Dear Parent / Guardian of: ____________________________________________________

Your child’s appointment in the General Pediatrics Genetics Clinic is scheduled for:
___________________________________________ at ____________________ am pm.

Please arrive at the clinic by ________________________________________________ am pm.

Genetic counseling and evaluation by a physician are each services provided for a fee. Emory Clinic Department of Human Genetics will bill your insurance company within one week of your appointment. Please bring your child’s insurance card to the appointment. You are responsible for any charges not covered by insurance as well as preauthorization for services that may be required by your insurance company.

FOR ALL APPOINTMENTS:

▪ The attached Questionnaire is for you to complete regarding your child. Please return it to us BEFORE YOUR APPOINTMENT via email to the address below (Attn: Pediatric Clinic) or via fax (404-778-8562). It is important that we receive this information prior to the appointment, as it helps us establish an appropriate evaluation plan for your child.
▪ Please allow for an extra 15-20 minutes before your appointment for parking. Fees for parking range from $4 to $8 depending on your length of stay. Valet parking is a flat rate of $8.
▪ Please arrive 30 minutes before your scheduled appointment time for registration, insurance processing, and patient triage.
▪ If you arrive 20 minutes or more after your scheduled appointment time, your appointment is subject to cancellation. Decisions regarding these matters are left to the discretion of the clinicians.
▪ Please plan to spend approximately 2 hours at Emory Genetics.
▪ Be sure to bring your child to this initial appointment and all follow-up appointments in the Pediatric Genetics Clinic. If you feel that your child might distract you from listening to what the counselor/physician has to say, try to bring another adult with you to supervise the child in the waiting area. An appointment in this clinic cannot take place without the child present.
▪ If you cannot keep your appointment, please call 404-778-8570 as far in advance as possible so that we can offer this appointment to another patient.

The enclosed packet should contain the following forms:

▪ This cover letter
▪ Directions to Emory Genetics Clinic
▪ Emory Clinic Department of Human Genetics Patient Registration Form
▪ Financial Services Statement
▪ Special Questionnaire Regarding your Child’s Genetics Clinic Visit

Thank you,
Emory Genetics

1365 Clifton RD., Building B, Suite 2200 • Atlanta, Georgia 30322
Tel 404.778.8570 • Fax 404.778.8562
An equal opportunity, affirmative action university
Version 12302016
### PATIENT REGISTRATION FORM

#### PATIENT (CHILD) INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>City, State, Zip:</th>
<th>Home Telephone: ( )</th>
<th>Date of Birth:</th>
<th>Sex:</th>
<th>Child’s Social Security #:</th>
</tr>
</thead>
</table>

#### PARENTAL / BILLING INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>City, State, Zip:</th>
<th>Home Telephone: ( )</th>
<th>Social Security #:</th>
<th>Date of Birth:</th>
<th>Employer:</th>
<th>Employer’s Address:</th>
<th>City, State, Zip:</th>
<th>Work Telephone: ( )</th>
<th>( )</th>
<th>( )</th>
</tr>
</thead>
</table>

With whom does the patient reside? (Circle one) Mother Father Legal Guardian

Language (if not English): Other – please specify:

#### Referred By:

Physician ____________________________ Specialty ____________________________
Address ____________________________ City ______ State ______ Zip ______
Telephone ( ) ______________________ Pre-cert # ______________________

#### Primary Care Physician:

Name: ____________________________ Phone: ____________________________
Address: __________________________

Chief Complaint (Reason for Visit): ______________________________________

Please provide insurance information below:

#### MEDICAID

Insured’s Name: ____________________________ Medicaid # (include letters):

Please check one:
- GBHC ____________________________
- HMO ____________________________
- Family Plus ____________________________
- American ____________________________
- Other ____________________________

#### INSURANCE POLICY NO. 1

Insured’s Name: ____________________________
ID # (include letters): ____________________________
Group # or Name: ____________________________
Ins. Co. Name: ____________________________
Address for Mailing Claims: ____________________________

#### INSURANCE POLICY NO. 2

Insured’s Name: ____________________________
ID # (include letters): ____________________________
Group # or Name: ____________________________
Ins. Co. Name: ____________________________
Address for Mailing Claims: ____________________________
ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the Emory Clinic Department of Human Genetics. I understand I am financially responsible for non-covered services, remaining deductible and co-pay. I also authorize the Emory Clinic Department of Human Genetics to release any information required in the processing of this claim.

Signed (Patient or Parent of Minor) ________________________________ Date ____________

In case of emergency, please notify:

Name_________________________________ Telephone No._________________

Address____________________________________________________________
A Special Questionnaire Regarding Your Child’s Genetics Clinic Visit

In order to help us develop an appropriate evaluation plan for your child BEFORE you arrive for your appointment, it is essential that you complete this questionnaire to the best of your ability.

Part of a genetics evaluation involves looking at a person’s physical features. These physical features may suggest certain genetic conditions and rule out others. We ask that you provide a CLEAR, RECENT photograph of your child so that we may begin to evaluate for these things ahead of time. Feel free to include any pictures that are relevant to the reason your child has been referred. We will be able to return these photos to you if you need them at your clinic visit.

If English is not your first language and you are having trouble filling out this form, please contact us at 404-778-8570 and we will be happy to assist you.

Attach Photograph Here
What are the main reasons why your child’s doctor has requested this genetic evaluation? What questions / concerns do you have about your child? ____________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

Is your child adopted? Yes _____ No _____
Is the child being seen today currently in foster care? Yes _____ No _____

If YES, to either question above, please fill out this questionnaire to the best of your ability.

**Pregnancy History** (For the pregnancy of the child with the appointment)

Mother’s age at delivery? _____ Father’s age at delivery? _____
The pregnancy was confirmed by (circle one) blood test / urine test at about ____ (circle one) weeks / months.
What number pregnancy was this for the mother (1st, 2nd, 3rd, etc.)? _____
When did the mother begin prenatal care? (circle one)
1st Trimester 2nd Trimester 3rd Trimester No prenatal care

Please answer the following Yes / No questions about the pregnancy, providing detail where appropriate. Use the back of the page if necessary.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal vitamins?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications (prescription)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications (over-the-counter)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol (beer, liquor, wine)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street drugs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness / Infection?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Problems?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays / radiation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature labor?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization? (Do not count the delivery/birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal growth of baby?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other concerns?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please answers the following Yes / No questions regarding testing that may have been done during the pregnancy.

<table>
<thead>
<tr>
<th>Category</th>
<th>Test</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>First Trimester Screen (ultrasound of baby’s neck / Nucal Translucency / NT measurement plus blood work)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Second Trimester Screen (Triple Screen, Quad Screen, AFP Test)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Chronic Villus Sampling (CVS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amniocentesis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Glucose Tolerance Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routine Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialized Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (please explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Were any of the tests ABNORMAL? If YES, please explain: __________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

First movements of the baby were felt at: _________ weeks / months (circle one): Yes  No

Were the baby’s movements normal during the pregnancy? (circle one): Yes  No

Mother’s total weight gain during pregnancy: __________pounds

**Birth History** (For birth of the child with the appointment)

Due date: __________  Date delivered: __________

The child was born (circle one):  Early  On Time  Late

If early or late, by how many weeks? _____________________________________________

Birth Hospital (if not in GA, please include the state): ___________________________

Was the labor (circle one):  Spontaneous (happened on its own) OR Induced?

If induced, please explain the reason why and the method used (ex: doctor broke your water, pitocin, etc.) if known: ____________________________________________
____________________________________________________________________________
____________________________________________________________________________
Department of Human Genetics

How was the child delivered? (circle one): Vaginal C-section

If C-section, please explain the reason why (ex: previous child born that way, failure to progress, etc.): ________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Was the baby born head first? (circle one): Yes No I don’t know

Baby’s weight: _________ Baby’s length:_________ Baby’s head size:_________

Were there complications with the delivery? (circle one): Yes No

If YES, please list complications:________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Were there any problems right after birth (ex: need to go to the NICU, breathing problems, jaundice, etc)? (circle one):

Yes No

Did the baby have any feeding difficulties? (circle one): Yes No

If YES to either question, please explain:___________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Was your child born with any birth defects (ex: club foot, cleft lip and/or cleft palate, heart defects, extra fingers, etc.)? (circle one):

Yes No

If YES, please explain:_________________________________________________________________

After the baby was born, how did he/she feed? (circle one): Breast Bottle Other

If Other, please explain:_________________________________________________________________

Your baby was discharged home at_____________________________ days / weeks (circle one)
# Past Medical History

Please answer the following Yes / No questions about possible tests / procedures / etc. that your child may have had. If your child has had one of these things, please provide more detail in the far right box. Use the back of the page for extra space if you need it.

<table>
<thead>
<tr>
<th>Category</th>
<th>Has your child…</th>
<th>Yes</th>
<th>No</th>
<th>Comment (When? Why? Where? Results?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Had a formal eye examination with pediatric ophthalmology?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Had a formal hearing examination?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Been hospitalized overnight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Had surgery?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Currently taking any medications?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Been tested for allergies?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetics</td>
<td>Ever had genetic testing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>Had an MRI of the <strong>brain</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of the <strong>kidney</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of the <strong>heart</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Had a CT scan of the brain?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of the <strong>kidney</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of the <strong>heart</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Had an ultrasound of the <strong>brain</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of the <strong>kidney</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of the Heart (echocardiogram)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Had an X-ray of the <strong>brain</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of <strong>kidney</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Of <strong>heart</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Had any other special procedures (ex: EEG, swallow study, etc.)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Does your child have any significant problems with any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusual weight gain or loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes / vision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears / Nose / Mouth / Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs / Breathing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart / Veins / Arteries / Circulations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach/ Intestines/ Bowels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney/ Bladder/ Genitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bones/Muscles (pain, weakness, abnormalities, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint pains / Swelling / Stiffness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin / Hair / Nails</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bruising / Bleeding or poor wound healing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches / Seizures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of balance or coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of developmental skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep disturbances / Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior / Psychological Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat or cold intolerance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delays or problems with puberty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hormones</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Early Development**

WHEN did you or your doctor first become concerned about your child’s development?

____________________________________________________________________________
____________________________________________________________________________

If there are any concerns about your child’s development, HOW were they noticed?

____________________________________________________________________________
____________________________________________________________________________
**Other than a pediatrician, what doctors is your child **ACTIVELY** seeing? (Please list specialty and name, if known).**

<table>
<thead>
<tr>
<th>Name of Doctor</th>
<th>Specialty (ex: neurology, cardiology, GI, etc.)</th>
<th>Reason your child is seen</th>
<th>How often child sees this doctor (ex: once a year, every 3 months, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other than a pediatrician, what doctors has your child seen **IN THE PAST?**

<table>
<thead>
<tr>
<th>Name of Doctor</th>
<th>Specialty (ex: neurology, cardiology, GI, etc.)</th>
<th>Reason your child was seen</th>
<th>Date of last visit with this specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old was your child when he/she began:
- Rolling Over? ________________
- Crawling? ________________
- Cruising? ________________
- Pulling to stand? ________________
- Sitting alone? ________________
- Walking alone? ________________
- First word? ________________
- Sentences? ________________
- Toilet trained? ________________

Has your child lost any skills that he/she previously mastered (regression)? (circle one): **Yes**  **No**
If **YES**, please explain:_________________________________________________________
______________________________________________________________________________

**School Information**

Does your child currently attend school or daycare? (circle one): **Yes**  **No**
If **YES**, what is the name of the school / daycare? _______________________________________
Grade (if applicable)? ____________________________________________________________
Does your child attend special classes or need special help? (circle one): Yes  No
If YES, please explain. (For example, what subjects does he/she need help in? Is he/she in an inclusion class or self-contained class? If possible, please send us a copy of your most recent IEP).
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

<table>
<thead>
<tr>
<th>Does your child receive any of the following?</th>
<th>Yes</th>
<th>No</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Therapy (please describe)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child have any behavioral problems? (circle one): Yes  No
If YES, please explain: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you feel that your child’s language skills are where they should be for your child’s age? (circle one): Yes  No
If NO, please explain: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Has your child even had IQ testing or a formal developmental assessment? (circle one): Yes  No
If Yes, when? And what were the results? Please send us a copy if possible.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Family History**

Are Biological parents related to one another (blood relatives)?   Yes  No  Don’t Know
Are the patient’s biological parents still together?           Yes  No  Don’t Know
Are the biological parents thinking of having more children?      Yes  No  Don’t Know
Is the biological mother (or partner the biological father, if applicable) currently pregnant?  
Yes  No  Don’t Know  
Has the patient been known by any other names in the past?    
Yes  No  Don’t Know  

Patient Name: ____________________________ Date of birth: __________

Please complete all sections and return to Medical Genetics two weeks prior to your visit. If you need additional space, use the backs of the pages and indicate which section (A, B, C, D) is being supplemented.

**SECTION A: PATIENT INFORMATION**

Patient name: ____________________________ Birthdate: __/__/__  Sex: M___ F___

Has the patient ever been known by any other name(s)? If yes, what name(s): ____________________________

**SECTION B: PATIENT'S SISTERS AND BROTHERS**

Please list--include miscarriages of the patient’s mother. Indicate “S” for sisters/brothers with the same two parents, “M” for sisters/brothers who have only the same Mother as the patient, or “F” for sisters/brothers who have only the same Father as the patient. Use back of page if needed.

<table>
<thead>
<tr>
<th>Name</th>
<th>S/M/F</th>
<th>Age</th>
<th>Sex</th>
<th># of children</th>
<th>Living, or approximate age at death</th>
<th>Abnormalities (if any) or cause of death (Also note death or any abnormalities of the children of these individuals)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>
**SECTION C: PATIENT'S PARENTS AND THEIR SISTERS AND BROTHERS, i.e. THE AUNTS AND UNCLES OF THE PATIENT**

Indicate “S” for sisters/brothers with the Same two parents, “M” for sisters/brothers who have only the same Mother, or “F” for sisters/brothers who have only the same father.

<table>
<thead>
<tr>
<th>Name</th>
<th>S/M/F</th>
<th>Age</th>
<th>Sex</th>
<th># of children</th>
<th>Living, or approximate age at death</th>
<th>Abnormalities (if any) or cause of death (Also note death or any abnormalities of the children of these individuals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s mother</td>
<td></td>
<td></td>
<td>F</td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td>Patient’s father</td>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>
### SECTION D: PATIENT'S GRANDPARENTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th># of children</th>
<th>Living, or approximate age at death</th>
<th>Abnormalities (if any) or cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's father</td>
<td></td>
<td>M</td>
<td></td>
<td>Yes  No</td>
<td></td>
</tr>
<tr>
<td>Mother's mother</td>
<td></td>
<td>F</td>
<td></td>
<td>Yes  No</td>
<td></td>
</tr>
<tr>
<td>Father's father</td>
<td></td>
<td>M</td>
<td></td>
<td>Yes  No</td>
<td></td>
</tr>
<tr>
<td>Father's mother</td>
<td></td>
<td>F</td>
<td></td>
<td>Yes  No</td>
<td></td>
</tr>
</tbody>
</table>