Patient Name: **<PATIENT NAME>** Mother’s Name: **<MOTHER NAME>**

Date of Birth: **<DOB>**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Normal or Abnormal** | **Age or Date of Exam** | **Please describe all abnormal findings.** |
| **APGAR Score at Birth** | Normal (≥ 8)Abnormal (≤ 7) |  |  |
| **Physical Findings at Birth**(within 24 hours) | NormalAbnormal |  |  |
| **Physical Findings** **after Birth**(1 day – present) | NormalAbnormal |  |  |
| **Learning Disorders**(e.g., Dyslexia) | NormalAbnormal |  |  |
| **Neurodevelopmental Disorders**(e.g., Autism) | NormalAbnormal |  |  |
| **Mental Disorders**(e.g., Bipolar) | NormalAbnormal |  |  |
| **Mental Retardation** | NormalAbnormal |  |  |

This form was completed by: <PHYSICIAN NAME> A Qualified Staff Member:

**FOR STAFF USE ONLY:**

Entered by: Date:

Entered by: Date:

 Specialty: <SPECIALTY> Name, Qualification

Date Completed:

**Thank you for supporting your patient’s participation in this study.**