

AUTISM MEDICAL HISTORY QUESTIONNAIRE – DRAFT 2.8.07

NAME: _____

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 If YES NO YES Don't know
 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 <i>If yes</i>	NO	YES	Don't know
7. 6.b.1. Please describe 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? <i>(If yes):</i>	NO	YES	Don't know
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 <i>(If yes)</i>	NO	YES	Don't know
	Please describe type of infection:		
	When did it occur?		
10.b. Viral illness <i>(If YES): Circle all that apply and check when during pregnancy it occurred</i>	1 st trimester NO 1 st trimester	2 nd trimester YES 2 nd trimester	3 rd trimester Don't know 3 rd 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
<i>If YES</i>			
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
<i>If YES</i>			
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
<i>If YES</i>			
Please describe:			
11. In this pregnancy did the birth mother take prenatal vitamins?	NO	YES	Don't know
<i>If YES</i>			
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? (<i>circle all that apply</i>)	FIRST	SECOND	THIRD
12. In this pregnancy did the birth mother take any other nutritional supplements?	NO	YES	Don't know
<i>If YES</i>			
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	<u>1st</u>	<u>2nd</u>	<u>3rd</u>	<u># weeks</u>
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 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) | 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

- Did the baby have a poor suck? NO YES DON'T KNOW
- Did the baby require special feeds (e.g. thickened liquid or special nipples)? NO YES DON'T KNOW
- 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
Chronic 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~~

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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 BFAR			
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 (re-peat EEGs, ERP's etc)			

~~History of SURGERIES and HOSPITALIZATIONS~~

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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?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Chelating medications	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Hyperbaric oxygen chamber	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Supplemental vitamins	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Herbal supplements such as Gingko or Echinacea	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Fatty acid supplements?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Amino acid supplements?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Mineral supplements like iron or zinc?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Is the child's diet limited in any way to help behaviors?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Gluten free?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Casein free?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Feingold?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
No processed sugars?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
No sugars or salicylates?	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> Not sure
Other: _____	<input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/> 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	
	Neurofibromatosis	
	Prader Willi or Angelman Syndrome	
	Down Syndrome	
	Other genetic syndrome (eg Sotos syndrome, Joubert syndrome, Williams syndrome)	
	Phenylketonuria (PKU)	
Developmental Problems	Mental retardation	
	Speech delay requiring therapy	
	Learning Disabilities	