



**CEDARS-SINAI MEDICAL CENTER.**  
**Medical Genetics**

Dear Parent(s),

Enclosed you will find a questionnaire required for our Plagiocephaly Clinic. The questionnaire was designed to be respectful of your time, and targeted to obtain the information pertinent to this clinic. We ask that you complete the questionnaire and return it to us, preferably to fax number **310-423-9890**, as soon as possible.

**Appointments will be scheduled ONLY AFTER we receive this completed questionnaire.**

Our clinic is located in the (Steven Spielberg Building) Child Health Care Clinic at 8723 Alden Drive, 2<sup>nd</sup> Floor, Room 240, Los Angeles, CA 90048.

If your insurance is an HMO, you will need prior authorization for the visit from your pediatrician's office **BEFORE** your appointment is scheduled. It is your responsibility to obtain any needed authorizations.

**Please enclose a copy of the front and back of your insurance card with your questionnaire.**

It is important to keep you child's appointment as we are scheduling patients a few weeks in advance. If for some reason you are unable to keep your appointment, please call our office at the number below at least 24 hours prior to your clinic appointment so we can re-assign your clinic time to another patient. If you are late 15 minutes or more, your appointment will be subject to cancellation and will need to be rescheduled. **Please be on time.**

If you have a co-payment, we will collect it at the time of your appointment. We will be billing the insurance company and will need your insurance information at the time you check in for your appointment.

If you have any questions, please call the office at the number below.

Thank you,

Lisa Downs

## MEDICAL GENETICS - PEDIATRICS

Date:	Expected DOS:
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**PATIENT INFORMATION:**

Name:	DOB:	Sex:	MRN:
Address:		City, State, Zip Code:	
Mother's Maiden Name:		Race:	Birthplace:
Home #:	Social Security No:		Religion:
Emergency Contact:	Relationship:		Phone:

**PARENT/GUARDIAN OR NEAREST RELATIVE INFORMATION:**

Mother's Name:	Soc Sec. No.	Race:
Employer:	Occupation:	DOB:
Phone:	Employ. Address:	
Father's Name:	Soc. Sec. No:	Race:
Employer:	Occupation:	DOB:
Phone:	Employ. Address:	

**PRIMARY CARE PHYSICIAN INFORMATION:**

Physician:	Contact:
Address:	City, State:
Phone:	Fax:

**REFERRING PHYSICIAN INFORMATION [If Different from Primary Care Physician]:**

Physician:	Contact:
Address:	City, State, Zip:
Phone:	Fax:

**INSURANCE INFORMATION: (circle one) PPO HMO POS EPO**

Insurance Name:		Phone #	
		Medical Group Phone#	
Address:		City, State, Zip:	
Subscriber:	ID #:	Group #:	
Plan#:	Effective:		Co-Pay: \$
Diagnosis:		Medications:	
COMMENTS/NOTES			

**THIS FORM MUST BE FILLED  
OUT COMPLETELY.  
THANK YOU**



**CEDARS-SINAI MEDICAL CENTER.**  
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**A. Parent Questionnaire/ Plagiocephaly Clinic**

Name of the baby to be evaluated: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mother's name: \_\_\_\_\_  
 Father's name: \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_  
 Primary MD:  Same as above  Other: \_\_\_\_\_

**Pregnancy History:** Are you the  Birth parent  Adoptive parent  Other \_\_\_\_\_  
 How many pregnancies have you had (including this child)? \_\_\_\_\_ Prenatal Care:  Yes  No  
 Was this a multiple gestation?  No  Yes  Twins  Triplets  Other \_\_\_\_\_  
 Mother's age during pregnancy: \_\_\_\_\_ Father's age: \_\_\_\_\_  
 How long was your pregnancy? \_\_\_\_\_ Did the baby move normally?  Yes  No  
 Did you have pre-term labor?  No  Yes \_\_\_\_\_  
 Did you feel that you carried the baby low?  No  Yes \_\_\_\_\_  
 Did you drop early?  No  Yes \_\_\_\_\_

**Birth History:** Please fill in as much of the baby's birth history as possible.  
 Birth weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Head circumference: \_\_\_\_\_  
Check all that apply:  
 Delivery was:  Induced  Spontaneous  Vaginal  C-section  
 Delivery was assisted by:  Forceps  Vacuum Extraction  
 Presentation of the baby at birth was:  Head first  Breech position  
 Head shape at birth:  Normal  Molding  'Coned'  Flattened  
 Other: \_\_\_\_\_  
 Did you notice any facial asymmetry at birth?  No  Yes \_\_\_\_\_  
 Did your baby have a head tilt at birth?  No  Yes \_\_\_\_\_

Children's Health Center \* 8723 Alden Drive \* 2<sup>nd</sup> Floor \* Suite 240 \* Los Angeles, CA 90048

(Steven Spielberg Building)

**Medical history:**

Has your baby been hospitalized since birth?  No  Yes: \_\_\_\_\_

Has your baby had any surgeries?  No  Yes: \_\_\_\_\_

Has your baby had any x-rays or imaging studies completed?  No  Yes: \_\_\_\_\_

Has your baby been evaluated by any specialists?  No  Yes: \_\_\_\_\_

Does your baby have any other medical problems?  No  Yes: \_\_\_\_\_

What are your concerns with your baby's head shape?  None  Concerns: \_\_\_\_\_

When did you first notice the change in head shape?  None  Comments: \_\_\_\_\_

Does your baby like to face one side over the other?  No  Yes. If yes, does your baby like to face toward the  Left  Right?

Has your baby been evaluated by a physical therapist?  Yes  No

Is your baby currently receiving physical therapy?  Yes  No

How do you place your baby to sleep?  On his back  On his side  In a baby positioner  Other: \_\_\_\_\_

Does your baby have any *Allergies*?  No  Yes: \_\_\_\_\_

Is your baby taking any *Medications*?  No  Yes: \_\_\_\_\_

Are your baby's *immunizations* up to date?  Yes  No

**Social History:**

Who cares for the baby during the day? \_\_\_\_\_

**Development:**

Is your baby's development  Normal  Abnormal

If abnormal, please describe \_\_\_\_\_

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If abnormal, is your child receiving developmental services?  No  Yes

If yes, please write in \_\_\_\_\_

**Family History:**

Are there any family members with a head shape abnormality?  No  Yes

If yes, please fill in the relation of the family member \_\_\_\_\_

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Are there any known genetic conditions in your family?  No  Yes

If yes, please describe \_\_\_\_\_

Please check the appropriate boxes concerning your baby.

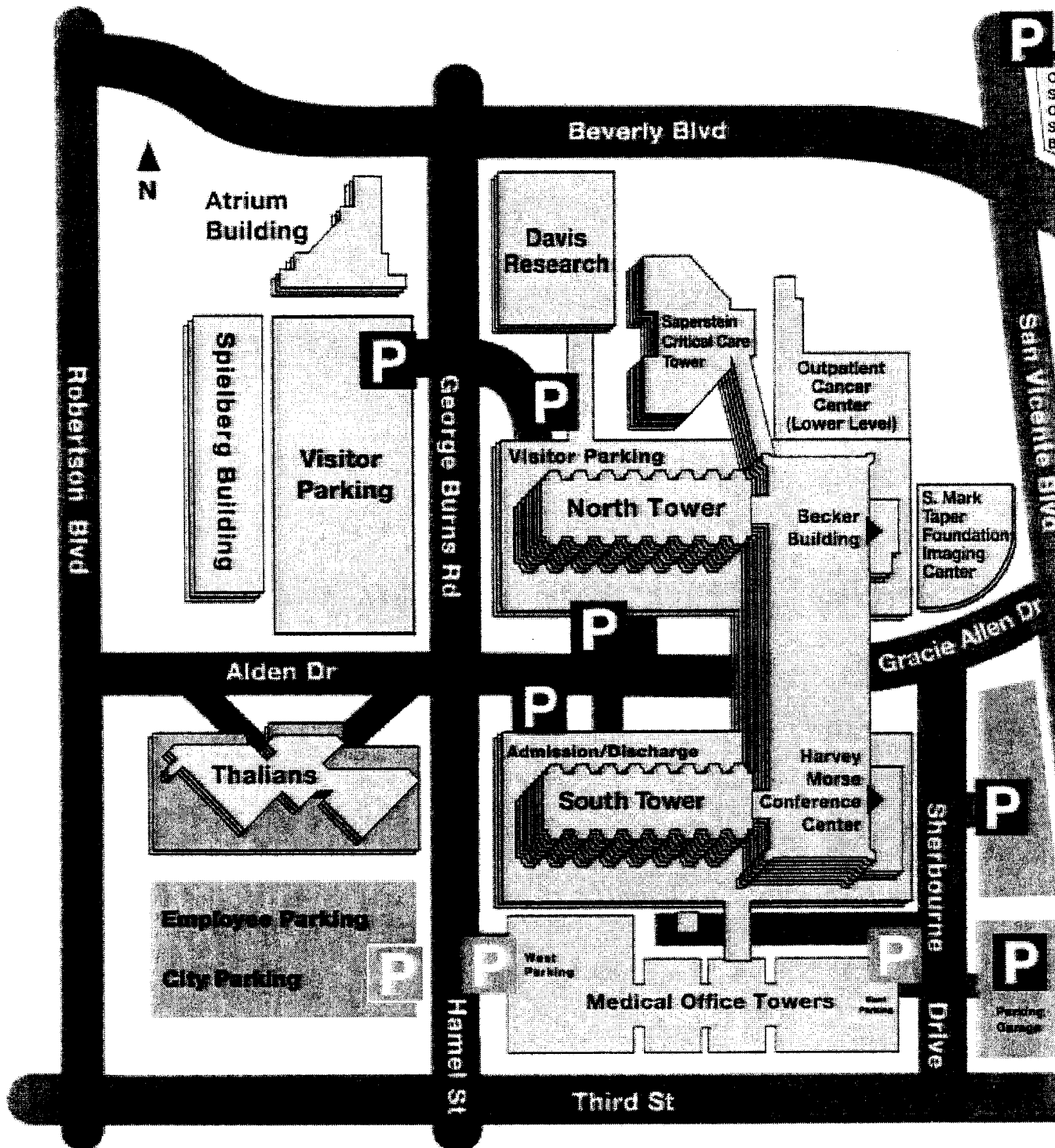
Review of Systems:	Check if normal	Check and describe if abnormal
General Behavior	<input type="checkbox"/>	<input type="checkbox"/>
Eyes/Ears	<input type="checkbox"/>	<input type="checkbox"/>
Nose/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>

Check if normal

Check and describe if abnormal

	Check if normal	Check and describe if abnormal
Respirations/ Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal (diet)	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (elimination)	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Growth/ Height and weight	<input type="checkbox"/>	<input type="checkbox"/>
Blood/ Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/ Immunologic	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by (please print) \_\_\_\_\_  
Relationship to this baby? \_\_\_\_\_ Date completed: \_\_\_\_\_



**P** Validated parking

**P** Non-validated parking