Attachment 10b

Adolescent Medical History Form

Affix Case ID Label Here

Centers for Disease Control and Prevention
Registry of Unexplained Fatiguing Illnesses and Chronic Fatigue Syndrome (CFS)

Adolescent Medical History Form

Date: _____/_____/_____

Time: _____am/pm

1. If you have to list your child's three **major** health problems, what would they be? Please start with what bothers you the most about your child's health.

Problem/Complaint/Concern	When did this problem start?	Does your child still have this health problem?
1.	_____ /_____ MONTH YEAR	☐ Yes ☐ No
2.	_____ /_____ MONTH YEAR	☐ Yes ☐ No
3.	_____ /_____ MONTH YEAR	☐ Yes ☐ No

1a. From the time these problems began until now, how have they changed? If there is such a thing as a typical episode, please describe it. If your child has no problems, go to question 2.

Problem 1.

Problem 2.

Problem 3.

PAST MEDICAL HISTORY

2. **Before having the problems discussed above**, how would you describe your child's health? (Circle your answer).

Poor Fair Good Very Good Excellent

3. Has your child had any major **health problems**? Please include problems that made your child go to the doctor more often (not just for "check ups"), go to a hospital, or take medications. These problems include bad infections, reactions to immunizations or vaccinations, and other serious medical problems.

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION 4**.

3a. Please describe these health problems your child has had and write below how old your child was when he or she had the health problem. (If you don't remember your child's age, give his or her approximate age or think of political or historic events that were happening at that time to help you remember.) If problems or bad reactions to immunizations happened more than once, list them separately. If you need more space, use another sheet of paper.

Health problems	**Age when problem occurred**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

4. Has your child ever had any serious injuries, such as head injury, broken bones, burns or others that required visiting your child's doctor, an emergency room, or being hospitalized?

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION 5**

4a. Please describe your child's injuries and ages at which the injuries occurred. If you need more space, please use another sheet of paper.

Description of Injury	**Age at which your child was injured**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

5. Has your child ever had other surgeries or hospitalizations? Please do not include the illnesses or injuries you described in item 4 above?

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION 6**

5a. Please describe your child's surgeries and hospitalizations. Please include the age at the time of the surgery or hospitalization. If you need more space, please use another sheet of paper.

Description of Surgery/Hospitalization	**Age at Surgery/ Hospitalization**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

6. In the last year, did your child's weight change a lot?

☐ 1 Yes ☐ 2 No → **IF NO, GO TO QUESTION 7**

6a. Did your child intend to gain or lose this weight?

☐ 1 Yes ☐ 2 No

6b. How much weight did your child gain in the last year? _____ pounds

6c. How much weight did your child lose in the last year? _____ pounds

7. The rest of this questionnaire is about health history. For each condition or health problem your child has had, please tell us the age at which it began and whether your child has had this condition or illness in the past 12 months. The clinic doctor and nurse will review your completed form with you and your child during your clinic appointment.

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
7a. Asthma	☐ Yes ☐ No (SKIP TO 7b)	AGE: ____	☐ Yes ☐ No	Ask about the allergens.
7b. Sudden, severe swelling of the face, mouth, and throat (Quincke's edema)	☐ Yes ☐ No (SKIP TO 7c)	AGE: ____	☐ Yes ☐ No	Ask about the allergens.
7c. Anaphylactic shock	☐ Yes ☐ No (SKIP TO 7d)	AGE: ____	☐ Yes ☐ No	Ask about the allergens.
7d. Other allergies	☐ Yes ☐ No (SKIP TO 8a)	AGE: ____	☐ Yes ☐ No	Ask about the allergens
7e. What other allergies has your child had?				Ask about the allergens.
Skin				
8a. Eczema	☐ Yes ☐ No (SKIP TO 8b)	AGE: ____	☐ Yes ☐ No	
8b. Hives	☐ Yes ☐ No (SKIP TO 8c)	AGE: ____	☐ Yes ☐ No	
8c. Skin rashes	☐ Yes ☐ No (SKIP TO 8d)	AGE: ____	☐ Yes ☐ No	
8d. Skin discoloration or swelling	☐ Yes ☐ No (SKIP TO 8e)	AGE: ____	☐ Yes ☐ No	
8e. Other skin problems	☐ Yes ☐ No (SKIP TO 9a)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
8f. What other skin problems has your child had?				
Head				
9a. **Headaches** (for example, tension headaches, migraines)	☐ Yes ☐ No (SKIP TO 10a)	AGE: _____	☐ Yes ☐ No	
Eyes				
10a. Glaucoma	☐ Yes ☐ No (SKIP TO 10b)	AGE: _____		
10b. Eye infection	☐ Yes ☐ No (SKIP TO 10c)	AGE: _____	☐ Yes ☐ No	
10c. Cataract	☐ Yes ☐ No (SKIP TO 10d)	AGE: _____		
10d. Other eye problems	☐ Yes ☐ No (SKIP TO 11a)	AGE: _____	☐ Yes ☐ No	
10e. What other eye problems has your child had?				
Ears, Nose, Mouth and Throat				
11a. Problems hearing	☐ Yes ☐ No (SKIP TO 11b)	AGE: _____	☐ Yes ☐ No	
11b. Ringing in your child's ears	☐ Yes ☐ No (SKIP TO 11c)	AGE: _____	☐ Yes ☐ No	
11c. Ear infections	☐ Yes ☐ No (SKIP TO 11d)	AGE: _____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
11d. Problems with a stuffy nose or drainage from his or her nose to the throat.	☐ Yes ☐ No (SKIP TO 11e)	AGE: ____	☐ Yes ☐ No	
11e. Sores in your child's mouth or nose	☐ Yes ☐ No (SKIP TO 11f)	AGE: ____	☐ Yes ☐ No	
11f. Problems with dry mouth	☐ Yes ☐ No (SKIP TO 11g)	AGE: ____	☐ Yes ☐ No	
11g. Gum disease (for example: bleeding gums, gum recession)	☐ Yes ☐ No (SKIP TO 11h)	AGE: ____	☐ Yes ☐ No	
11h. Problems swallowing or the feeling of a lump in his or her throat	☐ Yes ☐ No (SKIP TO 12a)	AGE: ____	☐ Yes ☐ No	
Neck				
12a. Tenderness or pain in your child's neck	☐ Yes ☐ No (SKIP TO 13a)	AGE: ____	☐ Yes ☐ No	
Digestive System				
13a. Poor appetite appetite	☐ Yes ☐ No (SKIP TO 13b)	AGE: ____	☐ Yes ☐ No	
13b. Excessive appetite	☐ Yes ☐ No (SKIP TO 13c)	AGE: ____	☐ Yes ☐ No	
13c. Heartburn or gastro-esophageal reflux (GER)	☐ Yes ☐ No (SKIP TO 13d)	AGE: ____	☐ Yes ☐ No	
13d. Gastritis or ulcer	☐ Yes ☐ No (SKIP TO 13e)	AGE: ____	☐ Yes ☐ No	
13e. Blood in bowel movements	☐ Yes ☐ No (SKIP TO 13f)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
13f. Hemorrhoids	☐ Yes ☐ No (SKIP TO 13g)	AGE: ____	☐ Yes ☐ No	
13g. Inflammatory bowel disease, ulcerative colitis or Crohn's disease	☐ Yes ☐ No (SKIP TO 13h)	AGE: ____	☐ Yes ☐ No	
13h. Hepatitis	☐ Yes ☐ No (SKIP TO 13i)	AGE: ____	☐ Yes ☐ No	
13i. Cirrhosis	☐ Yes ☐ No (SKIP TO 13j)	AGE: ____	☐ Yes ☐ No	
13j. Gallbladder problems	☐ Yes ☐ No (SKIP TO 13k)	AGE: ____	☐ Yes ☐ No	
13k. Recurring or persistent nausea or vomiting	☐ Yes ☐ No (SKIP TO 13l)	AGE: ____	☐ Yes ☐ No	
13l. Recurring or persistent diarrhea	☐ Yes ☐ No (SKIP TO 13m)	AGE: ____	☐ Yes ☐ No	
13m. Recurring or persistent constipation	☐ Yes ☐ No (SKIP TO 13n)	AGE: ____	☐ Yes ☐ No	
13n. Chronic or persistent bloating	☐ Yes ☐ No (SKIP TO 13o)	AGE: ____	☐ Yes ☐ No	
13o. Other problems with digestive system	☐ Yes ☐ No (SKIP TO 13q)	AGE: ____	☐ Yes ☐ No	
13p. What other problems has your child had with his or her digestive system?				
13q. High cholesterol	☐ Yes ☐ No (SKIP TO 13r)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
13r. High triglycerides	☐ Yes ☐ No (SKIP TO 14a)	AGE: ____	☐ Yes ☐ No	
Chest: Heart and Lungs				
14a. Chronic cough	☐ Yes ☐ No (SKIP TO 14b)	AGE: ____	☐ Yes ☐ No	
14b. Chronic bronchitis	☐ Yes ☐ No (SKIP TO 14c)	AGE: ____	☐ Yes ☐ No	
14c. Chronic obstructive pulmonary disease (COPD) or emphysema	☐ Yes ☐ No (SKIP TO 14d)	AGE: ____	☐ Yes ☐ No	
14d. Shortness of breath when inactive (sitting or in bed)	☐ Yes ☐ No (SKIP TO 14e)	AGE: ____	☐ Yes ☐ No	
14e. Shortness of breath when your child walks, runs, or climbs stairs	☐ Yes ☐ No (SKIP TO 14f)	AGE: ____	☐ Yes ☐ No	
14f. Fluid in your child's lungs	☐ Yes ☐ No (SKIP TO 14g)	AGE: ____	☐ Yes ☐ No	
14g. Pneumonia	☐ Yes ☐ No (SKIP TO 14h)	AGE: ____	☐ Yes ☐ No	
14h. Wheezing	☐ Yes ☐ No (SKIP TO 14i)	AGE: ____	☐ Yes ☐ No	
14i. Chest pain	☐ Yes ☐ No (SKIP TO 14j)	AGE: ____	☐ Yes ☐ No	
14j. **High** blood pressure	☐ Yes ☐ No (SKIP TO 14k)	AGE: ____	☐ Yes ☐ No	
14k. **Low** blood pressure	☐ Yes ☐ No (SKIP TO 14l)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
14l. Heart problems or irregular heart beat (arrhythmia)	☐ Yes ☐ No (SKIP TO 14m)	AGE: ____	☐ Yes ☐ No	
14m. Problems with your child's arteries	☐ Yes ☐ No (SKIP TO 14n)	AGE: ____	☐ Yes ☐ No	
14n. Swelling of your child's legs	☐ Yes ☐ No (SKIP TO 14o)	AGE: ____	☐ Yes ☐ No	
14o. Feet or hands get cold very easily	☐ Yes ☐ No (SKIP TO 14p)	AGE: ____	☐ Yes ☐ No	
14p. Other lung, heart or vascular problems?	☐ Yes ☐ No (SKIP TO 15a)	AGE: ____	☐ Yes ☐ No	
14q. What other lung, heart or vascular problems has your child had?				
Urinary Tract				
15a. Bladder or kidney infection, or urinary tract infection (UTI)	☐ Yes ☐ No (SKIP TO 15b)	AGE: ____	☐ Yes ☐ No	
15b. Kidney stones	☐ Yes ☐ No (SKIP TO 15c)	AGE: ____	☐ Yes ☐ No	
15c. Frequent need to urinate (pee)	☐ Yes ☐ No (SKIP TO 15d)	AGE: ____	☐ Yes ☐ No	
15d. Problems with starting to urinate (pee)	☐ Yes ☐ No (SKIP TO 15e)	AGE: ____	☐ Yes ☐ No	
15e. Burning sensation or pain when urinating (peeing)	☐ Yes ☐ No (SKIP TO 15f)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
15f. Other kidney or urinary problems	☐ Yes ☐ No (SKIP TO 15h)	AGE: ____	☐ Yes ☐ No	
15g. What other kidney or urinary problems has your child had?				
15h. How many times per night, on average, does your child get up to go to the bathroom? ___ times				
Nervous System				
16a. Dizziness or vertigo ("head spinning")	☐ Yes ☐ No (SKIP TO 16b)	AGE: ____	☐ Yes ☐ No	
16b. Feeling faint or fainting	☐ Yes ☐ No (SKIP TO 16c)	AGE: ____	☐ Yes ☐ No	
16c. Poor balance	☐ Yes ☐ No (SKIP TO 16d)	AGE: ____	☐ Yes ☐ No	
16d. Poor coordination	☐ Yes ☐ No (SKIP TO 16e)	AGE: ____	☐ Yes ☐ No	
16e. Numbness or tingling on face, trunk, arms or legs	☐ Yes ☐ No (SKIP TO 16f)	AGE: ____	☐ Yes ☐ No	
16f. Loss of consciousness (other than fainting)	☐ Yes ☐ No (SKIP TO 16g)	AGE: ____	☐ Yes ☐ No	
16g. Seizures	☐ Yes ☐ No (SKIP TO 16h)	AGE: ____	☐ Yes ☐ No	
16h. Encephalitis	☐ Yes ☐ No (SKIP TO 16i)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
16i. Meningitis	☐ Yes ☐ No (SKIP TO 16j)	AGE: ____	☐ Yes ☐ No	
16j. Other neurological problems	☐ Yes ☐ No (SKIP TO 17a)	AGE: ____	☐ Yes ☐ No	
16k. What other neurological problems has your child had?				
Musculo-skeletal System				
17a. Pain in muscles, tendons or joints	☐ Yes ☐ No (SKIP TO 17b)	AGE: ____	☐ Yes ☐ No	
17b. Stiffness in joints or back	☐ Yes ☐ No (SKIP TO 17c)	AGE: ____	☐ Yes ☐ No	
17c. Carpal tunnel syndrome or other tendon problems	☐ Yes ☐ No (SKIP TO 17d)	AGE: ____	☐ Yes ☐ No	
17d. Bone problems (including osteopenia and osteoporosis)	☐ Yes ☐ No (SKIP TO 17e)	AGE: ____	☐ Yes ☐ No	
17e. Muscle weakness	☐ Yes ☐ No (SKIP TO 17f)	AGE: ____	☐ Yes ☐ No	
17f. Systemic Lupus Erythematosus	☐ Yes ☐ No (SKIP TO 17g)	AGE: ____	☐ Yes ☐ No	
17g. Rheumatoid Arthritis	☐ Yes ☐ No (SKIP TO 17h)	AGE: ____	☐ Yes ☐ No	
17h. Other arthritis	☐ Yes ☐ No (SKIP TO 17j)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
17i. What other arthritis has your child had?				
17j. Fibromyalgia	☐ Yes ☐ No (SKIP TO 18a)	AGE: ____	☐ Yes ☐ No	
Endocrine System				
18a. Diabetes or high blood sugar	☐ Yes ☐ No (SKIP TO 18b)	AGE: ____	☐ Yes ☐ No	
18b. Problems with his or her thyroid gland	☐ Yes ☐ No (SKIP TO 18c)	AGE: ____	☐ Yes ☐ No	
18c. Other endocrine problems	☐ Yes ☐ No (SKIP TO 19a)	AGE: ____	☐ Yes ☐ No	
18d. What other endocrine problems has your child had?				
Blood				
19a. Anemia, low hemoglobin, "thin blood," or low number of red blood cells	☐ Yes ☐ No (SKIP TO 19b)	AGE: ____	☐ Yes ☐ No	
19b. Easy bruising or bleeding	☐ Yes ☐ No (SKIP TO 19c)	AGE: ___	☐ Yes ☐ No	
19c. Very **low** white blood cell count	☐ Yes ☐ No (SKIP TO 19d)	AGE: ___	☐ Yes ☐ No	
19d. Very **high** white blood cell count	☐ Yes ☐ No (SKIP TO 19e)	AGE: ___	☐ Yes ☐ No	
19e. Leukemia	☐ Yes ☐ No (SKIP TO 19f)	AGE: ____	☐ Yes ☐ No	

Has your child ever had this condition or illness?		If "YES": How old was your child when he or she first had this condition?	If "YES": Has your child had this condition in the last 12 months?	DOCTOR/NURSE USE ONLY
19f. Hodgkin's Lymphoma	☐ Yes ☐ No (SKIP TO 19g)	AGE: ____	☐ Yes ☐ No	
19g. Lymphoma (non-Hodgkin's)	☐ Yes ☐ No (SKIP TO 19h)	AGE: ____	☐ Yes ☐ No	
19h. Swollen lymph nodes (for example, around your child's neck, or in his or her groin, or armpits or other places on your child's body)	☐ Yes ☐ No (SKIP TO 19i)	AGE: ____	☐ Yes ☐ No	
19i. Infectious mono-nucleosis (also called "Mono")	☐ Yes ☐ No (SKIP TO 19j)	AGE: ____	☐ Yes ☐ No	
19j. Blood diseases (such as sickle cell anemia, thalassemia or hemophilia)	☐ Yes ☐ No (SKIP TO 19l)	AGE: ____	☐ Yes ☐ No	
19k. What blood diseases has your child had? (Check all that apply.) ☐ Sickle cell anemia ☐ Thalassemia ☐ Hemophilia ☐ Other, please specify: _____ _____ Age started: _____				
19l. Has your child ever had blood transfusions?	☐ Yes ☐ No (SKIP TO 20a)	AGE: ____		For what reason

20a. Are there any other particular problems or concerns related to your child's health that you would like to mention?

☐ 1 Yes → **GO TO QUESTION 20b**

☐ 2 No → **GO TO NEXT PAGE**

20b. Please describe the problems or concerns below. Use more pages if necessary.

Other diseases (or health problems/ concerns)	How old was your child when this problem began?	Does your child still have this problem?	**DOCTOR/NURSE USE ONLY**
1.	AGE: _____	☐ Yes ☐ No	
2.	AGE: _____	☐ Yes ☐ No	
3.	AGE: _____	☐ Yes ☐ No	
4.	AGE: _____	☐ Yes ☐ No	
5.	AGE: _____	☐ Yes ☐ No	
6.	AGE: _____	☐ Yes ☐ No	

Additional notes to questions

If you wish to explain more about a condition or illness that your child had, please use the space provided below (Remember to enter the number of the question to which your explanation applies).

Thank You!
Please bring this form with you to your clinic appointment.