

**Primary Microcephaly
Clinical Checklist**
Please complete and return with sample

Name: _____

DOB _____

Date _____

Male

Female

Features	Present:	Yes	No
Growth			
IUGR		<input type="checkbox"/>	<input type="checkbox"/>
Failure to Thrive		<input type="checkbox"/>	<input type="checkbox"/>
Gestational Age	_____ wks		
Birth weight	_____ gms		
Birth length	_____ cm		
Birth OFC	_____ cm		
OFC	_____ cm at age _____		
OFC	_____ cm at age _____		
Age at Exam	_____ yrs & mos		
Height	_____ cm		
Weight	_____ kg		
OFC	_____ cm		

Cognitive Delay Yes No

Severity _____

Motor Delay Yes No

Never walked Yes No

Age Sat _____

Age Walked _____ Verbal IQ _____

Age Talked _____ Performance IQ _____

Speech Delay Yes No

Absent speech Yes No

Any communication Yes No

Neurologic

Seizures Yes No

Age of onset _____

Hypotonia Yes No

Ataxia/awkward gait Yes No

Cerebral palsy/spasticity Yes No

Other neurological findings:
(please describe)

Eye findings

Normal fundal exam Yes No

Eye findings
(please describe):

Features	Present:	Yes	No
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Previous testing:

Chromosome analysis normal Yes No

Array CGH analysis normal Yes No

Other testing:

Additional findings:

Family history:

Consanguinity Yes No

Ethnicity _____

MRI findings

Normal MRI Yes No

MRI previously reviewed by Dr. Dobyns?

Yes No

MRI findings:
(please attach reports)

LAB USE ONLY (Do not write in this box):

ASPM: