

**CLINICAL CHECKLIST - KABUKI SYNDROME****Patient:**

First name : Referring physician:  
 Last name : Referring Center:  
 Date of Birth: Sex: M  F

**Pregnancy – Birth – Neonatal period information:**

	Yes	-	No	-	NE	
Pregnancy :						
Cystic hygroma:	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Two-vessel cord:	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Birth :						
Premature	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	( weeks)
Weight < P3	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	( kg)
Length < P3	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	( cm)
Head circumference < P3	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	( cm)
Neonatal period :						
Hypoglycemia	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

**CRANIUM****Head circumference:**

cm at age	y	m	Yes	No	NE		Yes	No	NE
Microcephaly			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Lips:</u>			
Craniosynostosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broad, prominent philtrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malar hypoplasia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tented upper lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Eye brows:</u>						Cleft upper lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arched			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prominent, droopy lower lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral sparseness			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notched			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Palate:</u>			
<u>Orbital region:</u>						Cleft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long palpebral fissures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High arched	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long eyelashes			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Narrow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Everted lower lids			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Velopharyngeal dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper lids: heavy, thick			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Teeth, tongue:</u>			
Ptosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epicanthic folds			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malocclusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lagophthalmos (sleep with eyes opened)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypodontia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Eyes:</u>						Abnormal tooth shape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blue sclera			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fissured tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coloboma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Ears:</u>			
Congenital glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prominent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optic nerve hypoplasia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cupped	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Simple in form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Astigmatism			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Large auricle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nystagmus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Large lobe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nose:</u>						Dimple, pit, fistula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broad tip			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent otitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed tip			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short columella			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inner ear abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	NE		Yes	No	NE
<b><u>GROWTH AND FEEDING</u></b>				<b><u>MUSCULOSKELETAL AND SKIN</u></b>			
Feeding difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent finger pads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Single palmar crease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspiration pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brachydactyly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure to thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clinodactyly of 5 <sup>th</sup> finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Small feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Start:				Long hallux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop:				Vertebral anomaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short stature (postnatal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Height:        cm at age				Sacral sinus or dimple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delayed bone age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clavicle hypo/aplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Growth hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patellar dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight:       kg at age				Chest deformities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Hyperlaxity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>CARDIOVASCULAR</u></b>				Beighton score                   /9			
Malformation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Small/hypoplastic/ deep set nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hirsutism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pilomatrixoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left sided obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other:							
<b><u>GASTROINTESTINAL</u></b>				<b><u>IMMUNITY</u></b>			
Anal malformation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal malrotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Comment:			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypogammaglobulinemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>GENITOURINARY</u></b>				<b><u>CANCER</u></b>			
<i>Kidney</i>				Comment:			
Renal dysplasia/agenesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Horseshoe/ ectopic kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>DEVELOPMENT AND BEHAVIOUR</u></b>			
Hydronephrosis/ vesico-ureteric reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Development delay: mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/>			
<i>Genital</i>				IQ:			
Hypospadias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cryptorchidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypotonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Micropenis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Labia hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressionless face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Dysarthria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Behavior trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>PUBERTY</u></b>				Comment:			
Areolar fullness in infancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Age of first menstruation:		years					
Gonadotropin abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				