

Study ID #: \_\_\_\_\_  
Date of Completion \_\_\_\_\_

## Study to Explore Early Development

### FATHER'S MEDICAL AND OCCUPATIONAL HISTORY

#### Respondent's relationship to the study child:

 Biological Father       Biological Mother       Other: Specify \_\_\_\_\_

#### Father's Medical History

**Instructions:** Please tell us if the child's biological father 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.

Condition	Has a doctor or other health care provider ever told you/him that you/he have any of the following conditions?		Age of Diagnosis (years)	Specify type
	No/ Don't Know	Yes		
Addison's disease	<input type="checkbox"/>	<input type="checkbox"/>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>		
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Aplastic anemia	<input type="checkbox"/>	<input type="checkbox"/>		
Asperger's syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Attention-deficit/hyperactivity disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Autism	<input type="checkbox"/>	<input type="checkbox"/>		
Autoimmune hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Birth defect	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding/clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>		

Public reporting burden of this collection of information is estimated to average 10 minutes, 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 (0920-0010).

Byler disease or intrahepatic cholestasis	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Condition</b>	<b>No/ Don't Know</b>	<b>Yes</b>	<b>Age of Diagnosis (years)</b>	<b>Specify type</b>
Cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>		
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>		
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>		
Childhood disintegrative disorder (CDD)	<input type="checkbox"/>	<input type="checkbox"/>		
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>		
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>		
Dermatitis herpetiformis	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes: Uses insulin	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes: Does not use insulin	<input type="checkbox"/>	<input type="checkbox"/>		
Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Eating disorder (i.e., bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>		
Eczema/psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		
Endocrine disorder (hormonal disorder)	<input type="checkbox"/>	<input type="checkbox"/>		
Fragile X syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Gastrointestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>		
Giant Cell arteritis	<input type="checkbox"/>	<input type="checkbox"/>		
Graves disease	<input type="checkbox"/>	<input type="checkbox"/>		
Guillain-Barre syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Hashimoto thyroiditis	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Hemolytic anemia	<input type="checkbox"/>	<input type="checkbox"/>		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>		
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>		
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>		
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>		
Lupus, or systemic lupus erythematosus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>		
Mental retardation - Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>		
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>		

Condition	No/ Don't Know	Yes	Age of Diagnosis (years)	Specify type
Motor problem/movement or coordination problem	<input type="checkbox"/>	<input type="checkbox"/>		
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		
Myasthenia gravis	<input type="checkbox"/>	<input type="checkbox"/>		
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>		
Neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Obesity	<input type="checkbox"/>	<input type="checkbox"/>		
Obsessive compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Optic neuritis	<input type="checkbox"/>	<input type="checkbox"/>		
Pemphigus	<input type="checkbox"/>	<input type="checkbox"/>		
Personality disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Pervasive developmental disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Reading difficulty	<input type="checkbox"/>	<input type="checkbox"/>		
Reiter's syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>		
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>		
Scleroderma (progressive systemic sclerosis, CREST)	<input type="checkbox"/>	<input type="checkbox"/>		
Seizure disorder/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		
Self-injuring behavior	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle cell anemia/ thalassemia/other hereditary anemias	<input type="checkbox"/>	<input type="checkbox"/>		
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Speech problem	<input type="checkbox"/>	<input type="checkbox"/>		
Stevens-Johnson syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>		
Sydenham's chorea	<input type="checkbox"/>	<input type="checkbox"/>		
Thrombocytopenia, (immune, idiopathic)	<input type="checkbox"/>	<input type="checkbox"/>		
Tourette's syndrome	<input type="checkbox"/>	<input type="checkbox"/>		
Tuberous sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>		
Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Other: Specify condition below				

1.	<input type="checkbox"/>	<input type="checkbox"/>		
2.	<input type="checkbox"/>	<input type="checkbox"/>		
3.	<input type="checkbox"/>	<input type="checkbox"/>		
4.	<input type="checkbox"/>	<input type="checkbox"/>		
5.	<input type="checkbox"/>	<input type="checkbox"/>		

### Father's Occupational History

We are interested in the father's *main* job or educational activity during the year before the child's birth. Think of a main job as one that took at least 10 hours per week and lasted for at least one month. If more than one job was worked, please answer about the job worked the most during this period.

1. What was the father's main employment during the year before the child was born (the period just before the mother became pregnant until the child's birth)?

- EMPLOYED
- STUDENT, specify the field of study \_\_\_\_\_, Degree sought \_\_\_\_\_
- UNPAID WORK, VOLUNTEER
- UNEMPLOYED
- OTHER, please specify: \_\_\_\_\_

Please continue if the father was employed. If not, you are finished with this section.

2. What was the main job title or occupation during this time?

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3. What type of business was this, or what did the company make or do?

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4. Please check the time periods this job was worked around the mother's pregnancy and child's birth.

- just before the mother became pregnant
- during *first 3 months* of the mother's pregnancy
- during the *middle 3 months* of the mother's pregnancy
- during the *last 3 months* of the mother's pregnancy

5. Describe the main duties or activities for this job.

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