

DYSMORPHOLOGY CORE PHYSICAL EXAMINATION FORM - CIFASD

Please record a value in each blank. If unknown, not applicable, or not measured, record 9999.

Child's Last Name: _____

Child's First Name: _____

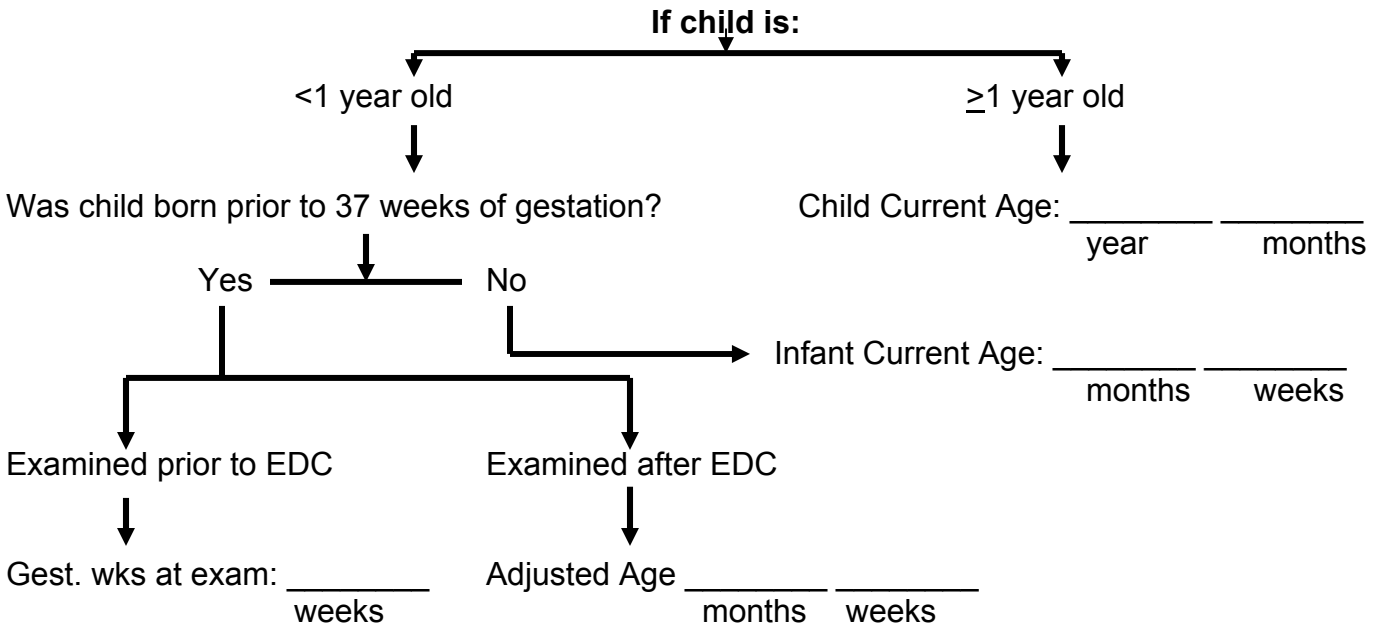
Child's Gender: Male
 Female

Child's Date of Birth: _____
dd-mmm-yy
Example: 10-Dec-06

Examiner Last Name: _____

Date of Examination: _____
dd-mmm-yy

Completed weeks of gestation: _____
weeks



Growth:

1. Height (cm) _____ 1a. Height percentile _____
 2. Weight (kg) _____ 2a. Weight percentile _____

Head/Face:

3. OFC (cm) _____ 3a. OFC percentile _____
 4. ICD (cm) _____ 4a. ICD percentile _____
 5. PFL-left (cm) _____ 5a. PFL-left percentile _____
 6. PFL-right (cm) _____ 6a. PFL-right percentile _____
 7. Maxillary Arc (cm) _____
 8. Hypoplastic midface Yes No
 9. Mandibular Arc (cm) _____
 10. Railroad track configuration of ears Yes No
 11. Strabismus Yes No
If yes: Unilateral Bilateral
 12. Ptosis Yes No
If yes: Unilateral Bilateral
 13. Epicanthal folds Yes No
If yes: Unilateral Bilateral
 14. Anteverted Nares Yes No
 15. Philtrum length (cm) _____ 15a. Philtrum length percentile _____
 16. Philtrum Lipometer _____
 17. Vermillion border lipometer _____

Joints:

18. Clinodactyly 5th fingers Yes No
If yes: Unilateral Bilateral
 19. Camptodactyly Yes No
If yes: Unilateral Bilateral
 20. Difficulty pronation/supination elbows Yes No

21. Contractures in other joints Yes No
If yes, specify:

- Hips
- Knees
- Other _____

Hands:

22. Hockey stick upper palmar crease Yes No
If yes: Unilateral Bilateral

23. Other altered palmar creases Yes No
If yes: Unilateral Bilateral

Single crease Yes No

Hypoplastic thenar crease Yes No

Other _____

Heart:

24. Heart murmur Yes No

25. Heart defect Yes No

If yes, specify:

Atrial Septal Defect Yes No

Ventricular Septal Defect Yes No

Patent Ductus Arteriosus Yes No

Other _____

Neurological Status:

26. Neurological problems Yes No

If yes, specify if child is:

Hyperactive Yes No

Hypertonic Yes No

Hypotonic Yes No

Has seizures Yes No

Comments:

27. Other comments: _____

Abnormalities Compatible with FAS

28. Growth Deficiency Yes No
29. Microcephaly Yes No
30. Structural abnormality Yes No
31. Does child have FAS based on this exam? Yes Deferred No
32. Photographs taken Yes No

Other Diagnoses:

33. Does the child have a diagnosis that precludes a diagnosis of FAS? (check one)

- None
- Williams Syndrome
- Toluene embryopathy
- Dubowitz Syndrome
- Deletion 22q11.2

Other _____

34. Does the child have one or more other diagnoses that DO NOT preclude FAS? If so, please list.

Other _____

Other _____

Other _____

Instructions for the Scribe: After the examination, please review of this form carefully to check that all items have been appropriately completed. The examination will be discarded if even one of the highlighted items is missing. Please make sure the child's subject identifier (Global ID) is written at the top of each sheet.