



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 _____

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	<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's 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

Public Reporting Burden Statement

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

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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	<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

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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