# 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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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?

# 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:**

|  |  |  |  |
| --- | --- | --- | --- |
| IllnessMedication taken | NONO | YESYES | Describe: 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:** |  |  |  |
| InducedLasted over 12 hours Cesarean section | NONONO | YESYESYES | If yes, reason: If yes, reason:  |
| Anesthesia | NO | YES | If yes, type: Spinal/Epidural/General (asleep) |

Labor Complications:

|  |  |
| --- | --- |
| **Newborn Period:** |  |
| Complications Cried right away | NONO | YESYES | If yes, describe:  |

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

|  |  |  |
| --- | --- | --- |
| **Name** | **Max Dose****if known** | **Side effects/Reason for Discontinuing** |
|  |  |  |
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**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 seizuretypes 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 |
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|  |  |  |  | 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: