



**DIETARY INTERVENTION STUDY IN CHILDREN
 PARTICIPANT 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 the DISC participant? (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 the DISC participant has any of the following medical conditions?

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

4. Has the DISC participant ever intentionally gained or lost seven pounds or more over a period of two weeks or less in the PAST YEAR?

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| Yes | No |
| 1 | 2 |

5. Has the DISC participant been admitted to a hospital
in the LAST 12 MONTHS?
Yes No
1 2

IF NO, SKIP TO ITEM 6.
If YES, answer Items 5A and 5B.

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

- B. Has the DISC participant had any operations in
in the LAST 12 MONTHS?
Yes No
1 2

IF NO, SKIP TO ITEM 6.
If YES, answer Item C.

- C. List dates and names of operations:

6. Is the DISC participant CURRENTLY taking medications prescribed by a doctor?
Yes No
1 2

IF NO, SKIP TO ITEM 7.
If YES, answer Items 6A-K.

Does the DISC participant take:

- | | 1
Yes | 2
No |
|--|--------------------------|--------------------------|
| A. Ritalin | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Phenobarbital | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Dilantin | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Other seizure medications (such as Tegretol or Depakene) | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Diuretics (such as Lasix, Diuril or Hydrodiuril) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Retinoids (such as Acutane) | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Steroids (such as cortisone, cortisol, prednisone, steroids for asthma or steroids for athletics) | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Lipid lowering medications (such as Questran, Colestid or nicotinic acid) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Thyroid (such as Synthroid) | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Therapeutic iron (such as Fer-in-sol) | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Other medications prescribed by a doctor | <input type="checkbox"/> | <input type="checkbox"/> |

If YES, list other medications:

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

7. Has the DISC participant taken any medications prescribed by a doctor in the LAST 12 MONTHS? Yes No
1 2

| |
|--|
| IF NO, SKIP TO ITEM 8. If YES, answer Items 7A-K. |
|--|

Does the participant take:

- | | 1
Yes | 2
No |
|--|--------------------------|--------------------------|
| A. Ritalin | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Phenobarbital | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Dilantin | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Other seizure medications (such as Tegretol or Depakene) | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Diuretics (such as Lasix, Diuril or Hydrodiuril) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Retinoids (such as Acutane) | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Steroids (such as cortisone, cortisol, prednisone, steroids for asthma or steroids for athletics) | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Lipid lowering medications (such as Questran, Colestid or nicotinic acid) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Thyroid (such as Synthroid) | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Therapeutic iron (such as Fer-in-sol) | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Other medications prescribed by a doctor | <input type="checkbox"/> | <input type="checkbox"/> |

If YES, list other medications:

8. Does the DISC participant take any medications prescribed by a doctor OCCASIONALLY which he/she is currently not taking (such as inhalers for asthma or allergies)?
Yes No
1 2

If YES, list these medications:

9. Does the DISC participant usually take vitamins, minerals or diet supplements?
Yes No
1 2

IF NO, AND THE PARTICIPANT IS MALE, SKIP TO END.
IF NO, AND THE PARTICIPANT IS FEMALE, SKIP TO ITEM 11.
If YES, answer Item 10.

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

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

If the DISC participant is MALE, skip to END.

11. A. We ask all girls in the DISC study about their periods because menstruation causes changes in the amount of cholesterol in a girl's blood. Has your daughter EVER had a period or any menstrual bleeding? Yes 1 No 2

If NO, skip to Item 12.

- B. When did she have her FIRST period or menstrual bleeding? _____ - _____ - _____
Month Year

12. Now we are going to ask you about some other things that can cause changes in a girl's blood cholesterol. They may not all apply to your daughter. Is she practicing birth control or contraception with pills, Norplant, or injections now or has she taken any of these medications in the PAST MONTH? **BCMNLMO**
 Yes 1 No 2

13. A. Some girls in this age group become pregnant. Is your daughter pregnant now? Yes 1 No 2

If NO, skip to item 14.

- B. If YES, what is her due date? _____ - _____ - _____
Month Day Year

Skip to END.

14. A. Has she been pregnant in the last 4 months? Yes 1 No 2

If NO, skip to Item 15.

- B. When did the pregnancy end? _____ - _____ - _____
Month Day Year

15. If she has been pregnant in the recent past, is she currently breast feeding? Yes 1 No 2 N/A 3

END

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