocyst transfer ☐ Egg donor ☐ Surrogate

☐ Sperm donor ☐ Preimplantation genetic diagnosis (PGD)

How many biological children does the mother have? _

Are all of these children currently living? ☐NO ☐YES

If no, please provide as much information as possible regarding any children who have passed away:

____

____

____

Were there pregnancy losses/miscarriages before this pregnancy? ☐NO ☐YES How many?_____________

Were there pregnancy losses/miscarriages after this pregnancy? ☐NO ☐YES How many?_____________

Biological mother's age at delivery _______________

Biological father's age at delivery _______________

Please check No or Yes if the following occurred; if Yes please describe.

During pregnancy:

Illness	☐NO	☐YES	Describe:________________________________
Medication taken	☐NO	☐YES	Describe:________________________________
Bleeding	☐NO	☐YES	Describe:________________________________
Smoking	☐NO	☐YES	Describe:________________________________
Alcohol	☐NO	☐YES	Describe:________________________________
Prenatal testing	☐NO	☐YES	Type &Results: ____________________________
Ultrasounds/Imaging	☐NO	☐YES	When &Results:____________________________

Length of pregnancy (in weeks):__________________

Please describe any problems during pregnancy:____

____

____

Labor and Delivery:

Induced	☐NO	☐YES	If yes, reason:___________________________
Lasted over 12 hours	☐NO	☐YES	
Cesarean section	☐NO	☐YES	If yes, reason:___________________________
Anesthesia	☐NO	☐YES	If yes, type: Spinal/Epidural/General (asleep)

Labor Complications: ____

Newborn Period:

Complications	☐NO	☐YES	If yes, describe:______________________
Cried right away	☐NO	☐YES	

APGAR scores, if known:______________@ 1 minute;__________@ 5 minutes

Birth Measurements: Head circumference________________; Weight___________; Length______________

Went home after______________days in the hospital

Infancy:

Enjoyed cuddling	☐NO	☐YES
Fussy/Irritable	☐NO	☐YES
Less active than other babies	☐NO	☐YES
Floppy/low muscle tone	☐NO	☐YES
Poor feeding	☐NO	☐YES

Other information we should know:____

____

DEVELOPMENTAL HISTORY

If you can recall, please record the age (in months or years) at which your child reached the following developmental milestones. If you do not recall the specific age, please indicate your best guess at to whether this was early, normal or late. If your child has not yet achieved a milestone please indicate this. Please indicate if your child has ever lost a skill (regressed) after having previously acquired that skill.

Gross Motor Skills

Skill	No	Yes	Lost Skill
Lifts head when prone	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Rolls front to back	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Rolls back to front	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Sits when placed	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Comes to a sit	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Crawls	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Stands w/o support	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Walks with assistance	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Walks independently	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________

Communication

Skill	No	Yes	Lost Skill
Smiles	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Coos	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Babbles	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Says single words	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Speaks in phrases	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Speaks in sentences	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Speaks clearly	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Gestures (waves)	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Points for wants	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Understands commands	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________

Fine Motor Skills

Skill	No	Yes	Lost Skill
Reaches for objects	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Holds objects	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Brings hands together	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Brings hands to mouth	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Uses pincer grasp	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Points with one finger	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________
Hand preference	☐ No	☐ Yes; *Age when acquired*________	☐Lost Skill; *Age when lost*________

Was the loss of any of these skills at the same time your child first developed seizures?

☐ No ☐ Yes ☐ Not applicable (no loss of skills)

List any services or therapies that your child receives & frequency:

Physical therapy: ☐ *Times per week* _____

Occupational therapy: ☐ *Times per week* _____

Speech therapy: ☐ *Times per week* _____

Other (please list type and frequency): ____

____

____

School Information

School Name/Location: ____

Grade in School: ________

Classroom type: ☐ Fully integrated ☐ Partially integrated ☐ Separate special education

Accommodations: ____

____

____

EPILEPSY HISTORY (if applicable)

Age at time of 1st seizure: ☐less than 1 month ☐1 –3 months ☐4–6 months ☐7–12 months ☐> 1 year

Longest seizure free period: ☐< 1 week ☐1 week to 1 month ☐2–3 months ☐4-6 months ☐7–12 months ☐1–2 years ☐>2 years

Has your child ever had a very long seizure, lasting >15 minutes? ☐No ☐Yes

If yes, number of times this has happened____________

Please describe seizure types in detail below:

#	Seizure type	Description	Age of onset/ Age of resolution (if resolved)	Current frequency/ max. frequency
1				
2				
3				
4				

MEDICAL HISTORY

Please tell us if your child has ever had any of the following medical concerns:

Concerns involving…	**Yes**	**Describe** (ex. frequency, type, starting at what age)
Seizures		
Hearing		
Vision		
Headaches		
Allergies		
Heart		
Lungs		
Ear infections		
Blood (such as anemia)		
Kidney or bladder		
Stomach or bowel		
Bones		
Muscles		
Growth		
Serious head injury		
Serious injury		
Hospitalization		
Surgery		
Intellectual disability		
Developmental delay		
Behavior		
Mental health		
Sleep		
Learning disabilities		

List any other health problems including genetic diagnoses:____________________________________

Imaging/MRI information:

What have you been told by your doctors about any structural brain abnormalities?

[ ] No structural brain abnormalities

[ ] Yes, structural brain abnormality present

If yes, please describe as you understand the findings

____

____

____

MEDICATIONS

List any medications and doses that your child currently takes:

Name	Dose	Frequency (such as twice daily)	Side effects

List any other anti-seizure medications that your child has taken in the past:

Name	Max Dose if known	Side effects/Reason for Discontinuing

FAMILY HISTORY

Please complete this section to the best of your ability. If there are limitations in your knowledge of biological family members due to adoption, egg/sperm donation or other family circumstances please indicate this.

Parents

	Child's Biological Mother	Child's Biological Father
Current age		
Occupation		
Highest grade completed in school		
Medical problems		
Learning problems		
Mental health problems		
History of epilepsy, age of onset and seizure types if known, syndrome diagnosis? Cause? Febrile seizures?		

Because it can be important to know for genetic evaluations, are you child's parents related to each other by blood or do they share any blood relatives in common? ☐Yes ☐No

- Child's biological MOTHER's family's ethnic background/ancestry? (example: English, Nigerian, Russian, Jewish etc.)

  ____

Your child's biological MOTHER has how many sisters?_____________ How many brothers? ___________________

Please list mother's siblings' names, with the age of each person & how many children each person has. *Use back if necessary.*

First Name	Full or Half Sibling	Age	# Daughters	#Sons

- Child's biological FATHER's family's ethnic background/ancestry? (example: English, Nigerian, Russian, Jewish etc.)

  ____

Your child's biological FATHER has how many sisters?______________ How many brothers? ___________________

Please list father's siblings' names, with the age of each person & how many children each person has. *Use back if necessary.*

First Name	Full or Half Sibling	Age	# Daughters	#Sons

Siblings

Your CHILD has how many full sisters (same mother & same father)?__________ Half sisters? _______________

Your CHILD has how many full brothers (same mother & same father)?_________ Half brothers? ______________

Other Family History *Use back if necessary.*

- On the following page, please indicate the type of *medical, neurological, behavioral, mental health or learning problems* diagnosed in any relatives including siblings, cousins, aunts, uncles, grandparents (examples: **seizures, cancer of any type, mental illness including depression/anxiety/bipolar disorder, vascular/heart disease, intellectual disability, learning disabilities, developmental delays, birth defects, autism, fertility problems or multiple miscarriages). Please indicate whether the relative is related to your child through the maternal or paternal side of the family.**
- In last column, please circle A for alive, D for deceased and indicate the current age, or age at death

RELATIONSHIP TO CHILD	FIRST NAME	TYPE OF PROBLEM	AGE DIAGNOSED	STATUS & AGE
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age
				A D Age

Please add any other information you would like us to know about your child and his/her family history:

CLINIC NOTES

If you would like the medical note from our meeting sent to other healthcare providers, please include their names and addresses below:

Health Care Provider	Name	Address	Fax
Primary Care/ Pediatrician			
Neurologist			
Other (please specify)			

INFORMATION NEEDS

We will discuss a number of topics during your visit. In order to help us meet your personal needs, please indicate if any of the following areas are of particular interest to you.

Review of diagnosis, including review of previous studies & results such as genetic tests, MRI, and/or EEG.

Discussion of treatments.

Genetic counseling, including discussion of genetics and inheritance and/or possible concerns for future pregnancies or other family members.

Discussion of emotional aspects of caring for a child with special needs and/or sources of information and support.

Discussion of potential enrollment into genetic research studies.

Additional questions or concerns you would like to discuss: ______________________________

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