

ID # : _____

Interviewer: _____

Date: _____

Respondent: _____

Modified CHARGE Family Medical History *

Please note if relatives are affected by any of these conditions.

Family member codes:

MGM Maternal Grandmother **PGM** Paternal Grandmother

MGF Maternal Grandfather **PGF** Paternal Grandfather

For siblings, aunts and uncles, use code from FAMILY MEMBER WORKSHEET (page 5)

* Adapted with permission from MIND Institute’s CHARGE Study (Childhood Autism Risks from Genetics and the Environment) and the Centers For Disease Control and Prevention’s CADDRE (Centers for Autism and Developmental Disabilities Research and Epidemiology) Study to Explore Early Development (SEED)

Condition	Child	Biological Mother			Biological Father	Siblings, Aunts, Uncles and Grandparents (Use codes)
	Yes/No	Yes/No	Onset Age	Have during pregnancy with CHILD?	Yes/No	Yes/No (if yes, indicate Family Member Code)
ALLERGIES						
1. Food Allergy. Specify type						
2. Skin Allergy. Specify type						
3. Eczema						
4. Environmental. Specify type						
5. Medication. Specify type						
6. Other allergy. Specify type						
AUTISM SPECTRUM DISORDERS						
7. Autism						
8. Asperger’s Syndrome						

ID # : _____

Condition	Child	Biological Mother			Biological Father	Siblings, Aunts, Uncles and Grandparents (Use codes)
	Yes/No	Yes/No	Onset Age	Have during pregnancy with CHILD?	Yes/No	Yes/No (if yes, indicate Family Member Code)
9. Rett's Syndrome						
10. PDD-NOS (Pervasive Development Disorder- Not Otherwise Specified)						
NEURODEVELOPMENTAL DISORDERS						
11. Speech/Language Delay						
12. Developmental Delay						
13. Learning Disability						
14. Seizure disorder/Epilepsy						
15. Cerebral Palsy						
16. Down's Syndrome						
17. Mental Retardation						
18. Tuberous Sclerosis						
19. Fragile X						
20. Neuromuscular disorder						
21. Known Genetic Disorder. Specify						
21a. Testing done? Specify type						
SENSORY						
22. Vision impairment						
22a. Vision corrected?						
23. Hearing impairment						

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Condition	Child	Biological Mother			Biological Father	Siblings, Aunts, Uncles and Grandparents (Use codes)
	Yes/No	Yes/No	Onset Age	Have during pregnancy with CHILD?	Yes/No	Yes/No (if yes, indicate Family Member Code)
23a.Hearing corrected?						
MENTAL HEALTH						
24. Bipolar disorder (Manic/depression)						
25. Depression						
26. Anxiety disorder						
27. Obsessive compulsive disorder						
28. Schizophrenia						
29. Personality disorder. Specify type						
30. Self-injuring behavior						
31. Suicide attempt/suicide						
32. Other psychiatric disorder. Specify type						
33. Attention deficit hyperactivity disorder (ADHD)						
34. Eating disorder. Bulimia, Anorexia, Other. Specify type						
35. Sleep disorder. Insomnia, Narcolepsy, Other						
36. Victim of abuse						
37. Substance abuse. Specify type						
OTHER CONDITIONS						
38. Migraine headaches						

ID # : _____

Condition	Child	Biological Mother			Biological Father	Siblings, Aunts, Uncles and Grandparents (Use codes)
	Yes/No	Yes/No	Onset Age	Have during pregnancy with CHILD?	Yes/No	Yes/No (if yes, indicate Family Member Code)
39. Irritable bowel syndrome						
40. Other Gastrointestinal disorders						
41. Cancer. Specify type						
42. Congenital Defect (Cleft palate, Cleft lip, other: write in type)						
43. Obesity						
44. Sickle cell anemia						
45. Thyroid Disease						
46. Other. Specify condition.						
46a.						
46b.						
46c.						
46d.						

ID # : _____

Family Member Worksheet

Child							
SISTERS		BROTHERS					
Code	Name	Half? P/M	Subject ID	Code	Name	Half? P/M	Subject ID
S1				B1			
S2				B2			
S3				B3			
S4				B4			
S5				B5			
S6				B6			
S7				B7			

Biologic Mother's Family						Biologic Father's Family					
Aunts			Uncles			Aunts			Uncles		
Code	Name	Half? P/M	Code	Name	Half? P/M	Code	Name	Half? P/M	Code	Name	Half? P/M
MA1			MU1			PA1			PU1		
MA2			MU2			PA2			PU2		
MA3			MU3			PA3			PU3		
MA4			MU4			PA4			PU4		
MA5			MU5			PA5			PU5		
MA6			MU6			PA6			PU6		
MA7			MU7			PA7			PU7		