Center for Autism and Developmental Disabilities Research and Epidemiology
CADDRE

Attachment 8.c.

Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/2020

Study ID #: _____
Date of Completion_____

Study to Explore Early Development

CHILD HEALTH HISTORY

Respondent's relationship to the study child:

☐ Biological Mother ☐ Biological Father ☐ Other: Specify _____

How many full siblings does your child have*:_____ **How many half siblings*:_____**

- Full siblings are brothers and sisters that have the same biological mother AND same biological father as your child.
- Half siblings are brothers and sisters who have the same biological mother OR same biological father as your child.

SECTION A: CONDITIONS DIAGNOSED BY A DOCTOR

In the following two tables, please tell us if your child has ever been diagnosed **by a doctor or other health care provider** with any of these conditions.

See the enclosed glossary of terms if you don't know the meaning of a condition.

If you check "Yes," tell us the age at diagnosis.

For the chronic conditions in the first table, we also would like to know how many full siblings and how many half siblings have each condition

For some allergies and infections in the second table, we also ask that you tell us the specific type of allergy or number of times your child had the infection.

Section A.1. Chronic Conditions

	Enrolled CHILD			SIBLINGS
	Doctor or other health care provider has diagnosed the condition?			Doctor or other health care provider has diagnosed the condition?
	No/ Don't Know	Yes	Age at Diagnosis (in years) (*Write <1 if younger than 1 year*)	If any have been diagnosed, please write in the number of siblings with this condition. If your child has no siblings or none of the siblings have the condition, mark None
Addison's Disease	☐	☐		_____ # Full _____ # Half ____ None
Ankylosing spondylitis	☐	☐		_____ # Full _____ # Half ____ None
Aplastic anemia	☐	☐		_____ # Full _____ # Half ____ None
Asthma	☐	☐		_____ # Full _____ # Half ____ None
Autoimmune hepatitis	☐	☐		_____ # Full _____ # Half ____ None
Bleeding/Clotting Disorder	☐	☐		_____ # Full _____ # Half ____ None
Cancer	☐	☐		_____ # Full _____ # Half ____ None
Celiac Disease	☐	☐		_____ # Full _____ # Half ____ None
Congenital Heart Defect/ Cardiovascular condition	☐	☐		_____ # Full _____ # Half ____ None
Crohn's Disease	☐	☐		_____ # Full _____ # Half ____ None
Cystic Fibrosis	☐	☐		_____ # Full _____ # Half ____ None
Dermatitis herpetiformis	☐	☐		_____ # Full _____ # Half ____ None
Diabetes: Uses insulin	☐	☐		_____ # Full _____ # Half ____ None
Diabetes: Does not use insulin	☐	☐		_____ # Full _____ # Half ____ None
Eczema/psoriasis	☐	☐		_____ # Full _____ # Half ____ None
Feeding Disorder	☐	☐		_____ # Full _____ # Half ____ None
Giant cell arteritis	☐	☐		_____ # Full _____ # Half ____ None
Graves disease	☐	☐		_____ # Full _____ # Half ____ None
Gullain-Barre Syndrome	☐	☐		_____ # Full _____ # Half ____ None
Hashimoto thyroiditis	☐	☐		_____ # Full _____ # Half ____ None
Hemolytic anemia	☐	☐		_____ # Full _____ # Half ____ None
Hyperthyroidism	☐	☐		_____ # Full _____ # Half ____ None
Hypothyroidism	☐	☐		_____ # Full _____ # Half ____ None
Irritable bowel syndrome	☐	☐		_____ # Full _____ # Half ____ None
Lupus, or systemic lupus erythematosus (SLE)	☐	☐		_____ # Full _____ # Half ____ None
Migraine headaches	☐	☐		_____ # Full _____ # Half ____ None
Mixed connective tissue disease	☐	☐		_____ # Full _____ # Half ____ None
Multiple sclerosis	☐	☐		_____ # Full _____ # Half ____ None
Myasthenia gravis	☐	☐		_____ # Full _____ # Half ____ None
Narcolepsy	☐	☐		_____ # Full _____ # Half ____ None
Optic neuritis	☐	☐		_____ # Full _____ # Half ____ None

	Enrolled CHILD			SIBLINGS
	Doctor or other health care provider has diagnosed the condition?			Doctor or other health care provider has diagnosed the condition?
	No/ Don't Know	Yes	Age at Diagnosis (in years) (*Write <1 if younger than 1 year*)	If any have been diagnosed, please write in the number of siblings with this condition. If your child has no siblings or none of the siblings have the condition, mark None
Pemphigus	☐	☐		_____ # Full _____# Half ____None
Reiter's syndrome	☐	☐		_____ # Full _____# Half ____None
Rheumatoid arthritis	☐	☐		_____ # Full _____# Half ____None
Scleroderma (progressive systemic sclerosis, CREST)	☐	☐		_____ # Full _____# Half ____None
Sickle cell anemia/ thalassemia/other hereditary anemias	☐	☐		_____ # Full _____# Half ____None
Sjogren's syndrome	☐	☐		_____ # Full _____# Half ____None
Stevens-Johnson syndrome	☐	☐		_____ # Full _____# Half ____None
Sydenham's chorea	☐	☐		_____ # Full _____# Half ____None
Thrombocytopenia, (immune, idiopathic)	☐	☐		_____ # Full _____# Half ____None
Ulcerative colitis	☐	☐		_____ # Full _____# Half ____None
Other condition (specify):	☐	☐		_____ # Full _____# Half ____None
Other condition (specify):	☐	☐		_____ # Full _____# Half ____None
Other condition (specify):	☐	☐		_____ # Full _____# Half ____None

Section A.2. Allergies and Infections

For the allergies and infections below, please mark whether or not the enrolled child has, or had, the condition. For some of the allergies and infections, please also write in the specific type of allergy or number of times the enrolled child had the infection.

	Enrolled CHILD			
	Doctor or other health care provider has diagnosed the condition?			
	No/ Don't Know	Yes	Specify type or number of times (as indicated)	Age at 1st Diagnosis (years) (*Write <1 if younger than 1 year*)
Allergy, Drug ***(specify type)***	☐	☐		
Allergy, Food ***(specify type)***	☐	☐		
Allergy, Hay Fever	☐	☐		
Allergy, Skin ***(specify type)***	☐	☐		
Allergy, Other ***(specify type)***	☐	☐		
Chicken Pox	☐	☐		
Cytomegalovirus	☐	☐		
Ear Infection, Recurrent ***(specify # of times)***	☐	☐		

	Enrolled CHILD			
	Doctor or other health care provider has diagnosed the condition?			
	No/ Don't Know	**Yes**	**Specify type or number of times (as indicated)**	**Age at 1st Diagnosis (years) (*Write <1 if younger than 1 year*)**
German Measles or Rubella	☐	☐		
Group A Strep (includes Strep Throat and Scarlet Fever) **(specify # times)**	☐	☐		
Group B Strep (GBS)	☐	☐		
Hepatitis A	☐	☐		
Hepatitis B	☐	☐		
Hepatitis C	☐	☐		
Hepatitis, Unknown type	☐	☐		
Herpes Infection	☐	☐		
HIV or AIDS	☐	☐		
Impetigo **(specify # times)**	☐	☐		
Influenza **(specify # times)**	☐	☐		
Lyme Disease	☐	☐		
Measles	☐	☐		
Meningitis, Bacterial	☐	☐		
Meningitis, Viral	☐	☐		
Meningitis, Unknown Type	☐	☐		
Mumps	☐	☐		
Parvovirus or Fifth Disease	☐	☐		
Pneumonia ***(specify # times)***	☐	☐		
Respiratory Synctial Virus or RSV	☐	☐		
Tetanus	☐	☐		
Tonsillitis ***(specify # times)***	☐	☐		
Toxoplasmosis	☐	☐		
Tuberculosis	☐	☐		
Urinary Tract Infection or UTI ***(specify # times)***	☐	☐		
Other Infection ***(specify type)***	☐	☐		
Other Infection ***(specify type)***	☐	☐		
Other Infection ***(specify type)***	☐	☐		

Has your child ever had an allergic reaction that required medical attention such as an office contact (by telephone or in-person visit) or hospitalization?

☐ Yes ☐ No ☐ Don't Know

SECTION B: GASTROINTESTINAL SYMPTOMS (answer all 3 questions)

1. Has your child taken medication for gastrointestinal problems <u>regularly</u> within the past year?

<u>Regularly</u> means at least once per month for at least 3 months within the past year.

This can include a medicine prescribed by a doctor or an over the counter medication, such as TUMS or Miralax.

☐ No

☐ Yes Specify all medications, what they are treating, and how often your child took the medication in the past year.

Medications:	**Reason for taking medications:**	**Often** *(daily or almost daily)*	**Sometimes** *(1-2 times per week)*	**Rarely** *(less than once per week*
1.		☐	☐	☐
2.		☐	☐	☐
3.		☐	☐	☐
4.		☐	☐	☐
5.		☐	☐	☐

2. Tell us how often your child has had the following problems

	How often has child had the issue in the past 12 months? *(Choose ONE for each issue)*			
	Often *(4 or more times per month)*	**Sometimes** *(2-3 times per month)*	**Rarely/ Never** *(once per month or less)*	**Don't Know**
Vomiting not associated with illness	☐	☐	☐	☐
Diarrhea not associated with illness	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Abdominal pain not associated with diarrhea or constipation	☐	☐	☐	☐
Gastroesophageal reflux	☐	☐	☐	☐
Pain on stooling or having a bowel movement	☐	☐	☐	☐
Eats a limited variety of foods	☐	☐	☐	☐
Abdominal distension or tummy bloating	☐	☐	☐	☐
Gaseousness	☐	☐	☐	☐
Passage of unformed/loose or watery stools	☐	☐	☐	☐
Passage of hard, pebble like stools	☐	☐	☐	☐
Other gastrointestinal problem, specify: _____	☐	☐	☐	☐

3. How many stools does your child usually have currently?

☐ Less than 3 stools per week

☐ 0-1 stools per day and 3 or more stools per week

☐ 2-3 stools per day

☐ Don't know

SECTION C: SLEEP CHARACTERISTICS (answer all 3 questions)

1. **Has your child taken medication for sleep difficulty or sleep disorder <u>regularly</u> within the past year?**
   <u>Regularly</u> means at least once per month for at least 3 months within the past year
   This can include a medicine prescribed by a doctor or an over the counter medication, such as melatonin.

☐ No

☐ Yes *Specify all medications, what they are treating, and how often your child took the medication in the past year.*

Medications:	**Reason for taking medications:**	**Often** *(daily or almost daily)*	**Sometimes** *(1-2 times per week)*	**Rarely** *(less than once per week)*
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

2. Tell us how often your child has had the following problems.

	How often has child had problem in past 12 mths? *(Select one of the following)*			
	Often *(5 days per week or more)*	**Sometimes** *(2-4 days per week)*	**Rarely/ Never** *(one day per week or less)*	**Don't Know**
Takes more than 20 minutes to fall asleep	☐	☐	☐	☐
Does not falls asleep alone in own bed	☐	☐	☐	☐
Moves to someone else's bed during the night (e.g., parent, brother, sister)	☐	☐	☐	☐
Is restless or moving a lot during sleep	☐	☐	☐	☐
Seems to stop breathing during sleep	☐	☐	☐	☐
Grinds teeth during sleep (your dentist may have told you this)	☐	☐	☐	☐
Snores during sleep	☐	☐	☐	☐
Wakes during night screaming, sweating, and inconsolable	☐	☐	☐	☐
Wakes once per night	☐	☐	☐	☐
Wakes more than once per night	☐	☐	☐	☐
• If your child **sometimes** or **often** wakes once or more per night: How long does your child typically stay awake before going back to sleep (within the past year)? _____ minutes				
Wakes very early in the morning	☐	☐	☐	☐
Takes a long time to become alert in the morning	☐	☐	☐	☐
Other sleep problem, Specify _____	☐	☐	☐	☐

3. On a typical weekday, what time does your child:

Go to bed at night? _____ Wake up in the morning? _____

SECTION D: HEALTH INSURANCE AND HEALTH CARE

1. Does your child currently have any of the following types of health insurance coverage?
(*Choose YES or No for each option. Select No/Don't Know if you are not sure. Include health insurance through you or someone else)*:

	Yes	No/ Don't Know
Private insurance including HMOs *(provided through a job or private purchase)*	☐	☐
Government plans (e.g., Medicaid or the Children's Health Insurance Program (CHIP)	☐	☐
Other type of insurance, specify _____	☐	☐
Child is currently uninsured	☐	☐

2. During the past 12 months, was there any time when your child was not covered by ANY health insurance? ☐ Yes ☐ No ☐ Don't Know

3. Other than the emergency room, is there a place that you USUALLY take your child when he or she is sick or you need advice about his or her health?

☐ Yes, one usual place ☐ Yes, but more than one usual place ☐ No ☐ Don't Know

A personal doctor or nurse is a health professional who is familiar with your child's health history. This can be a general doctor ("GP"), a family practice doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant.

4. Do you have one or more persons you think of as your child's personal doctor or nurse?

☐ Yes, one person ☐ Yes, more than one person ☐ No ☐ Don't Know

5. During the past 12 months did your child need a referral to see any doctors or receive any services? ☐ Yes ☐ No ☐ Don't Know

5a. If YES, was getting referrals: ☐ A big problem ☐ A small problem ☐ Not a problem

Care coordination means that someone helps you make sure that your child gets all the health care and services needed and that health care providers share information.

6. During the past 12 months, how often did you get as much help as you wanted with arranging and coordinating your child's care among the different doctors or services that he or she uses?

☐ Never ☐ Sometimes ☐ Usually ☐ Always ☐ Don't Know ☐ I didn't need any help

7. During the past 12 months, how often did your child's doctors and other health care providers spend enough time with him or her?

☐ Never ☐ Sometimes ☐ Usually ☐ Always ☐ Don't Know

☐ I didn't see my child's health care providers in past 12 months

Information about a child's health or health care can include things such as the causes of any health problems, how to care for a child now, and what changes to expect in the future.

8. During the past 12 months, how often did you get the specific information you needed from your child's doctors and other health care providers?

☐ Never ☐ Sometimes ☐ Usually ☐ Always ☐ Don't Know

☐ I didn't see my child's health care providers in past 12 months