

Study ID #: _____

Study to Explore Early Development

Date of Completion: _____

AUTOIMMUNE DISEASE SURVEY

Please mark your relationship to the child in the study:

- Birth Mother

 Birth Father

 Step Mother

 Step Father
 Grandparent on Mother's side

 Grandparent on Father's side
 Other: (*Specify*) _____

Instructions: Please fill in the table below for each of the study child's brothers and sisters. List them in order, from *oldest to youngest*.

Name (List oldest to youngest)	Date of birth (MM/DD/YYYY)	Sex	Relationship to the Child in the Study
#1	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full brother/sister <input type="checkbox"/> Half brother/sister
#2	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full brother/sister <input type="checkbox"/> Half brother/sister
#3	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full brother/sister <input type="checkbox"/> Half brother/sister
#4	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full brother/sister <input type="checkbox"/> Half brother/sister
#5	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full brother/sister <input type="checkbox"/> Half brother/sister
#6	___/___/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full brother/sister <input type="checkbox"/> Half brother/sister

Public Reporting Burden Statement

Public reporting burden of this collection of information is estimated to average 20 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 (0920-0741)

The table below lists autoimmune conditions. These conditions occur when the body produces a substance (antibodies) against itself that can damage parts of the body. We are interested in knowing these conditions for the birth mother and birth father of the study child, the study child, and the brothers and sisters (including half brothers and sisters) of the study child.

Please fill out the information for each condition listed in the table. If a family member has one of the conditions, please check the box for the person in that column. On the dashed lines underneath the marked box, write the age at which a diagnosis was first made for this person. If none of your family members have the condition, please check "None". If you don't know the meaning of the condition, please use the Glossary. If you still don't know the meaning of the condition after reviewing the Glossary, please check "Don't Know".

Note: For the brothers and sisters of the study child, please use the same color-coded number of the child from the table above to fill out the table below.

Condition	Mother	Father	Study CHILD	Brothers/Sisters						None	Don't Know
				#1	#2	#3	#4	#5	#6		
Addison's disease	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Ankylosing spondylitis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Aplastic anemia	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Asthma	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Autoimmune hepatitis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----

Condition	Mother	Father	Study CHILD	Brothers/Sisters						None	Don't Know
				#1	#2	#3	#4	#5	#6		
Celiac disease	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Dermatitis herpetiformis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Uses insulin	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Does not use insulin	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Gestational diabetes (Diabetes during pregnancy only)	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/psoriasis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Giant Cell arteritis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>
Graves disease	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/>	<input type="checkbox"/>

Condition	Mother	Father	Study CHILD	Brothers/Sisters						None	Don't Know
				#1	#2	#3	#4	#5	#6		
Guillain-Barre syndrome	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Hashimoto thyroiditis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Hemolytic anemia	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Hyperthyroidism	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Hypothyroidism	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Irritable bowel syndrome	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Lupus, or systemic lupus erythematosus (SLE)	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Migraine headaches	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Mixed connective tissue disease	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----

Condition	Mother	Father	Study CHILD	Brothers/Sisters						None	Don't Know
				#1	#2	#3	#4	#5	#6		
Multiple sclerosis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Myasthenia gravis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Narcolepsy	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Optic neuritis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Pemphigus	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Reiter's syndrome	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Rheumatoid arthritis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Scleroderma (progressive systemic sclerosis, CREST)	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Sjogren's syndrome	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----

Condition	Mother	Father	Study CHILD	Brothers/Sisters						None	Don't Know
				#1	#2	#3	#4	#5	#6		
Stevens-Johnson syndrome	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Sydenham's chorea	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Thrombocytopenia, (immune, idiopathic)	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Tourette's syndrome	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Ulcerative colitis	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
Other. (List the condition)											
1.	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
2.	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
3.	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----
4.	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----	<input type="checkbox"/> -----

