

Appendix E.13 Maternal Medical History

Study ID #: _____

Study to Explore Early Development

MATERNAL MEDICAL HISTORY FORM

Respondent (Please indicate your relationship to study child):

- Biological Mother** **Biological Father** **Step Mother**
 Step Father **Maternal Grandparent** **Paternal Grandparent**
 Other: Specify _____

Instructions: Indicate whether or not the biological mother of the study child has/had the condition listed by placing a in the appropriate 'Yes' column. If you marked 'Yes' for any of the conditions please fill out the remaining information for that condition. Please keep in mind that these conditions must have been diagnosed by a doctor. Also, having symptoms or being treated for a particular condition during pregnancy would be defined as having the condition during pregnancy. If you are unclear about the definition of some of the conditions, please see the glossary of terms attached. If the biological mother of the study child does/did not have the condition listed; or if you are unclear about whether the biological mother has/had the condition listed, please check the box in the 'No/Don't know' column.

Condition	Yes	No/Don't know	Specify	Age of Onset	Did you/she have the condition during pregnancy with CHILD?
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Asperger's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Attention deficit hyperactivity disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism					
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth defect	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding/clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Childhood Disintegrative Disorder (CDD)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating disorder (i.e., bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine disorder (hormonal disorder)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No

Fragile X Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Condition	Yes	No	Specify	Age of Onset	Did you have the condition during your pregnancy with CHILD? (Yes or No)
Gastrointestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Motor problem/movement or coordination problem	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Obesity	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Obsessive compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Personality disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pervasive developmental disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Reading difficulty	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Rett's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-injuring behavior	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure disorder/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle cell anemia/thalassemia/other hereditary anemias	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech Problem	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberous sclerosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other. Specify condition.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
1.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No

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