CEDARS-SINAI MEDICAL CENTER®

Charcot-Marie-Tooth Hereditary Neuropathy Clinic

NEW PATIENT QUESTIONNAIRE

SECTION ONE: Patient Information – Please answer ALL questions regarding the patient, whether it is you or your child.

Patient's Name: ☐ **Male** ☐ **Female**

Mother's Name:	**Father's Name:**

Are both of the above the natural parents? ☐ **Yes** ☐ **No**

Referring M.D.	Phone Number ( )
Address	Fax Number ( )
Primary M.D.	Phone Number ( )
Address	Fax Number ( )

Briefly describe the nature of your problem(s) and what you hope to gain from this appointment.

Please list all physicians that take care of the patient:

Name	Phone #	Specialty	Last & Next Visit

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SECTION TWO: (Part A) Prenatal History

Which of the following applied to your pregnancy, if applicable?

☐ Chronic Illness	☐ Tobacco Use	☐ Prenatal Vitamins
☐ Fever	☐ Drug Use	☐ Fever
☐ Infection	☐ Alcohol consumption	☐ Folic Acid Use before conception/ or during pregnancy
☐ Bleeding	☐ Exposure to Chemicals	
☐ Abnormal fetal movements	☐ Use of medication	
☐ Normal Pregnancy	☐ Exposure to X-Rays	☐ Other

Please explain any that you have checked: ________________________________

____

Birth History:

Length of patient's mother's pregnancy:____________

Delivery type: ☐ Vaginal ☐ C-Section

Birth length:__________ Birth weight:_________ Head circumference _______

Presentation: ☐ Head first ☐ Bottom first ☐ Other________________________

Hospital:___________________________ Apgar Scores (if known) ___________

Length of stay in nursery: ____

Birth complications, if any: ____

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SECTION TWO: (Part B) Medical History

What studies have been performed on the patient?

Copies of these reports/imaging should be forwarded to our office prior to any appointment.

- ☐ X-Rays
- ☐ CT Scan/MRI
- ☐ Ultrasound
- ☐ EEG
- ☐ EKG (electrocardiogram)
- ☐ Echocardiogram
- ☐ Other Studies ____________________
- ☐ Chromosome Analysis
- ☐ Specialized Genetics Studies
- ☐ Other Bloodwork
- ☐ Skin or Organ Biopsy
- ☐ Eye/Vision Exam
- ☐ Hearing Evaluation
- ☐ Developmental Assessment

Please list any medications that the patient takes.

Name of Medication	Dosage	Reason
____________	______	____________
____________	______	____________
____________	______	____________
____________	______	____________

Do you feel that your child is developing normally? ☐ Yes ☐ No

Does your doctor feel that your child is developing normally? ☐ Yes ☐ No

If no, please explain: ______________________________

____

What grade is your child in? ___________

☐ Regular Classes ☐ Special Education ☐ Adaptive PE

Has your child been referred to a Regional Center? ☐ Yes ☐ No

Which Center? ____________________

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SECTION TWO: (Part B) Medical History (con't)

Please check any of the following that apply to the patient's medical history.

Muscle/Bone: ☐ Weakness of _______________ ☐ Cramps of _______________
☐ Stiffness of _______________ ☐ Deformity of _______________
☐ Joint Pain of _______________ ☐ Limitation of movement of _______________

General: ☐ Fever ☐ Chills ☐ Sweats ☐ Fatigue
☐ Change in Weight ☐ Change in Height ☐ Hospitalizations/Surgeries
☐ Temperature Sensitivity ☐ Surgeries ☐ Significant Illnesses
☐ Chronic Medical Issues ☐ Birth Defects

Behavioral: ☐ Speech Delay ☐ Motor Delays ☐ ADHD/ADD
☐ Feeding Difficulties ☐ Sleeping Problems ☐ Behavior Problems
☐ Learning Disability

Therapy: ☐ Physical Therapy ☐ Occupational Therapy
☐ Infant Stimulation ☐ Speech Therapy ☐ Other___________

Skin: ☐ Rashes ☐ Easy Bruising ☐ Eczema ☐ Lumps
☐ Birthmarks ☐ Skin Disorder ☐ Nail Changes

Head: ☐ Headaches

Eyes: ☐ Redness ☐ Discharge ☐ Change in vision
☐ Glaucoma ☐ Cataracts ☐ Eyeglasses ☐ Sensitivity to light
☐ Droopy Eyelids ☐ Crossed eyes (Strabismus) ☐ Color Blind

Ears: ☐ Infections ☐ Ringing ☐ Hearing Problems
☐ Deafness

Nose: ☐ Bleeding ☐ Allergies ☐ High frequency of "colds"

Mouth: ☐ Teeth Problems ☐ Gum Problems ☐ Unusual voice
☐ Cleft Lip/Palate

Neck: ☐ Lumps ☐ Pain ☐ Thyroid issues

Chest: ☐ Cough ☐ Pain ☐ Respiratory problems
☐ Asthma ☐ Wheezing ☐ Pneumonia ☐ Snoring
☐ Apnea ☐ Restlessness (Frequent waking while sleeping)

Heart: ☐ Palpitations ☐ Shortness of breath with exertion
☐ Heart murmur ☐ Abnormal blood pressure

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SECTION TWO: (Part B) Medical History (con't)

Digestive: ☐ Poor appetite ☐ Excessive hunger ☐ Excessive thirst
☐ Nausea ☐ Swallowing difficulty ☐ Constipation ☐ Diarrhea ☐ Reflux
☐ Vomiting ☐ Stomach aches ☐ Liver disease ☐ Food intolerance

Urinary: ☐ Pain on urination ☐ Frequent urination ☐ Blood in urine
☐ Bed-Wetting ☐ Strong or unusual odor of urine ☐ Unusual color of urine
☐ Infections

Neurologic: ☐ Fainting ☐ Dizziness ☐ Numbness ☐ Tingling
☐ Tremors ☐ Tics ☐ Seizures ☐ Unsteady Gait ☐ Mood changes

SECTION THREE: Family History

The patient's mother's history:

Date of birth_______ # of Pregnancies____ # of Livebirths_________
Height ___________ # of Miscarriages___ # of Stillbirths__________

Please check any of the following that apply to the patient's mother's medical history.

Muscle/Bone: ☐ Weakness of _______________ ☐ Stiffness of _______________
☐ Cramps of _______________ ☐ Deformity of ______________
☐ Joint Pain of ______________ ☐ Limitation of movement of ______________
☐ Ankle sprains_________ ☐ Toe walking ______________
☐ Difficulty with shoe wear ______________

Please list any other medical problems/medications: ________________________
____

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NEW PATIENT QUESTIONNAIRE

The patient's father's medical history:

Date of birth_______ Height ___________

Please check any of the following that apply to the patient's father's medical history.

Muscle/Bone: ☐ Weakness of _______________ ☐ Stiffness of _______________
☐ Cramps of _______________ ☐ Deformity of ______________
☐ Joint pain of ______________ ☐ Limitation of movement of ______________
☐ Ankle sprains, year _________ ☐ Toe walking ______________
☐ Difficulty with shoe wear ______________

Please list any other medical problems/medications: _____________________

Are the patient's mother and father related? (for example, cousins)
☐ Yes ☐ No ☐ Possibly

Continued on next page.

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NEW PATIENT QUESTIONNAIRE

SECTION THREE: Family History (con't)

List patient's brothers and sisters: (If half sibling's, please note maternal or paternal)

A-Alive D-Deceased

Name	Age	Sex	Health Problems	Muscle/Bone Probs.	A/D	Full/half sibling

List mother's brothers and sisters: (If half sibling's, please note maternal or paternal)

A-Alive D-Deceased

Name	Age	Sex	Health Problems	Muscle/Bone Probs.	A/D	Full/half sibling

List father's brothers and sisters: (If half sibling's, please note maternal or paternal)

A-Alive D-Deceased

Name	Age	Sex	Health Problems	Muscle/Bone Probs.	A/D	Full/half sibling

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NEW PATIENT QUESTIONNAIRE

SECTION THREE: Family History (con't)

Grandparent's information:
A-Alive D-Deceased

	Name	A/D	Age	Ethnic Background	Health Problems	
Maternal Grandmother						☐ Foot Deformity ☐ Toe Deformity
Maternal Grandfather						☐ Foot Deformity ☐ Toe Deformity
Paternal Grandmother						☐ Foot Deformity ☐ Toe Deformity
Paternal Grandfather						☐ Foot Deformity ☐ Toe Deformity

Is there a family history of …?

- ☐ Miscarriages
- ☐ Stillbirths
- ☐ Infertility
- ☐ Birth Defects
- ☐ Newborn/Childhood deaths
- ☐ Cancer
- ☐ Mental Retardation
- ☐ Learning Disorders/ Developmental Delay
- ☐ Autism
- ☐ Psychiatric Disorder
- ☐ Unusual Appearance
- ☐ Hand Weakness
- ☐ Toe Deformity
- ☐ Foot Deformity
- ☐ Toe Walking
- ☐ Other disease, please list:____

____

This form was filled out by: ____

Date: __________________

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