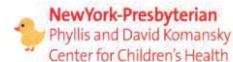


Division of Medical Genetics

Medical History Intake Form



Weill Cornell Medical College



Department of Pediatrics
Division of Human Genetics

505 East 70th Street, 3rd Floor, Box 128
New York, NY 10065
Telephone: 646-962-2205
Fax: 646-962-0273

Patient Name: _____ Date: _____

DOB: _____ Age: _____ MRN: _____

Person completing form: _____ Relationship to patient: _____

Referred by: _____ Pediatrician: _____

Reason for Referral: _____

Medical History of Chief Concern: _____

Birth History

Full Term: Yes No (If no: _____ weeks)

Birth Weight: _____ Birth Length: _____

Prenatal Problems: Yes No

Complications: Yes No

Age at discharge from hospital: _____

Medical Problems None

1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations and Surgical Procedures None

Month/Year	Name of Hospital	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Has the patient had any of the following procedures/tests? Where were they done?

- Chromosome testing: _____
- Metabolic testing: _____
- MRI or CT scan: _____
- X- Rays: _____
- Ultrasound: _____
- Other: _____

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Medical History Intake Form



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Department of Pediatrics
 Division of Human Genetics

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Previous Subspecialty Evaluations:

Specialty	Month/Year	Findings
Previous Genetics Evaluation <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiology		
Neurology		
Endocrinology		
Gastroenterology		
Other: _____		

Developmental History:

Rolled over: _____ Sat independently: _____ Walked: _____
 Single words: _____ Two word sentences: _____ Toilet trained: _____
 History of regression (loss of milestones): Yes No

Education History:

Early intervention: Yes No
 School setting: _____
 Therapy: _____

Social & Family History:

Primary caregiver: _____
 Day care: Yes No
 Language(s) spoken at home: _____

 Is there anyone in the family with similar medical problems: Yes No

Please use this space to specify any additional concerns you may have or additional relevant information:
