



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) <i>(Write &lt;1 if younger than 1 year)</i>	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	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Aplastic anemia	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Autoimmune hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Congenital Heart Defect/ Cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Dermatitis herpetiformis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Diabetes: Uses insulin	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Diabetes: Does not use insulin	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Eczema/psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Feeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Giant cell arteritis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Graves disease	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Gullain-Barre Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Hashimoto thyroiditis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Hemolytic anemia	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Lupus, or systemic lupus erythematosus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Mixed connective tissue disease	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Myasthenia gravis	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		___ # Full ___ # Half ___ None
Optic neuritis	<input type="checkbox"/>	<input type="checkbox"/>		___ # 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) <i>(Write &lt;1 if younger than 1 year)</i>	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	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Reiter's syndrome	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Scleroderma (progressive systemic sclerosis, CREST)	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Sickle cell anemia/ thalassemia/other hereditary anemias	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Stevens-Johnson syndrome	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Sydenham's chorea	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Thrombocytopenia, (immune, idiopathic)	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Other condition (specify):	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Other condition (specify):	<input type="checkbox"/>	<input type="checkbox"/>		# Full # Half None
Other condition (specify):	<input type="checkbox"/>	<input type="checkbox"/>		# 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 1 <sup>st</sup> Diagnosis (years) <i>(Write &lt;1 if younger than 1 year)</i>
Allergy, Drug ( <i>specify type</i> )	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy, Food ( <i>specify type</i> )	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy, Skin ( <i>specify type</i> )	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy, Other ( <i>specify type</i> )	<input type="checkbox"/>	<input type="checkbox"/>		
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>		
Cytomegalovirus	<input type="checkbox"/>	<input type="checkbox"/>		
Ear Infection, Recurrent ( <i>specify # of times</i> )	<input type="checkbox"/>	<input type="checkbox"/>		

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

**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 regularly within the past year?**

*Regularly 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 <i>(daily or almost daily)</i>	Sometimes <i>(1-2 times per week)</i>	Rarely <i>(less than once per week)</i>
1.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

**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 regularly within the past year?**  
*Regularly 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)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	How often has child had problem in past 12 mths?			
	<i>(Select one of the following)</i>			
	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not falls asleep alone in own bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moves to someone else's bed during the night (e.g., parent, brother, sister)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is restless or moving a lot during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seems to stop breathing during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grinds teeth during sleep (your dentist may have told you this)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snores during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wakes during night screaming, sweating, and inconsolable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wakes once per night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wakes more than once per night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• If your child <b>sometimes</b> or <b>often</b> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Takes a long time to become alert in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other sleep problem, Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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 <i>(provided through a job or private purchase)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Government plans (e.g., Medicaid or the Children's Health Insurance Program (CHIP))	<input type="checkbox"/>	<input type="checkbox"/>
Other type of insurance, specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Child is currently uninsured	<input type="checkbox"/>	<input type="checkbox"/>

**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