# AUTISM MEDICAL HISTORY QUESTIONNAIRE – DRAFT 2.8.07

**NAME:** ____________________________

**DATE OF BIRTH:** _______ / _______ / _______

**Date:** _______ / _______ / _______

**Person Filling out the Form**

- [ ] Mother
- [ ] Father
- [ ] Other ____________________________

(please specify)

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**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.

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**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

2. Was this child part of a multiple pregnancy? ________
   - [ ] NO
   - [ ] YES
   - [ ] Don’t know

   (If yes):
   2a. How many babies? ________________________________
   2b. Were they identical? ________________________________

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):
   4a. 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 if YES ________
   - [ ] NO
   - [ ] YES
   - [ ] Don’t know

5a. 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

If yes
6.b.1. Please describe

7. When did the birth mother first feel the baby start to move?............................................................ Months: ________

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


Don't know

9. Did the birth mother have any shots or vaccinations during the pregnancy? .................

NO YES

Don't know

9a. What type? (circle all that apply)

Rhogam

Flu shot

Tetanus booster

Other: ___________________

Don't know

10. At any 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

(If YES): Circle all that apply and check when during pregnancy it occurred

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?

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  

Please list:

12.a. What type?
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)?

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

*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)

<table>
<thead>
<tr>
<th>Activity</th>
<th>NO</th>
<th>YES</th>
<th>Before</th>
<th>After</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Drink alcohol</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Smoke cigarettes or other tobacco products</td>
<td>NO</td>
<td>YES</td>
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<td>c. Use recreational drugs (e.g. marijuana, cocaine, etc)</td>
<td>NO</td>
<td>YES</td>
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</table>

When was this done

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 baby 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 total did this baby 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)
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 □
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
- 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

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Age at test</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral audiometry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABR or BEAR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tympanogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Otoacoustic emissions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Age at test</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT or CT scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRS scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPECT scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PET scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Age at test</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>EEG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER (repeat EEGs, ERP’s etc)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### History of SURGERIES and HOSPITALIZATIONS

#### Has the child ever had surgery?  NO  YES  DON'T KNOW

If YES, please fill in table below

<table>
<thead>
<tr>
<th>TYPE OF SURGERY</th>
<th>WHY IT WAS DONE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Has the child had any other hospitalizations besides these surgeries?  NO  YES  DON'T KNOW

If YES, please fill in the table below

<table>
<thead>
<tr>
<th>WHY HOSPITALIZED</th>
<th>HOW MANY DAYS DID HE/SHE STAY</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### History of Medications, Supplements, Special Diets

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

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