Center for Autism and Developmental Disabilities Research and Epidemiology
CADDRE

Attachment 17.b.

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

Study to Explore Early Development

Interviewer_____

Study ID#_____
Date of Completion _____
Time of Completion_____

Blood Draw Information Form

1. Please tell me all vaccinations, medications, vitamins, and supplements, both prescription and over the counter, <*you have*> taken in the last month.

[Interviewer: Check box for MOST RECENT time frame when medication was last taken.]

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

Type of substance	**Last 7 days**	**Last month**
1)_____	☐	☐
2) _____	☐	☐
3)_____	☐	☐
4) _____	☐	☐
5) _____	☐	☐
6) _____	☐	☐
7) _____	☐	☐
8) _____	☐	☐

2. List any cold, flu, fever, or other illness <*you have*> had in the last 2 weeks. *[Interviewer: Check box for MOST RECENT time frame when illness occurred.]*

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

Illness	**Last 2 days**	**Last 2 weeks**
1) _____	☐	☐
2) _____	☐	☐
3) _____	☐	☐

4) _____ ☐ ☐

3. Have you or anyone else smoked cigarettes, cigars, or pipes anywhere inside your home in the past week?

☐ No

☐ Yes, person giving blood smoked

☐ Yes, someone else in home smoked