

Study ID #: _____

Date of Completion _____

Study to Explore Early Development

MOTHER'S MEDICAL HISTORY

Respondent's relationship to the study child:

Biological Mother Biological Father Other: Specify _____

Instructions: Please tell us if your child's biological mother has ever been diagnosed with any of these conditions. If you check "Yes," tell us the age at diagnosis and type, if requested (where the space is clear and not shaded in the "specify type" column). **Keep in mind these conditions must have been diagnosed by a doctor.** See the glossary of terms if you don't know the meaning of a condition. Also, having symptoms or being treated for a particular condition during pregnancy would be defined as having the condition during pregnancy.

	Has a doctor or other health care provider <u>ever</u> told you/her that you/she have any of the following conditions?				
Condition	No/ Don't Know	Yes	Age of Diagnosis (years)	Specify type	Did you/she have the condition during pregnancy with the study child?
Addison's disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Aplastic anemia	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Asperger's syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Attention-deficit/hyperactivity disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No

Autism	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth defect	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding/clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Condition	No/ Don't Know	Yes	Age of Diagnosis (years)	Specify type	Did you/she have the condition during pregnancy with the study child?
Byler Disease or intrahepatic cholestasis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Childhood disintegrative disorder (CDD)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cholestasis (Obstetric or Intrahepatic during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatitis herpetiformis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes: Uses insulin	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes: Does not use insulin	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes: Gestational (during pregnancy only)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating disorder (i.e., bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema/psoriasis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine disorder (hormonal disorder)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Fragile X syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Giant Cell arteritis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No

Graves disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Guillain-Barre syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hashimoto thyroiditis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemolytic anemia	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Condition	No/ Don't Know	Yes	Age of Diagnosis (years)	Specify type	Did you/she have the condition during pregnancy with the study child?
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Lupus, or systemic lupus erythematosus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental retardation – Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Mixed connective tissue disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Motor problem/movement or coordination problem	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Myasthenia gravis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Obesity	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Obsessive compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Optic neuritis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pemphigus	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Personality disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pervasive developmental disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Reading difficulty	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No

Reiter's syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Condition	No/ Don't Know	Yes	Age of Diagnosis (years)	Specify type	Did you/she have the condition during pregnancy with the study child?
Scleroderma (progressive systemic sclerosis, CREST)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizure disorder/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-injuring behavior	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle cell anemia/ thalassemia/other hereditary anemias	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech problem	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Stevens-Johnson syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sydenham's chorea	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Thrombocytopenia, (immune, idiopathic)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tourette's syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberous sclerosis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: Specify condition below	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
1.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No