



Personal Information

Baby

Last Name. Name.
Place of Birth: Date of Birth:

Mother

Last Name. Name.
Place of Birth: Date of Birth:

Dati Padre

Last Name. Name.
Place of Birth: Date of Birth:

Pregnancy Data

- Spontaneous pregnancy
Pregnancy obtained with medically assisted procreation techniques (MAR):
homologous male heterologous
female heterologous embryo donation
Pre-implantation diagnosis performed YES NO

- Single pregnancy Twins pregnancy Monochorionic Bichorial

Eurofins Genoma Group S.r.l a socio unico / sole shareholder

<u>Prenatal screening performed</u>	Result (if altered, specify value obtained)	
Nuchal translucency (NT):	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
Bi-test/combined test:	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
NIPT (Fetal DNA):	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
1st trimester ultrasound:	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
Morphological ultrasound:	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
Growth ultrasound:	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:

<u>Invasive prenatal diagnosis</u>	Result (if altered, specify value obtained)	
<input type="checkbox"/> Villocentesis	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:

Course of pregnancy:

Normal

Complicated by:

<input type="checkbox"/> Infections,	<input type="checkbox"/> Intrauterine	<input type="checkbox"/> Oligohydramnios,
<input type="checkbox"/> Pre-eclampsia,	growth retardation,	<input type="checkbox"/> Polyhydramnios,
<input type="checkbox"/> Gestiaional	diabetes,	<input type="checkbox"/> Other
	

Data at Birth

To fill out this section, you can use the form that is usually given to the family when discharged after childbirth)

<u>Childbirth</u>	<input type="checkbox"/> Spontaneous	<input type="checkbox"/> Induced
	<input type="checkbox"/> Natural (eutocic)	<input type="checkbox"/> Cesarean section or sucker
	<input type="checkbox"/> Term (>38 weeks)	<input type="checkbox"/> Preterm: weeks

Biometrics (measurements) at birth

Weight: g Length: cm Head circumference: cm

Apgar index: 1' 5'

<u>Screening at birth or in the first months</u>	Result (if altered, specify value obtained)	
Neonatal metabolic:	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
Neonatal hearing:	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:
Neonatal vision:	<input type="checkbox"/> Normal	<input type="checkbox"/> Altered:



Ultrasound of the hips: Normal Altered:

Cardiology screening (ECG): Normal Altered:

Renal ultrasound: Normal Altered:

Breastfeeding and feeding

Breastfeeding: Maternal Artificial Mixed

Difficulty in sucking: No Yes

Weaning month Regular With difficulty

(Difficulty chewing? Selectivity for some texture or color of food?).....

Any allergies/intolerances?

Development of the first months

Indicate which of the various stages of motor and language development have been reached, and when they were reached

Motor development

Holds the head:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....
Sits:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....
Crawls:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....
First steps:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....
Goes up/down stairs:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....
Runs:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....
Jumps:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....
Pedal:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months:.....



Language development

Babbling: No Yes Months:.....

First words: No Yes Months:.....

Verbal understanding: No Yes Months:.....

Social/psychological development and socialisation

Uses or has used pacifier-bottle: No Yes Months:.....

Transitional object (e.g. Linus blanket): No Yes Months:.....

Gaze contact, social smile, points, waves "bye-bye" with little hand: No Yes Months:.....

Sphincter control: No Yes Months:.....

Sleep-wake cycle: Regular difficulty falling asleep Other problems:.....

Nursery attendance: No Yes Months:.....

Play Activity: No Yes Preferred:.....

Symbolic play: No Yes Which one:.....

Current growth

Weight:kg Centile:

Length/height:cm Centile:

Head circumference:cm Centile:

Other issues (report any issues present in the child and not previously reported):

.....

.....

.....

Family medical history

Please indicate if they are present in your families some diseases/conditions are listed below

You and your partner are blood relatives Yes No

Problematic	No	Yes	If Yes, specify
Mediterranean anemia/Thalassaemia	<input type="checkbox"/>	<input type="checkbox"/>
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Blindness/Hypovision	<input type="checkbox"/>	<input type="checkbox"/>
Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular diseases (e.g., SMA)	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal dysplasias	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability/Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Syndromic pictures	<input type="checkbox"/>	<input type="checkbox"/>
Congenital malformations	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Neonatal or early life deaths	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent miscarriages	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

Eurofins Genoma Group S.r.l a socio unico / sole shareholder