



Center for
Autism and
Developmental
Disabilities
Research and
Epidemiology

Study to Explore Early Development

Interviewer _____

Study ID# _____

Date of Completion _____

Time of Completion _____

Blood Draw Information Form

1. List all medications, vitamins, and supplements, both prescription and over the counter, <child> has taken in the last month. Check box for MOST RECENT time frame when medication was last taken:

If no medications, vitamins, or supplements given in last month, check here: ____

Name of medication, vitamin or supplement	Last 4 hours	Last 24 hours	Last 3 days	Last 7 days	Last month
1) _____	<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"/>
3) _____	<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"/>
5) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. List any cold, flu or other illness child has had in the last 2 weeks. Check box for MOST RECENT time frame when illness occurred:

If no illness in last 2 weeks, check here: _____

Illness	Today	Last 2 days	Last 2 weeks
1) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 3) _____
- 4) _____
- 5) _____

3. Has <child> been exposed to tobacco smoke in the last 4 hours? __Yes __No

4a. What food or foods did <child> eat during their last meal or snack? List:

4b. What time was that food eaten? Time:

5. Has there been a significant event in the child's life during the past month?
Examples of a significant event may include: illness or death in the family,
divorce, moving or relocation, new school or day care, or other potentially
stressful situation for <child>.

Describe: