Center for Autism and Developmental Disabilities Research and Epidemiology
CADDRE

Appendix E13 **Studyid #: _____**

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 _____

Form Approved
OMB NO. _____
Exp. Date _____

Instructions: Indicate whether or not the biological mother of the study child has/had the condition listed by placing a ☑ in the appropriate Yes or No 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.

Condition	Yes	No	Specify	Age of Onset	Did you/she have the condition during pregnancy with CHILD?
Allergies	☐	☐			☐ Yes ☐ No
Asperger's Syndrome	☐	☐			☐ Yes ☐ No
Attention deficit hyperactivity disorder	☐	☐			☐ Yes ☐ No
Anxiety disorder	☐	☐			☐ Yes ☐ No
Autism					
Bipolar disorder	☐	☐			☐ Yes ☐ No
Birth defect	☐	☐			☐ Yes ☐ No
Bleeding/clotting disorders	☐	☐			☐ Yes ☐ No
Cancer	☐	☐			☐ Yes ☐ No
Cardiovascular condition	☐	☐			☐ Yes ☐ No
Cerebral Palsy	☐	☐			☐ Yes ☐ No
Childhood Disintegrative Disorder (CDD)	☐	☐			☐ Yes ☐ No
Cystic fibrosis	☐	☐			☐ Yes ☐ No
Depression	☐	☐			☐ Yes ☐ No
Down's Syndrome	☐	☐			☐ Yes ☐ No
Eating disorder (i.e., bulimia, anorexia)	☐	☐			☐ Yes ☐ No
Endocrine disorder (hormonal disorder	☐	☐			☐ Yes ☐ No

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

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4.	☐	☐			☐ Yes ☐ No
5.	☐	☐			☐ Yes ☐ No