AUTISM MEDICAL HISTORY QUESTIONNAIRE – DRAFT 2.8.07

NAME:____
(last) *(first)*

DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___
(month) *(day* *)(year)*

Date ___ ___ / ___ ___ / ___ ___ ___ ___
(month) *(day)* *(year)*

Person Filling out the Form
❑ ***Mother*** ❑ ***Father*** ❑ **Other** ____ (please specify)

Instructions

Please fill out the following form about the medical history of the child participating in this study. It includes sections on the pregnancy, birth history, early development and overall medical and behavioral history. We know it is sometimes difficult to remember all the details so please feel free to refer to your baby book or any medical records you might have. For any questions you might have please write comments in the margins of the paper and we can go over them at your next visit.

PART I Questions regarding pregnancies and birth history for the child in the study.

1. Pregnancy History

1a. How many times had the birth mother been pregnant before giving birth to the child being evaluated in this study (including that pregnancy)? ____________ times

1b. How many babies had the mother had (including that child)? ____________ babies

1c. How many miscarriages had the mother had? __________________ miscarriages ____________ miscarriages

2. Was this child part of a multiple pregnancy? .... NO YES Don't know

(If yes):
2.a. How many babies? ____________ babies
2.b. Were they identical? .... NO YES Don't know

3. Was this pregnancy the result of Assisted Reproductive Technology (ART)? NO YES Don't know

4. Did the birth mother have an amniocentesis, Chorionic Villus Sampling (CVS) or a blood test to check for fetal abnormalities?............................. NO YES Don't know
(If yes):
4.a. Were the results ABNORMAL describe: NO YES Don't know

5. Did the doctor tell the mother that the baby had any fetal abnormalities not mentioned above NO YES Don't know
If YES
5.a. Please describe

6. Did the birth mother have any ultrasounds or sonograms? NO YES Don't know
(If yes): Number:

6.a. How many? ________

	6.b. Were the results ABNORMAL	NO	YES	Don't know
	If yes			
	6.b.1. Please describe			
7.	**When did the birth mother first feel the baby start to move?**	Months: ________		Don't know
7a.	**How were the movements?**	NORMAL INCREASED DECREASED DON'T KNOW		
7b.	**If decreased, where there any periods of stillness?**	NO	YES	Don't know
7c.	**(If YES)When?** ______________________________			Don't know

QUESTIONS ABOUT MOTHER

8.	**How much weight did the birth mother gain during pregnancy?**	______ lbs.			Don't know
9.	**Did the birth mother have any shots or vaccinations during the pregnancy?**	NO		YES	Don't know
	(If yes): **9.a. What type?** *(circle all that apply)*	Rhogam Flu shot Tetanus booster Other: ____________________			Don't know
10.	**At <u>any</u> time in this pregnancy, did the birth mother have any of the following health problems?**	NO		YES	Don't know
10.a.	**Infection (e.g., Strep Throat or Urinary Tract) requiring antibiotics**	NO		YES	Don't know
	(If yes) **Please describe type of infection:** **When did it occur?**	1st trimester	2nd trimester	3rd trimester	Don't know
10.b.	**Viral illness**	NO		YES	Don't know
	(If YES): *Circle all that apply and check when during pregnancy it occurred*	1st trimester	2nd trimester	3rd trimester	Don't know
	cold influenza (the flu) Chicken Pox Shingles Measles Mumps Rubella (German Measles) Herpes Type 1 (cold sores) Herpes Type 2 (genital herpes) Infectious mononucleosis ("mono") viral hepatitis OTHER___________________________				
10.c.	**Low grade fever (99-100.9)**	NO		YES	Don't know
10.d.	**Fever of 101°F or above**	NO		YES	Don't know
10.e.	**Anemia**	NO		YES	Don't know
10.f.	**Excessive vomiting (hyperemesis gravidarum)**	NO		YES	Don't know

10.g.	**If YES how was this treated?**	*Circle all that apply* No treatment needed Medications: _________________ Intravenous fluids in the doctors office Admission to the hospital		
10.h.	**Seizures**	NO	YES	Don't know
10.i.	**Asthma**	NO	YES	Don't know
10.j.	**Migraines**	NO	YES	Don't know
10.k.	**Severe allergies requiring medication treatment**	NO	YES	Don't know
10.l.	**Diabetes (including gestational diabetes)**	NO	YES	Don't know
10.m.	**Thyroid disease (overly active, underactive, Hashimoto's)**	NO	YES	Don't know
10.n.	**Preterm labor requiring treatment such as bed rest or medication**	NO	YES	Don't know
10.o.	**Placenta Previa**	NO	YES	Don't know
10.p.	**Cervical Incompetence**	NO	YES	Don't know
10.q.	**Trauma to the abdomen**	NO	YES	Don't know
10.r.	**Hypertension (High blood pressure)**	NO	YES	Don't know
	If YES **Was this treated with medication?**	NO	YES	Don't know
10.s.	**Severe swelling of the body (more than hands and feet)**	NO	YES	Don't know
10.t.	**Preeclampsia**	NO	YES	Don't know
	If YES **How was this treated?**	*Circle all that apply* Bed rest at home Admission to the hospital Intravenous infusion of Magnesium sulfate Don't know		
10.u.	**Other major illness or injury__________________**	NO	YES	Don't know
	If YES **Please describe:**			
11.	**In this pregnancy did the birth mother take prenatal vitamins?**	NO	YES	Don't know
	If YES **11.a. Did the birth mother take them continuously throughout the pregnancy?**	NO	YES	Don't know
	11.b. In what trimester did the birth mother take them? *(circle all that apply)*	FIRST	SECOND	THIRD
12.	**In this pregnancy did the birth mother take any other nutritional supplements?**	NO	YES	Don't know
	If YES **12.a. What type?**	Please list:		

13. In this pregnancy, did the birth mother take any of the following prescription medications? If so, did the birth mother take the medications in the first, second or third trimester of the pregnancy? And for how long did she take the medication (# of weeks)?

		NO	***YES***	***1st***	***2nd***	***3rd***	***# weeks***
a.	Antibiotics for infections *(e.g., Amoxicillin, Augmentin, Cephalosporins, Clindamycin, Erythromycin, Flagyl, Nystatin, Penicillin, Septra/Bactrim, Zithromax)*	NO	YES				
b.	Medications for acne *(e.g., Accutane)*	NO	YES				
c.	Medications for birth control *(e.g., Pills, Depo-Provera)*........	NO	YES				
d.	Medications for asthma *(e.g., inhalers, steroids, theophylline)*	NO	YES				
e.	Antihypertensives for high blood pressure *(e.g., Catapres (clonidine), Hydrochlorothiazide, Inderal (propranolol), Tenex (guanfacine))*........	NO	YES				
f.	Medications for heart or cardiac problems........	NO	YES				
g.	Medications for Attention Deficit Disorder *(e.g., Adderall, Ritalin, Concerta, Dexedrine, Metadate*........	NO	YES				
h.	Antiepileptics or anti-seizure medications *(e.g., Depakene/Depakote (Valproic acid), Dilantin, Keppra, Lamictal, Neurontin, phenobarbital, Tegretol, Carbatrol (Carbamazepine), Trileptal, Topamax)*........	NO	YES				
i.	Medications to control diabetes *(e.g., Insulin)*........	NO	YES				
j.	Medications to regulate thyroid *(e.g., Synthroid, Thyroxin)*........	NO	YES				
k.	Antidepressants *(e.g., Celexa, Effexor, Elavil (amitriptyline), Lexapro, Luvox, Paxil, Prozac (fluoxetine), Tofranil (imipramine), Wellbutrin (bupropion), Zoloft (sertraline))*	NO	YES				
l.	Mood stabilizers or anti-psychotics *(e.g., Carbatrol, Tegretol, Depakote (Valproic acid), Haldol, Lamictal, Lithium, Mellaril, Neurontin, Olanzapine, Risperdal, Seroquel, Thorazine, Trileptal, Topamax)*	NO	YES				
m.	Tranquilizers or nerve pills *(e.g., Ativan, BuSpar, Klonopin, Valium, Xanax)*........	NO	YES				
n.	Pain killers *(e.g., Darvon, Demerol, Dilaudid, Morphine, Percocet, Percodan, Tylenol with codeine, Codeine preparations)*	NO	YES				
o.	Migraine medications *(e.g., Amerge, Axert, Cafergot, Fiorinal, Imitrex, Maxalt, Midrin, Zomig)*	NO	YES				
p.	Muscle relaxers *(e.g., Baclofen, Flexeril, Zanaflex)*	NO	YES				
q.	Sedatives or sleeping pills *(e.g., Halcion, Methaqualone, Phenobarbital, Seconal)*	NO	YES				
r.	Anti-inflammatory or anti-immune drugs *(e.g., Cytoxan, Imuran, Prednisone, Steroids)*......	NO	YES				
s.	Treatment for HIV........	NO	YES				
t.	Thalidomide ______ *(please specify* ***why medication was prescribed****)*	NO	YES				
u.	Misoprostol ______ *(please specify* ***why medication was prescribed****)*	NO	YES				
v.	Other______ *(please specify* ***why medication was prescribed****)*	NO	YES				

**Before=Medications taken before knowledge of pregnancy, After=Medications taken after knowledge of pregnancy, Both=Medications taken before and after knowledge of pregnancy.*

14. In this pregnancy, did the birth mother do any of the following activities? If so, did she do so before or after she knew she was pregnant or both (i.e., before AND after she knew she was pregnant)?

(circle one for each item)

				When was this done		
		NO	***YES***	***Before***	***After***	***Both***
a.	Drink alcohol	NO	YES	Before	After	Both
b.	Smoke cigarettes or other tobacco products	NO	YES	Before	After	Both
c.	Use recreational drugs (e.g. marijuana, cocaine, etc)	NO	YES	Before	After	Both

Questions regarding labor, delivery and newborn information for the child in the study.

15. When did the birth mother go into labor __________________________ (weeks) DON'T KNOW

16. Did the doctor need to induce the birth mother's labor (i.e. get her labor started)? NO YES DON'T KNOW

17. Did the doctor need to restart or speed up her labor with pitocin? NO YES DON'T KNOW

18. How long was the birth mother's labor? ______________ hours DON'T REMEMBER

19. Were the doctors worried that the baby was in distress? (For example, the monitor showed a decrease in the baby's heart rate.) NO YES DON'T KNOW

If YES

19a. When did this happen? *(circle all that apply)* early in labor, after transition, just before delivery

20. Did the birth mother have any other problems during her labor? NO YES DON'T KNOW

If YES

20a. What happened? ____

21. Did the birth mother have any pain killing medication/anesthesia during the labor? NO YES DON'T KNOW

If YES

21a. What type? *(circle all that apply)* local nerve (pudendal) block, oral pain medications, IV pain medications, epidural/spinal, Don't Know

22. How was the baby delivered? VAGINAL C-SECTION

for C-SECTION

22a. Why was the c-section performed? *(circle all that apply)* Emergency, Failure to progress (the baby wasn't coming down the birth canal), Baby was feet first (breech) or turned sideways (transverse), Planned for repeat because mother had had one before, Planned for convenience, Concerns about the mother's ability to deliver vaginally, Other ______________________

for VAGINAL

22b. Did they use FORCEPS? NO YES DON'T KNOW

22c. Did they use a vacuum? NO YES DON'T KNOW

23. Was the baby's umbilical cord wrapped around its neck? NO YES DON'T KNOW

24. Were there any other problems with the umbilical cord (eg it collapsed or had a knot in it)? NO YES DON'T KNOW

25. Were there any problems with the placenta? NO YES DON'T KNOW

if YES

25a. Did the placenta separate from the uterus too early (abruption)? NO YES DON'T KNOW

26. Did this baby need to have resuscitation such as having the nurses and doctors help him/her breathe or get his/her heart started in the delivery room? NO YES DON'T KNOW

27. What were the baby's APGAR scores?

27a. first APGAR (at 1 minute) _________ DON'T KNOW

27b. second APGAR (at 5 minutes) ________ DON'T KNOW

27c. third APGAR (at 10 minutes- often not recorded) ___________ DON'T KNOW

28. How much did this <u>baby</u> weigh at birth? ____ ____ pounds ____ ____ ounces *or* ____ ____ grams DON'T KNOW

29. What was the baby's head circumference at birth? _______ cm *or* ___________ inches DON'T KNOW

30. What was the baby's length at birth? _______ cm *or* ___________ inches DON'T KNOW

31. Did this baby stay in the neonatal intensive care unit? NO YES DON'T KNOW

If YES

31a. .... How long? ____ ____ ____ days *or* ____ ____ hours

31b. Was the baby on a respirator (ventilator)? NO YES DON'T KNOW

if YES

31c. for how long? ___________ hours *or* ______________days DON'T KNOW

40. How many days or hours <u>total</u> did this <u>baby</u> stay in the hospital (after delivery up until discharge, including the neonatal ICU)?

____ ____ ____ days DON'T KNOW

41. How many days did the mom stay in the hospital? _______________ DON'T KNOW

Questions regarding early period (newborn & first year) for the child in the study.

42. Did the baby have any major problems in the newborn period (0-30 days of life)?

NO YES DON'T KNOW

IF YES, what type? *(circle one for each item)*

42.a. Birth defects: NO YES

	If YES please choose type	head deformities body deformities limb deformities heart deformities kidney deformities stomach/intestine deformities	
42.b.	Sepsis (bacterial blood infection)	NO	YES
42.c.	Jaundice, hyperbilirubinemia, yellow skin *If YES* what treatment was given (*circle all that apply)* No treatment, phototherapy (special lights), exchange transfusion (blood transfusion)	NO	YES
42d.	Seizures	NO	YES
42e.	Meningitis	NO	YES
42f.	High fever (>38.5 or 101.5)	NO	YES
42g.	Other_________________	NO	YES

43. Did the birth mother breast feed the baby? NO YES DON'T KNOW

44. How old was the child *in months* when s/he received the last/final breast milk feeding? _______ DON'T KNOW

45. Did the baby have any difficulty with feeding (breast or bottle)? NO YES DON'T KNOW

If YES

a. Did the baby have a poor suck? NO YES DON'T KNOW

b. Did the baby require special feeds (e.g. thickened liquid or special nipples)? NO YES DON'T KNOW

c. When did this happen (from age ___ mos to age ___ mos) DON'T KNOW

46. Did the baby have trouble gaining weight? NO YES DON'T KNOW

47. How was the baby's early temperament? *(Circle one.)*

- Easy
- Fussy or colicky
- Quiet or passive
- Can't say

48. How was the baby's early sleep pattern? *(Circle one.)*

- Regular/Predictable
- Irregular/Unpredictable
- Can't say

Questions regarding medical problems for the child in the study.

Birth Defects Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Cleft lip ☐
Cleft palate ☐
Ears deformed ☐
Nose deformity ☐
Arms, legs, hands, feet, trunk deformities ☐
Spine defect (spina bifida) ☐

Head/Face/Mouth Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Early closing of the sutures (craniosynostosis) ☐
Dental or Tooth Deformity (shape, enamel, number, location) ☐
Regurgitation through nose ☐
Other (list: ____) ☐

Eyes Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Abnormal structure of the eye ☐
Strabismus (lazy eye) ☐
Color blindness ☐
Poor vision☐
Blindness ☐
Other (list: ____) ☐

Ears Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Ears set too low or too high ☐
Tinnitus (ringing in the ear) ☐
Recurrent Infections ☐
Number per year when happening most frequently____________
Ear tubes placed ☐
Hearing trouble ☐
How was this diagnosed? _____________
At what age was the child when this was diagnosed? ________
Other (list: ____) ☐

Nose/throat Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Nosebleeds ☐
Trouble perceiving smells ☐
Too sensitive to smells ☐
Tonsillitis ☐
Snoring ☐
Tonsillectomy ☐
Adenoidectomy ☐
Other (list: _______________________________________) ☐

Neck/Back Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Deformity (scoliosis, lordosis, kyphosis, torticollis) ☐
Other (list: ____) ☐

Orthopedic Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Fractures ☐
Muscle/bone/joint pain ☐
Edema (swelling caused by excess fluid) ☐
Stiffness ☐
Joint swelling ☐
Heat or redness of joints ☐
Other (list: ____) ☐

Skin Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Eczema ☐
Psoriasis ☐
Frequent rashes ☐
Unexplained sores ☐
Infections ☐
Sensitive ☐
Birth marks ☐
Other (list: ____) ☐

Pulmonary Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Shortness of breath ☐
Asthma ☐
Recurrent pneumonias ☐
Chonic bronchitis ☐
Blood in sputum ☐
Other (list: ____) ☐

Cardiovascular Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Congenital heart disease ☐
Heart murmur ☐
Blue discoloration to skin and lips (cyanosis) ☐
Heart rate too slow or too fast or not rhythmic (arrhythmia) ☐
Other (list: ____) ☐

Gastrointestinal Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Poor appetite ☐
Swallowing difficulty ☐
Overeating ☐
Severe abdominal pain ☐
Abdominal bloating ☐
Chronic Diarrhea ☐
Chronic Constipation ☐
Blood in stool ☐
Pus in stool ☐
Unexpected weight loss or weight gain ☐
Gastroesophageal reflux (GERD) ☐
Indigestion ☐

Pica (eating non-food materials) ☐
Excessively picky eater ☐
Other (list: ________________________________) ☐

Genito-Urinary Is there any known abnormality in this area of development? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Deformity (ambiguous genitalia, hypospadias, etc.) ☐
Undescended testicles ☐
Testicle too large, too small, too hard, with lump ☐
Pain with urination ☐
Blood in urine ☐
Discharge ☐
Urinating too frequently, too seldom ☐
Urinary tract infection ☐
Other (list: ________________________________) ☐

Endocrine/Metabolic Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Problems with thyroid gland ☐
Swelling of neck ☐
Diabetes ☐
Hypoglycemia (documented low blood sugar) ☐
Significantly overweight or underweight ☐
History of failure to thrive as an infant ☐
Too tall for age ☐
Too short for age ☐
Overweight for age ☐
Underweight for age ☐
Gaining weight too fast, too slow ☐
Growing taller too slowly, too fast ☐
Developing sexually too fast, too slow ☐
Difficulty regulating body temperature (gets too hot or too cold) ☐
Unusual body odor or smell ☐
Unusual smell of the urine ☐
Child often shows a regression or loss of skills during illnesses ☐
Tires more easily than other children ☐
Unusual response to anesthesia ☐
Other (list: ________________________________) ☐

Allergic/Immunologic Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Allergies ☐
TYPE: *Circle all that apply:*
FOOD
ENVIRONMENTAL (dust, pets, etc)
SEASONAL (hayfever)
OTHER:
Immunodeficiency (immune system doesn't work right) ☐ TYPE: __________________________
Autoimmune disorder (Immune system overactive) ☐ TYPE: ______________________________
Swelling of lymph nodes (glands) ☐
Frequent infections ☐

Hematologic/Cancer Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Anemia (low red blood count) ☐
Tires more easily than other children ☐

Paleness ☐
Cancer ☐
TYPE: _______________________________________

Infectious Diseases Has the child had any of the following illness? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Influenza ☐
Roseola ☐
Fifth's disease) ☐
Rubella (German Measles) ☐
Rubeola (measles) ☐
Mumps ☐
Chicken Pox ☐
Herpes Type 1 (cold sores) ☐
Herpes Type 2 (genital) ☐
Lyme disease ☐
Epstein Barr Virus (mononucleosis) ☐
Cytomegalovirus (CMV) ☐
Viral Hepatitis ☐

Neurological Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Headache ☐
Muscle rigidity ☐
Tremor ☐
Tic movements ☐
Dystonia (a slow movement or extended spasm in a group of muscles) ☐
Akathisia (restlessness of arms and legs) ☐
History of meningitis or encephalitis ☐
Dizziness/faintness ☐
Unusual walking pattern ☐
Balance trouble ☐
Coordination trouble ☐
Weakness ☐
Loss of consciousness ☐
Severe sleep disturbance ☐
Seizures with fever only ☐
Seizures without fever (epilepsy) ☐
Speech articulation difficulties ☐
Speech or oral-motor apraxia ☐
Whole body apraxia (motor planning difficulty) ☐

Psychiatric Is there any known abnormality in this area? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Diagnosed with ADHD ☐
Trouble with attention or concentration☐
Excessively distractable ☐
Hyperactive ☐
Diagnosed with depression ☐
Diagnosed with bipolar/ manic depression ☐
Diagnosed with anxiety disorder ☐
Diagnosed with OCD ☐
Diagnosed with Schizophrenia ☐
Panic attacks ☐
Hallucinations ☐
Self injurious behavior ☐
Been admitted to a psychiatric hospital ☐

Genetic Syndromes Is there any known abnormality in this area of development? ☐ NO ☐ YES ☐ DON'T KNOW
If YES, check all that apply:

Fragile X ☐
Tuberous Sclerosis ☐
Neurofibromatosis ☐
Rett Syndrome ☐
Angelman Syndrome ☐
Prader Willi Syndrome ☐
Other chromosomal abnormality, disorder, or syndrome (specify): ____________________

Diagnostic Tests and Procedures the Child has had

Has the child ever had his/her hearing tested? NO YES DON'T KNOW
If YES *circle all that apply and tell us HOW OLD THE CHILD WAS WHEN TESTED*

	Age at test	Date	Location
Behavioral audiometry			
ABR or BEAR			
Tympanogram			
Otoacoustic emissions			

Has the child ever had a brain scan? NO YES DON'T KNOW
If YES *circle all that apply and tell us HOW OLD THE CHILD WAS WHEN SCANNED*

	Age at test	Date	Location
CAT or CT scan			
MRI scan			
MRS scan			
SPECT scan			
PET scan			
Other ________________			

Has the child ever had an EEG or MEG (test of the brain waves)? NO YES DON'T KNOW
If YES *circle all that apply and tell us HOW OLD THE CHILD WAS WHEN HE/SHE HAD THE EEG.*

	Age at test	Date	Location
EEG			
MEG			
OTHER (repeat EEGs, ERP's etc)			

History of SURGERIES and HOSPITALIZATIONS

Has the child ever had surgery? NO YES DON'T KNOW
If YES, please fill in table below

TYPE OF SURGERY	WHY IT WAS DONE	DATE

Has the child had any other hospitalizations besides these surgeries? NO YES DON'T KNOW
If YES, please fill in the table below

WHY HOSPITALIZED	HOW MANY DAYS DID HE/SHE STAY	DATE

History of Medications, Supplements, Special Diets

Is the child currently on any prescription medication?	❑ No	❑ Yes	❑ Not sure	
If yes please list:	1)			
	2)			
	3)			
	4)			
	5)			
In the past has the child been on prescription medication to help with his/her symptoms of autism?	❑ No	❑ Yes	❑ Not sure	
If yes please list	1)			
	2)			
	3)			
	4)			
	5)			
Please indicate all other medical treatments used to treat the child's symptoms of autism?				
IVIG	❑ Now	❑ In the past	❑ Never	❑ Not sure
Chelating medications	❑ Now	❑ In the past	❑ Never	❑ Not sure
Hyperbaric oxygen chamber	❑ Now	❑ In the past	❑ Never	❑ Not sure
Supplemental vitamins	❑ Now	❑ In the past	❑ Never	❑ Not sure
Herbal supplements such as Gingko or Echinacea	❑ Now	❑ In the past	❑ Never	❑ Not sure
Fatty acid supplements?	❑ Now	❑ In the past	❑ Never	❑ Not sure
Amino acid supplements?	❑ Now	❑ In the past	❑ Never	❑ Not sure
Mineral supplements like iron or zinc?	❑ Now	❑ In the past	❑ Never	❑ Not sure
Is the child's diet limited in any way to help behaviors?	❑ Now	❑ In the past	❑ Never	❑ Not sure
Gluten free?	❑ Now	❑ In the past	❑ Never	❑ Not sure
Casein free?	❑ Now	❑ In the past	❑ Never	❑ Not sure
Feingold?	❑ Now	❑ In the past	❑ Never	❑ Not sure
No processed sugars?	❑ Now	❑ In the past	❑ Never	❑ Not sure
No sugars or salicylates?	❑ Now	❑ In the past	❑ Never	❑ Not sure
Other: ______________________	❑ Now	❑ In the past	❑ Never	❑ Not sure
Has the diet been helpful?	NO	YES	CAN'T SAY	

PART IV Questions regarding family history for the child participating in the study. Many people don't know their family medical history very well and sometimes it helps to ask extended family members if they know anyone in the family who has had various illnesses or conditions. Below is a list of things we are interested in and we would like to know if they have been seen in the child's blood relatives (siblings, mother and/or father, grandparents, aunts, uncles or cousins).

TYPE OF DISORDER	EXAMPLES	WHO HAD IT?
Autism Spectrum Disorders:	Autism	
	Asperger's	
	PDD-NOS	
	Childhood Disintegrative Disorder	
Genetic Disorders or Syndromes:	Rett Syndrome	
	Fragile X	
	Tuberous Sclerosis	
	Neurofibramatosis	
	Prader Willi or Angelman Syndrome	
	Down Syndrome	
	Other genetic syndrome (eg Sotos syndrome, Joubert syndrome, Williams syndrome)	
	Phenylketonuria (PKU)	
	Chromosomal abnormalities (deletions, duplications)	
Developmental Problems	Mental retardation	
	Speech delay requiring therapy	
	Learning Disabilities	