Medical History

Instructions Please indicate if (you or the participant / your child) has ever had a history (past or present) of any of the following conditions.

The survey is divided into sections based on different body systems. This survey will take approximately 5 mins to complete.

_____

	Yes	No	Don't know	Prefer not to answer
Unintended weight loss (past 6 months)	◯	◯	◯	◯
Fatigue (past 6 months)	◯	◯	◯	◯
Chronic/Recurrent fever (past 6 months)	◯	◯	◯	◯

_____

	Yes	No	Don't know	Prefer not to answer
Cataracts	◯	◯	◯	◯
Cortical vision impairment	◯	◯	◯	◯
Vision loss/impairment (e.g., myopia, hyperopia, astigmatism)	◯	◯	◯	◯
Strabismus/squint	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Recurrent ear infections	◯	◯	◯	◯
Chronic sinusitis	◯	◯	◯	◯
Hearing testing	◯	◯	◯	◯

Results of hearing test: _____ _____

	Yes	No	Don't know	Prefer not to answer
Ringing in ears (tinnitus)	◯	◯	◯	◯
Hearing loss/impairment	◯	◯	◯	◯
Sensory neural hearing impairment	◯	◯	◯	◯
Conductive hearing loss	◯	◯	◯	◯

Use of hearing aids	◯	◯	◯	◯
Drooling (excessive salivation)	◯	◯	◯	◯
Difficulty chewing and/or swallowing	◯	◯	◯	◯
Cleft lip	◯	◯	◯	◯
Cleft palate	◯	◯	◯	◯
Dental abnormalities	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Congenital heart disease/defect	◯	◯	◯	◯
Left hypoplastic heart	◯	◯	◯	◯
Transposition of great arteries	◯	◯	◯	◯
Atrial Septal Defect (ASD)	◯	◯	◯	◯
Ventral Septal Defect (VSD)	◯	◯	◯	◯
Abnormal heart rate or rhythm	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Asthma (reactive airways disease)	◯	◯	◯	◯
Abnormal breathing	◯	◯	◯	◯
Lung disease	◯	◯	◯	◯
Chronic lung disease	◯	◯	◯	◯
Recurrent aspirations	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Gastroesophageal reflux disease (GERD)	◯	◯	◯	◯

Crohn's disease	◯	◯	◯	◯
Ulcerative colitis	◯	◯	◯	◯
Inflammatory bowel disease	◯	◯	◯	◯
Constipation	◯	◯	◯	◯
Recurrent abdominal pain	◯	◯	◯	◯
Use of feeding tube (eg. G-Tube, NG, J-tube)	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Polycystic kidney disease	◯	◯	◯	◯
Urinary incontinence	◯	◯	◯	◯
Urinary retention	◯	◯	◯	◯
Recurrent urinary tract infections	◯	◯	◯	◯
Nocturnal enuresis (nighttime bedwetting)	◯	◯	◯	◯
Kidney stones	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Muscular dystrophy	◯	◯	◯	◯
Spinal deformities (eg. Scoliosis, kyphosis)	◯	◯	◯	◯
Irregular gait	◯	◯	◯	◯
Foot deformities	◯	◯	◯	◯
Spasticity	◯	◯	◯	◯
Contractures requiring surgical release	◯	◯	◯	◯
Osteoporosis/ fragility fractures	◯	◯	◯	◯
Hip subluxation/dislocation	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Birthmarks (e.g., café-au-lait spots, white spots)	◯	◯	◯	◯
Pressure sores (bedsores)	◯	◯	◯	◯
Eczema	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Migraines	◯	◯	◯	◯
Recurrent headaches	◯	◯	◯	◯
Obstructive sleep apnea	◯	◯	◯	◯

Intellectual disability

◯ Yes
◯ No
◯ Probably no impairment
◯ Probably some impairment
◯ Don't know
◯ Prefer not to answer

Please specify severity: ◯ Mild ◯ Moderate ◯ Severe

	Yes	No	Don't know	Prefer not to answer
Attention deficit/hyperactivity disorder (ADHD)	◯	◯	◯	◯
Autism spectrum disorder (ASD)	◯	◯	◯	◯
Tourette's Syndrome	◯	◯	◯	◯
Tics	◯	◯	◯	◯

Please specify: ◯ Motor ◯ Vocal

	Yes	No	Don't know	Prefer not to answer
Language delay	◯	◯	◯	◯
Difficulties with motor coordination	◯	◯	◯	◯
Learning disability	◯	◯	◯	◯
Fetal alcohol syndrome exposure	◯	◯	◯	◯
Epilepsy	◯	◯	◯	◯
Seizures	◯	◯	◯	◯

Seizure type:

◯ Atonic
◯ Clonic
◯ Focal
◯ Myoclonic
◯ Tonic
◯ Other (specify)

Please specify:

_____

	Yes	No	Don't know	Prefer not to answer
Infantile spasms	◯	◯	◯	◯
Childhood disintegrative disease	◯	◯	◯	◯

_____

	Yes	No	Don't know	Prefer not to answer
Depression	◯	◯	◯	◯
Anxiety	◯	◯	◯	◯
Obsessive-Compulsive Disorder (OCD)	◯	◯	◯	◯
Specific phobia	◯	◯	◯	◯
Panic disorder	◯	◯	◯	◯
Mania/Bipolar disorder	◯	◯	◯	◯
Schizophrenia/Psychosis	◯	◯	◯	◯
Substance use disorder	◯	◯	◯	◯
Eating disorder	◯	◯	◯	◯
Self-Injury behavior	◯	◯	◯	◯
Oppositional Defiant Disorder (ODD)	◯	◯	◯	◯
Conduct disorder	◯	◯	◯	◯
Problems with the law	◯	◯	◯	◯
Gambling	◯	◯	◯	◯
Cerebral Palsy (CP)	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify:

_____

_____

	Yes	No	Don't know	Prefer not to answer
Early puberty	◯	◯	◯	◯

Age of puberty onset (e.g., first menses)

_____
(years)

	Yes	No	Don't know	Prefer not to answer
Delayed puberty	◯	◯	◯	◯

Age of puberty onset (e.g., first menses)

_____
(years)

	Yes	No	Don't know	Prefer not to answer
Painful menstruation	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯

_____ _____ _____

	Yes	No	Don't know	Prefer not to answer
Thyroid disorder	◯	◯	◯	◯
Obesity	◯	◯	◯	◯
High blood pressure	◯	◯	◯	◯
Malnutrition	◯	◯	◯	◯
High cholesterol (hypercholesterolemia)	◯	◯	◯	◯
Dyslipidemia	◯	◯	◯	◯
Overactive thyroid (hyperthyroidism)	◯	◯	◯	◯
Underactive thyroid (hypothyroidism)	◯	◯	◯	◯
Phenylketonuria (PKU)	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Anemia	◯	◯	◯	◯
Coagulation disorder	◯	◯	◯	◯
Bleeding disorder	◯	◯	◯	◯
Clotting disorder	◯	◯	◯	◯
Hemochromatosis	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

_____

	Yes	No	Don't know	Prefer not to answer
Food allergies	◯	◯	◯	◯
Skin allergies	◯	◯	◯	◯
Environmental allergies	◯	◯	◯	◯
Recurrent infections	◯	◯	◯	◯
Strep throat	◯	◯	◯	◯

Glandular infection (Epstein Barr)	◯	◯	◯	◯
Allergic rhinitis	◯	◯	◯	◯
Auto-immune diseases	◯	◯	◯	◯
Arthritis	◯	◯	◯	◯
Fibromyalgia	◯	◯	◯	◯
Sickle cell anemia	◯	◯	◯	◯
Multiple sclerosis	◯	◯	◯	◯
Lupus	◯	◯	◯	◯
HIV/AIDS	◯	◯	◯	◯
Other	◯	◯	◯	◯

Please specify: _____

Immunizations:

◯ Up-to-date ◯ Behind ◯ None ◯ Don't know ◯ Prefer not to answer

Genetic Disorder
(Have you or has the participant / Has your child) been identified with any Genetic Disorder (e.g., Down Syndrome, Fragile X, Neurofibromatosis, Rett Syndrome)?
(MEDDRA:10010331)

◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Please specify: _____

Congenital Malformation
(Have you or has the participant / Has your child) been identified with any congenital malformations/birth defects?

◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Please specify: _____

Cancer
(Do you or does the participant / Does your child) have or (have you or has the participant / has your child) ever had a cancer diagnosis?

◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Please specify: _____

Head Injury
(Do you or does the participant / Does your child) have or (have you or has the participant / has your child) ever had a head injury?

◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Please specify: _____

Concussion
(Do you or does the participant / Does your child) have or (have you or has the participant / has your child) ever had a concussion?

◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Please specify: _____

Other Surgeries or Conditions

Please describe in the sections below if (you have or the participant has / your child has) had any surgeries or conditions that were not listed in the previous sections.

Other Surgeries:

◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

How many other surgeries?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8

Other major surgery #1: _____

Other major surgery #2: _____

Other major surgery #3: _____

Other major surgery #4: _____

Other major surgery #5: _____

Other major surgery #6: _____

Other major surgery #7: _____

Other major surgery #8: _____

Other Conditions:

◯ Yes ◯ No other conditions ◯ Don't know ◯ Prefer not to answer

How many other conditions?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8

Other major condition #1: _____

Other major condition #2:

_____

Other major condition #3:

_____

Other major condition #4:

_____

Other major condition #5:

_____

Other major condition #6:

_____

Other major condition #7:

_____

Other major condition #8:

_____