**Appendix E14** **Studyid #: _______________**

# PATERNAL 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 father 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 we are asking about conditions that have been diagnosed by a doctor. If you are unclear about the definition of some of the conditions, please see the glossary of terms attached.**

Form Approved
OMB NO. __________
Exp. Date __________

| **Condition** | **Yes** | **No** | **Specify** | **Age of Onset** |
|---|---|---|---|---|
| Allergies | ☐ | ☐ | | |
| Asperger's Syndrome | ☐ | ☐ | | |
| Attention deficit hyperactivity disorder | ☐ | ☐ | | |
| Anxiety disorder | ☐ | ☐ | | |
| Autism | | | | |
| Bleeding/clotting disorders | ☐ | ☐ | | |
| Bipolar disorder | ☐ | ☐ | | |
| Cancer | ☐ | ☐ | | |
| Cardiovascular condition | ☐ | ☐ | | |
| Cerebral Palsy | ☐ | ☐ | | |
| Childhood Disintegrative Disorder (CDD) | ☐ | ☐ | | |
| Birth defect | ☐ | ☐ | | |
| Cystic fibrosis | ☐ | ☐ | | |
| Depression | ☐ | ☐ | | |
| Down's Syndrome | ☐ | ☐ | | |
| Eating disorder (i.e., bulimia, anorexia) | ☐ | ☐ | | |
| Endocrine disorder (hormonal disorder) | ☐ | ☐ | | |
| Fragile X Syndrome | ☐ | ☐ | | |
| Gastrointestinal disorders | ☐ | ☐ | | |
| Hearing impairment | ☐ | ☐ | | |

**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)

Center for Autism and Developmental Disabilities Research and Epidemiology
CADDRE

**Studyid #:** _______________

# PATERNAL MEDICAL HISTORY FORM

| Condition | Yes | No | Specify | Age of Onset |
|---|---|---|---|---|
| Learning disability | ☐ | ☐ | | |
| Mental retardation | ☐ | ☐ | | |
| Motor problem/movement or coordination problem | ☐ | ☐ | | |
| Neurofibromatosis | ☐ | ☐ | | |
| Neuromuscular disorder | ☐ | ☐ | | |
| Obesity | ☐ | ☐ | | |
| Obsessive compulsive disorder | ☐ | ☐ | | |
| Personality disorder | ☐ | ☐ | | |
| Pervasive developmental disorder | ☐ | ☐ | | |
| Reading difficulty | ☐ | ☐ | | |
| Respiratory condition | ☐ | ☐ | | |
| Rett's Syndrome | ☐ | ☐ | | |
| Schizophrenia | ☐ | ☐ | | |
| Self-injuring behavior | ☐ | ☐ | | |
| Seizure disorder/epilepsy | ☐ | ☐ | | |
| Sickle cell anemia/ thalassemia/other hereditary anemias | ☐ | ☐ | | |
| Sleep disorder | ☐ | ☐ | | |
| Speech Problem | ☐ | ☐ | | |
| Suicide attempt | ☐ | ☐ | | |
| Tuberous sclerosis | ☐ | ☐ | | |
| Vision impairment | ☐ | ☐ | | |
| Other. Specify condition. | ☐ | ☐ | | |
| 1. | ☐ | ☐ | | |
| 2. | ☐ | ☐ | | |
| 3. | ☐ | ☐ | | |
| 4. | ☐ | ☐ | | |
| 5. | ☐ | ☐ | | |