# Dietary Intervention Study In Children
# Child Medical Information Follow-up Form

Office Use Only

ID ___-___ ___ ___ ___-___

NC ___ ___ ___ ___ ___ ___

VN ___ ___ ___ ___

1. What is today's date? ..... _____-_____-_____
Month Day Year

2. What is your relationship to your child? (Mark one answer)

Mother or father ..... ☐ 1

Step-mother or step-father ..... ☐ 2

Legal guardian other than parent ..... ☐ 3

Other relationship ..... ☐ 4

(What is this relationship?)

_____
Relationship

3. Has a doctor told you in the LAST 12 MONTHS that your child has any of the following medical conditions?

| | | 1 Yes | 2 No |
|---|---|---|---|
| A. | Hypothyroidism (or underactive thyroid) ..... | ☐ *HYPOTHYRD* | ☐ |
| B. | Liver disease (such as jaundice or hepatitis) .... | ☐ | ☐ |
| C. | Diabetes ..... | ☐ | ☐ |
| D. | Severe long-term intestinal disease (such as colitis requiring long-term medication) ..... | ☐ | ☐ |
| E. | Kidney disease (such as nephrotic syndrome, nephritis or kidney failure) ..... | ☐ | ☐ |
| F. | Hemophilia ..... | ☐ | ☐ |
| G. | Anorexia (extreme undereating leading to weight loss) ..... | ☐ | ☐ |
| H. | Bulimia (binge eating, self-inducted vomiting) ... | ☐ | ☐ |
| I. | Cancer or other serious disease (describe below) ..... | ☐ *CANCER* | ☐ |

_____

_____

4. Has your child ever intentionally gained or lost seven pounds or more over a period of two weeks or less during the past year? .....

*GAINLOSE*

| 1 Yes | 2 No |
|---|---|
| ☐ | ☐ |

5. Has your child been admitted to a hospital in the LAST 12 MONTHS? .....

*HOSPTLZD*

Yes 1 | No 2

If YES, answer Items 5A and 5B.

If NO, skip to Item 6.

A. List dates and reasons for hospitalization(s):

_____

_____

B. Has your child had any operations in in the LAST 12 MONTHS? .....

*OPERATNS*

If YES, answer Item 5C.

If NO, skip to Item 6.

C. List dates and names of operations:

_____

_____

6. Is your child CURRENTLY taking medications prescribed by a doctor?..... ☐ Yes 1 ☐ No 2

If YES, answer Items 6A-K.

If NO, skip to Item 7.

Does your child take:

| | | 1 Yes | 2 No | |
|---|---|---|---|---|
| A. | Ritalin ..... | ☐ | ☐ | *RITALIN* |
| B. | Phenobarbital ..... | ☐ | ☐ | |
| C. | Dilantin ..... | ☐ | ☐ | |
| D. | Other seizure medications (such as Tegretol and Depakene) ..... | ☐ | ☐ | *SEIZMEDS* |
| E. | Diuretics (such as Lasix, Diuril or Hydrodiuril) . | ☐ | ☐ | |
| F. | Retinoids (such as Acutane) ..... | ☐ | ☐ | *RETNOIDS* |
| G. | Steroids (such as cortisone, cortisol, prednisone, steroids for asthma) ..... | ☐ | ☐ | *STEROIDS* |
| H. | Lipid lowering medications (such as Questran, Colestid or nicotinic acid) ..... | ☐ | ☐ | |
| I. | Thyroid (such as Synthroid) ..... | ☐ | ☐ | *THYROID* |
| J. | Therapeutic iron (such as Fer-in-sol) ..... | ☐ | ☐ | |
| K. | Other medications prescribed by a doctor ..... | ☐ | ☐ | *OTHRMEDS* |

If YES, list other medications:

_____

_____

_____

Please bring all your child's current medications/ prescriptions to the clinic visit.

7. Has your child taken any medications prescribed by a doctor in the LAST 12 MONTHS? .....

| Yes | No |
|---|---|
| 1 | 2 |

If YES, answer Items 7A-K.

If NO, skip to Item 8.

Does your child take:

| | | Yes (1) | | No (2) |
|---|---|---|---|---|
| A. | Ritalin ..... | | *RITAL12* | |
| B. | Phenobarbital ..... | | | |
| C. | Dilantin ..... | | | |
| D. | Other seizure medications (such as Tegretol and Depakene) ..... | | *SEZMED12* | |
| E. | Diuretics (such as Lasix, Diuril or Hydrodiuril) . | | | |
| F. | Retinoids (such as Acutane) ..... | | *RETIN12* | |
| G. | Steroids (such as cortisone, cortisol, prednisone, steroids for asthma) ..... | | *STER12* | |
| H. | Lipid lowering medications (such as Questran, Colestid or nicotinic acid) ..... | | | |
| I. | Thyroid (such as Synthroid) ..... | | *THYROD12* | |
| J. | Therapeutic iron (such as Fer-in-sol) ..... | | *IRON12* | |
| K. | Other medications prescribed by a doctor ..... | | *OTHMED12* | |

If YES, list other medications:

_____

_____

_____

8. Does your child take any medications prescribed by a doctor occasionally which he/she is currently not taking (such as inhalers for asthma or allergies)? ...

☐ Yes 1 ☐ No 2

If YES, list these medications:

_____

_____

_____

9. Does your child usually take vitamins, minerals or diet supplements? .....

***VITAMINS***

☐ Yes 1 ☐ No 2

If YES, answer Item 10.

If NO, skip to END.

10. What kinds does he/she usually take and how many does he/she usually take each day?

| | A. Type/Brand Name of Vitamin, Mineral or Diet Supplement | B. No. Each Day |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

END

Thank you very much for taking the time to complete this questionnaire. Please bring it with you when you bring your child to the DISC Clinical Center.