

Childhood Adenotonsillectomy Study
Adverse Event

Participant ID: _____
Participant Initials: _____
Site: _____

| AE # | CTCAE Name Please use CTCAE code number | Event Name | Date of Onset mm/dd/yyyy | Grade record one | Relationship to Study Treatment record one | Action taken regarding Study Treatment record one | Treatment for event record one | Seriousness record most appropriate | Date of Resolution Enter date OR check box if AE is continuing mm/dd/yyyy | Was Event Serious? |
|------|--|------------|---------------------------------|--|---|--|---------------------------------------|--|---|--|
| | | | ___/___/____ | 1.Mild 2.Moderate 3.Severe 4.Life threatening or disabling 5.Fatal | 1.Unrelated 2.Possibly related 3.Probably related 4.Definitely related | 0.No action taken 1.Treatment interrupted 2.Treatment discontinued | 0.No 1.Yes | See key below table | ___/___/____ <input type="checkbox"/> | 0.No 1.Yes Yes, if Seriousness 3-8 |
| | | | ___/___/____ | | | | | | ___/___/____ <input type="checkbox"/> | |
| | | | ___/___/____ | | | | | | ___/___/____ <input type="checkbox"/> | |
| | | | ___/___/____ | | | | | | ___/___/____ <input type="checkbox"/> | |
| | | | ___/___/____ | | | | | | ___/___/____ <input type="checkbox"/> | |
| | | | ___/___/____ | | | | | | ___/___/____ <input type="checkbox"/> | |

Seriousness Key

- 1.Resolved/ no follow-up needed
- 2.On-going/treatment continued
- 3.Hospitalization or prolongation of existing hospitalization

- 4.Resulted in persistent or significant disability/ incapacity
- 5.Congenital anomaly/ birth defect
- 6.Life threatening

- 7.Fatal
- 8.Other Important Medical Event/SAE

1. Date of the current measurements:

__ M __ / __ D __ / __ Y __ Y __ Y __

2. Time of the current measurements:

____ : ____
(24 Hour Clock)

3. What is the child's current standing height?

____ . ____ cm

4. What is the child's current weight?

____ . ____ kg

5. What is the child's current BMI?

_____ . _____

Please note, after BMI is calculated by the DMS write the result in the shaded area

5a. What is the child's BMI z-score?

□₉₉ . ____ Not required at this visit

*Please note, the BMI z-score be obtained from the following website:

<http://www.bcm.edu/cnrc/bodycomp/bmiz2.html> *

* Also note – the BMI z-score is only collected at the Baseline visit *

Body Measurements:

** Please note, AVERAGE totals for Neck, Waist, and Hip Circumference will be calculated by the DMS **

| | | Measurement 1 | Measurement 2 | Measurement 3 | Average |
|----|----------------------|----------------|----------------|----------------|-------------|
| 6. | Neck Circumference: | ____ . ____ cm | ____ . ____ cm | ____ . ____ cm | ____ . ____ |
| 7. | Waist Circumference: | ____ . ____ cm | ____ . ____ cm | ____ . ____ cm | ____ . ____ |
| 8. | Hip Circumference: | ____ . ____ cm | ____ . ____ cm | ____ . ____ cm | ____ . ____ |

* Please note, after Neck, Waist, and Hip Circumferences are calculated by the DMS write the results in the shaded area *

**** Please note, AVERAGE Resting Blood Pressure will be calculated by the DMS ****

1. Resting Blood Pressure 1: _____ / _____

1a. Time collected: _____ : _____
(24 Hour Clock)

2. Resting Blood Pressure 2: _____ / _____

2a. Time collected: _____ : _____
(24 Hour Clock)

3. Resting Blood Pressure 3: _____ / _____

3a. Time collected: _____ : _____
(24 Hour Clock)

4. Average Blood Pressure: _____ / _____

**** After Average Blood Pressure is calculated by the DMS, please write it in the shaded area ****

1. Was the form completed? ₀ No ₁ Yes
2. Who completed this form? ₁ Biological Parent ₂ Adoptive Parent ₃ Step Parent ₄ Foster Parent ₅ Grandparent ₉₈ Other, please specify: _____

Please provide the scores from the BRIEF questionnaire

| | Scale / Index | Raw Score | T Score | Percentile |
|-----|---------------------------|-----------|---------|------------|
| 3. | Inhibit | | | |
| 4. | Shift | | | |
| 5. | Emotional Control | | | |
| 6. | BRI | | | |
| 7. | Initiate | | | |
| 8. | Working Memory | | | |
| 9. | Plan / Organize | | | |
| 10. | Organization of Materials | | | |
| 11. | Monitor | | | |
| 12. | MI | | | |
| 13. | GEC (BRI + MI) | | | |

14. What is the negativity score?  ₁ Acceptable ₂ Elevated ₃ Highly Elevated
15. What is the inconsistency score?  ₁ Acceptable ₂ Questionable ₃ Inconsistent

1. Was the Brief Teacher's Form completed and returned? ₀ No ₁ Yes
2. How well does the teacher know the child? ₁ Not Well ₂ Moderately Well ₃ Very Well
3. How long has the teacher known the child? ___ Months

Please provide the scores from the BRIEF questionnaire

| | Scale / Index | Raw Score | T Score | Percentile |
|-----|---------------------------|-----------|---------|------------|
| 4. | Inhibit | | | |
| 5. | Shift | | | |
| 6. | Emotional Control | | | |
| 7. | BRI | | | |
| 8. | Initiate | | | |
| 9. | Working Memory | | | |
| 10. | Plan / Organize | | | |
| 11. | Organization of Materials | | | |
| 12. | Monitor | | | |
| 13. | MI | | | |
| 14. | GEC (BRI + MI) | | | |

15. What is the negativity score? ₁ Acceptable ₂ Elevated ₃ Highly Elevated
16. What is the inconsistency score? ₁ Acceptable ₂ Questionable ₃ Inconsistent

1. Was the Checklist completed? ₀ No ₁ Yes
2. Who completed this form? ₁ Biological Parent ₂ Adoptive Parent ₃ Step Parent ₄ Foster Parent ₅ Grandparent ₉₈ Other, please specify: _____

Please provide the summary scores from the CBCL questionnaire.

| | | Total Score | T Score | Percentile |
|-----|-------------------------|-------------|---------|------------|
| 3. | Activities: | | | |
| 4. | Social: | | | |
| 5. | School: | | | |
| 6. | Total Competence: | | | |
| 7. | Anxious / Depressed: | | | |
| 8. | Withdrawn / Depressed: | | | |
| 9. | Somatic Complaints: | | | |
| 10. | Social Problems: | | | |
| 11. | Thought Problems: | | | |
| 12. | Attention Problems: | | | |
| 13. | Rule-Breaking Behavior: | | | |
| 14. | Aggressive Behavior: | | | |
| 15. | Internalizing Problems: | | | |
| 16. | Externalizing Problems: | | | |
| 17. | Total Problems: | | | |
| 18. | Affective Problems: | | | |
| 19. | Anxiety Problems: | | | |
| 20. | Somatic Problems: | | | |

| | | Total Score | T Score | Percentile |
|-----|---|-------------|---------|------------|
| 21. | Attention Deficit / Hyperactivity Problems: | | | |
| 22. | Oppositional Defiant Problems: | | | |
| 23. | Conduct Problems: | | | |

1. Was this test performed? ₀ No
₁ Yes
- 1a. If NO, please provide a reason: ₁ Child is not of Age
₂ Other, specify: _____
2. Was any assistance given to the child during the administration of this test? ₀ No
₁ Yes
3. Did the child endorse a score of "3" on Item 9? ₀ No
₁ Yes

Please provide the Total Scores and T-Scores from the CDI

| | | Total Score | T-Score |
|----|---------------------------------|-------------|---------|
| 4. | Total CDI Score: | | |
| 5. | Scale A: Negative Mood | | |
| 6. | Scale B: Interpersonal Problems | | |
| 7. | Scale C: Ineffectiveness | | |
| 8. | Scale D: Anhedonia | | |
| 9. | Scale E: Negative Self-Esteem | | |

CHILDHOOD ADENOTONSILLECTOMY STUDY
Child Demographic Information
BASELINE

[Parent / Guardian Completed]

Participant ID: _____
Participant Initials: _____
Site: _____
Date: ____ / ____ / _____
RC ID: ____ - ____

1. What is your child's Date of Birth?

__ __ / __ __ / __ __ __ __

1a. What is your child's age?

__ __ Years __ __ Months

2. What is your child's gender?

₁ Male ₂ Female

3. What is your child's ethnicity?

₁ Hispanic or Latino
 ₂ Not Hispanic or Latino

4. What is your child's race?

₁ American Indian / Native Alaskan
 ₂ Asian
 ₃ Native Hawaiian / Other Pacific Islander
 ₄ Black / African American
 ₅ White / Caucasian
 ₆ Multiracial
 ₉₈ Other, specify: _____

5. What is your child's current or most recently completed grade in school?

__ __ Grade
 ₉₉ Not attending

5a. If your child is not attending, please provide a reason:

₁ Summer Vacation
 ₂ Child is home schooled
 ₃ Other, specify: _____

Directions:

This form should be read to the child (ages 5 – 7), use the template attached to this CRF (also included in the MOP), which has the smiley face icons as reference for each of the three possible answers – Not at all, Sometimes, and A lot.

Say to the child: Think about how you have been doing for the last few weeks. Please listen carefully to each sentence and tell me how much of a problem this is for you.

After reading each item below, gesture to the smiley face template. If the child hesitates or does not seem to understand how to answer, read the response options while pointing at the smiley face icons.

| 1. | Physical Functioning (problems with): | Not at all | Sometimes | A lot |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|
| 1a. | Is it hard for you to walk? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 1b. | Is it hard for you to run? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 1c. | Is it hard for you to play sports or exercise? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 1d. | Is it hard for you to pick up big things? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 1e. | Is it hard for you to take a bath or shower? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 1f. | Is it hard for you to do chores (like pick up your toys)? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 1g. | Do you have hurts or aches (Where _____)? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 1h. | Do you ever feel too tired to play? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |

| 2. | Emotional Functioning (problems with): | Not at all | Sometimes | A lot |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|
| 2a. | Do you feel scared? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 2b. | Do you feel sad? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 2c. | Do you feel mad? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 2d. | Do you have trouble sleeping? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 2e. | Do you worry about what will happen to you? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |

| 3. | Social Functioning (problems with): | Not at all | Sometimes | A lot |
|-----|--|---------------------------------------|---------------------------------------|---------------------------------------|
| 3a. | Is it hard for you to get along with other kids? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 3b. | Do other kids say they do not want to play with you? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 3c. | Do other kids tease you? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 3d. | Can other kids do things that you cannot? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 3e. | Is it hard for you to keep up when you play with other kids? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |

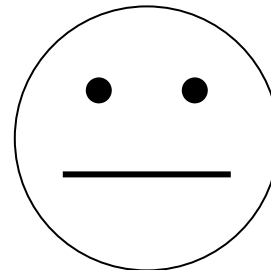
| 4. | School Functioning (problems with): | Not at all | Sometimes | A lot |
|-----|--|---------------------------------------|---------------------------------------|---------------------------------------|
| 4a. | Is it hard for you to pay attention in school? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 4b. | Do you forget things? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 4c. | Is it hard to keep up with schoolwork? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 4d. | Do you miss school because of not feeling good? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |
| 4e. | Do you miss school because you have to go to the doctor's or hospital? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₄ |

How much of a problem is this for you?

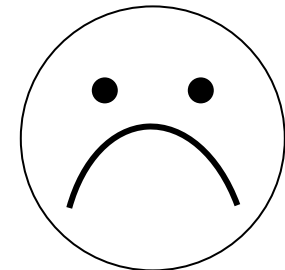
Not at all



Sometimes



A lot



[Child Completed]

Directions: The following is a list of things that might be a problem for you. Please tell us **how much of a problem** each one has been for you during the **past ONE month** by checking the box. There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has this been for you...

| 1. | About My Health and Activities (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 1a. | It is hard for me to walk more than one block | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1b. | It is hard for me to run | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1c. | It is hard for me to do sports activity or exercise | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1d. | It is hard for me to lift something heavy | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1e. | It is hard for me to take a bath or shower by myself | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1f. | It is hard for me to do chores around the house | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1g. | I hurt or ache | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1h. | I have low energy | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 2. | About My Feelings (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|--------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 2a. | I feel afraid or scared | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2b. | I feel sad or blue | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2c. | I feel angry | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2d. | I have trouble sleeping | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2e. | I worry about what will happen to me | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 3. | How I Get Along With Others (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 3a. | I have trouble getting along with other kids | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3b. | Other kids do not want to be my friend | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3c. | Other kids tease me | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3d. | I cannot do things that other kids my age can do | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3e. | It is hard to keep up when I play with other kids | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 4. | About School (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 4a. | It is hard to pay attention in class | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4b. | I forget things | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4c. | I have trouble keeping up with my schoolwork | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4d. | I miss school because of not feeling well | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4e. | I miss school to go to the doctor or hospital | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

1. Was the questionnaire given to the parent / guardian? ₀ No ₁ Yes

Please provide the summary scores from the Conners' questionnaire.

| | | Raw Score | T-Score |
|-----|-----------------------------------|-----------|---------|
| 2. | Oppositional: | | |
| 3. | Cognitive Problems / Inattention: | | |
| 4. | Hyperactivity: | | |
| 5. | Anxious / Shy: | | |
| 6. | Perfectionism: | | |
| 7. | Social Problems: | | |
| 8. | Psychosomatic: | | |
| 9. | Conners' ADHD Index: | | |
| 10. | Conners' GI Restless – Impulsive: | | |
| 11. | Conners' GI Emotional Liability: | | |
| 12. | Conners' GI Total | | |
| 13. | DSM-IV Inattentive: | | |
| 14. | DSM-IV Hyperactive-Impulsive: | | |
| 15. | DSM-IV Total: | | |
| 16. | Inattentive Symptoms: | | |
| 17. | Hyperactive-Impulsive Symptoms: | | |

1. Was the Conners' Teacher's form completed and returned? ₀ No
₁ Yes
2. How well does the teacher know the child? ₁ Not Well
₂ Moderately Well
₃ Very Well
3. How long has the teacher known the child? ___ Months

Please provide the summary scores from the Conners' Teacher's questionnaire.

| | | Raw Score | T-Score |
|-----|-----------------------------------|-----------|---------|
| 4. | Oppositional: | | |
| 5. | Cognitive Problems / Inattention: | | |
| 6. | Hyperactivity: | | |
| 7. | Anxious / Shy: | | |
| 8. | Perfectionism: | | |
| 9. | Social Problems: | | |
| 10. | Conners' ADHD Index: | | |
| 11. | Conners' GI Restless – Impulsive: | | |
| 12. | Conners' GI Emotional Liability: | | |
| 13. | Conners' GI Total | | |
| 14. | DSM-IV Inattentive: | | |
| 15. | DSM-IV Hyperactive-Impulsive: | | |
| 16. | DSM-IV Total: | | |
| 17. | Inattentive Symptoms: | | |
| 18. | Hyperactive-Impulsive Symptoms: | | |

1. Was the DAS-II administered? ₀ No ₁ Yes
2. What is the child's level? ₁ School-Age Level (Ages 7.0 – 17.11)
₂ Out-of-Level (Ages 5.0 – 6.11)
3. What is the child's handedness? ₁ Right ₂ Left ₃ Both

| | Core Subtest T-Scores | Ability Score | T-Score | Verbal | Nonverbal Reasoning | Spatial | GCA | SNC | Percentile |
|----|--|---------------|---------|--------|---------------------|---------|-----|-----|------------|
| 4. | Recall of Designs | | | | | | | | |
| 5. | Word Definitions | | | | | | | | |
| 6. | Pattern Construction <input type="checkbox"/> ₁ Std. <input type="checkbox"/> ₂ Alt. | | | | | | | | |
| 7. | Matrices | | | | | | | | |
| 8. | Verbal Similarities | | | | | | | | |
| 9. | Sequential & Quantitative Reasoning | | | | | | | | |

| | Cluster / Composite Scores | Verbal | Nonverbal Reasoning | Spatial | GCA | SNC |
|-----|------------------------------|--------|---------------------|---------|-----|-----|
| 10. | Sum of Core Subtest T-Scores | | | | | |
| 11. | Standard Score | | | | | |
| 12. | Percentile | | | | | |

Inclusion Criteria:

(Responses to questions 1 – 4 must be “YES” or “Not Applicable” to meet eligibility requirements)

- 1. Is the participant between the ages of 5.0 to 9.99? ₁ Yes ₀ No
- 2. Does the participant have obstructive sleep apnea defined as: ₁ Yes ₀ No
 - a. Obstructive apnea index OAI \geq 1 or Apnea hyponea index AHI \geq 2, confirmed on nocturnal, laboratory-based PSG and
 - b. Parental report of habitual snoring (on average occurring > 3 nights per week).
- 3. Does the participant have Tonsillar hypertrophy \geq 2 based on a standardized 0-4 scale:
- 3a. Does the participant have Tonsillar hypertrophy \geq 1 based on a standardized 0-4 scale: ₁ Yes ₀ No
 - a. 0 = Surgically absent
 - b. 1 = Taking up < 25% of the airway
 - c. 2 = 25 – 50% of the airway
 - d. 3 = 50-75% of the airway
 - e. 4 = > 75% of the airway
- 4. Has the participant been deemed to be a surgical candidate for AT by ENT evaluation? ₁ Yes ₀ No

Exclusion Criteria:

(Responses to questions 5 – 21 must be “No” or “Not Applicable” to meet eligibility requirements)

- 5. Has the participant had recurrent tonsillitis that meets published ENT clinical practice guidelines for surgery defined as \geq 3 episodes in each of 3 years, 5 episodes in each of 2 years, or 7 episodes in 1 year? ₁ Yes ₀ No
- 6. Does the participant have craniofacial anomalies, including cleft lip and palate or sub-mucosal palate le or any anatomic or systemic condition which would interfere with general anesthesia or removal of tonsils and adenoid tissue in the standard fashion? ₁ Yes ₀ No
- 7. Does the participant have obstructive breathing while awake that merits prompt AT in the opinion of the child’s physician? ₁ Yes ₀ No
- 8. Does the participant have severe OSAS and significant hypoxemia requiring immediate AT as defined by: ₁ Yes ₀ No
 - a. OAI > 20 or
 - b. AHI > 30,
 - c. Desaturation defined as SaO₂ < 90% for more than 2% sleep time
- 9. Does the participant have apnea hypopnea indices in the normal range (OAI < 1 and AHI < 2)? ₁ Yes ₀ No

10. Does the participant exhibit evidence of clinically significant cardiac Arrhythmia on PSG: ₁ Yes ₀ No
- a. Non-sustained ventricular tachycardia
 - b. Atrial fibrillation
 - c. Second degree AV block
 - d. Sustained bradycardia < 40 bpm (> 2 minutes)
 - e. Sustained tachycardia > 140 bpm (> 2 minutes)
11. Is the participant extremely overweight defined as: BMI > 2.5 for age group and sex-z score?
- 11a. Is the participant extremely overweight defined as: BMI > 2.99 for age group and sex-z score? ₁ Yes ₀ No
12. Does the participant have severe health problems that could be exacerbated by delayed treatment for OSAS including: ₁ Yes ₀ No
- a. Doctor-diagnosed heart disease or cor pulmonale
 - b. Stage II hypertension as defined > 99% percentile (CDC) plus 5 mmHg for either systolic or diastolic examination, based on the age, gender, and height norms, as measured on the baseline exam, or the PSG, or requiring medication
 - c. Therapy for failure to thrive or short stature
 - d. Psychiatric or behavioral disorders requiring or likely to require initiation of new medication, therapy, or other specific treatment during the 12 month trial period
 - e. For school aged children, parental report of excessive daytime sleepiness defined as unable to maintain wakefulness, at least three times per week, in routine activities in school or home, despite adequate opportunity to sleep.
13. Does the participant have severe chronic health conditions that might hamper participation, including: ₁ Yes ₀ No
- a. Severe cardiopulmonary disorders (e.g.: cystic fibrosis, congenital heart disease)
 - b. Sickle cell anemia
 - c. Poorly controlled asthma (with > 1 hospitalization in last year)
 - d. Epilepsy requiring medication
 - e. Diabetes (type I or type II) requiring medication
 - f. Conditions likely to preclude accurate polysomnography (e.g.: severe uncontrolled pain)
 - g. Mental retardation or enrollment in a formal school Individual Educational Plan (IEP) and assigned to a self-contained classroom for all academic subjects
 - h. History of inability to complete cognitive testing and / or score on DASII of ≤55
 - i. Chronic infection or HIV
14. Does the participant have known genetic, craniofacial, neurological or psychiatric conditions likely to affect the airway, cognition, or behavior? ₁ Yes ₀ No

15. Does the participant currently use any of the following medications: ₁ Yes ₀ No
- a. ADHD medications
 - b. Psychotropic medication (antidepressants, anxiolytics, antipsychotics)
 - c. Hypnotics
 - d. Hypoglycemic agents or insulin
 - e. Antihypertensives
 - f. Growth Hormone
 - g. Anticonvulsants
 - h. Anti-coagulants
 - i. Daily oral corticosteroids
 - j. Daily medications for pain
16. Has the participant had previous upper airway surgery on the nose, pharynx or larynx, including adenoidectomy. (Ear surgery – e.g.: PE tubes – is not an exclusion criterion).
- 16a. Has the participant had previous upper airway surgery on the nose, pharynx or larynx, including tonsillectomy (PE Tubes or prior adenoidectomy are not exclusion criteria)? ₁ Yes ₀ No
17. Has the participant received Continuous Positive Airway Pressure (CPAP) treatment? ₁ Yes ₀ No
18. Does the participant have a parent or guardian who cannot accompany the child on the night of PSG? ₁ Yes ₀ No
19. Does the participant have a parent or guardian who cannot read and understand the consent form; including families unable to understand or complete the standardized English language assessment forms and testing instruments?
20. Does the child belong to a family planning to move out of the area within the year? ₁ Yes ₀ No
21. For female participants, has the participant attained menarche by the time of study enrollment per parental report? ₁ Yes ₀ No
₉₉ Not Applicable

Eligibility Confirmation:

22. Are all of the Inclusion Criteria responses “Yes”? ₁ Yes ₀ No
If No, STOP. Participant is not eligible.
23. Are all of the exclusion Criteria responses “No” or “Not Applicable”? ₁ Yes ₀ No
If No, STOP. Participant is not eligible.

[Parent / Guardian Completed]

1. Did your child's biological mother smoke at least one cigarette a day while she was pregnant with your child?
₀ No
₁ Yes (1+ per day)
₈₈ Not sure

1a. Does your child's current primary caregiver smoke at least one cigarette a day?
₀ No
₁ Yes (1+ per day)
₈₈ Not sure

2. How many people currently smoke at least one cigarette a day in your child's home? _____

Brother and Sister History:

3. Does your child have any full brothers and / or sisters (same mother and father as child)?
₀ No
₁ Yes
₈₈ Not sure

3a. If YES, how many FULL sisters? _____

3b. If YES, how many FULL brothers? _____

4. Does your child have any half brothers and / or sisters (one parent in common with child)?
₀ No
₁ Yes
₈₈ Not sure

4a. If YES, how many HALF sisters? _____

4b. If YES, how many HALF brothers? _____

5. Do any of your child's brothers and / or sisters have any of the following conditions?
₉₉ Not applicable / No Brothers or Sisters

| | | <i>If Yes, please indicate who has the condition.</i> | |
|-------------------|---|---|---|
| Conditions | | Full Brothers / Sisters | Half Brothers / Sisters |
| 5a. | Acute Life Threatening Episode (ALTE) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure _____ <input type="checkbox"/> ₁ Sister(s) _____ <input type="checkbox"/> ₂ Brother(s) | _____ <input type="checkbox"/> ₁ Sister(s) _____ <input type="checkbox"/> ₂ Brother(s) |
| 5b. | Crib death or Sudden Infant Death Syndrome (SIDS) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure _____ <input type="checkbox"/> ₁ Sister(s) _____ <input type="checkbox"/> ₂ Brother(s) | _____ <input type="checkbox"/> ₁ Sister(s) _____ <input type="checkbox"/> ₂ Brother(s) |

[Parent / Guardian Completed]

| Conditions | | No / Yes | If Yes, please indicate who has the condition. | |
|------------|---|--|---|---|
| | | | Full Brothers / Sisters | Half Brothers / Sisters |
| 5c. | Anxiety Disorder | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5d. | Asthma | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5e. | Attention Deficit Hyperactivity Disorder (ADD / ADHD) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5f. | Cancer | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5g. | Cerebral Palsy | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5h. | Depression | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5i. | Diabetes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5j. | Eating Disorder (Anorexia, Bulimia) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5k. | Eczema (Atopic Dermatitis) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |

CHILDHOOD ADENOTONSILLECTOMY STUDY
Family History
BASELINE

[Parent / Guardian Completed]

Participant ID: _____
Participant Initials: _____
Site: _____
Date: ____ / ____ / _____
RC ID: ____ - ____

| | | <i>If Yes, please indicate who has the condition.</i> | | |
|------------|---|--|---|---|
| Conditions | | No / Yes | Full Brothers / Sisters | Half Brothers / Sisters |
| 5l. | Enlarged Tonsils or Adenoids | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5m. | Excessive Sleepiness (3 or more times per week) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5n. | Hay Fever (Nasal Allergies) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5o. | High Blood Pressure (Hypertension) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5p. | High Cholesterol | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5q. | Insomnia | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5r. | Loud Snoring (3 or more times per week) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5s. | Migraine Headache or Chronic Severe Headache | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5t. | Narcolepsy | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |
| 5u. | Sleep Apnea | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) | ___ <input type="checkbox"/> ₁ Sister(s) ___ <input type="checkbox"/> ₂ Brother(s) |

[Parent / Guardian Completed]

| | | <i>If Yes, please indicate who has the condition.</i> | | | |
|------------|--|--|---|---|--|
| Conditions | | No / Yes | Full Brothers / Sisters | Half Brothers / Sisters | |
| 5v. | Autism | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ ___ <input type="checkbox"/> ₁ Sister(s) ___ ___ <input type="checkbox"/> ₂ Brother(s) | ___ ___ <input type="checkbox"/> ₁ Sister(s) ___ ___ <input type="checkbox"/> ₂ Brother(s) | |
| 5w. | Aspergers Syndrome | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ ___ <input type="checkbox"/> ₁ Sister(s) ___ ___ <input type="checkbox"/> ₂ Brother(s) | ___ ___ <input type="checkbox"/> ₁ Sister(s) ___ ___ <input type="checkbox"/> ₂ Brother(s) | |
| 5x. | Other Significant Medical Conditions: _____ _____ _____ | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | ___ ___ <input type="checkbox"/> ₁ Sister(s) ___ ___ <input type="checkbox"/> ₂ Brother(s) | ___ ___ <input type="checkbox"/> ₁ Sister(s) ___ ___ <input type="checkbox"/> ₂ Brother(s) | |

Parental History:

6. Has either biological parent currently or ever had any of the following conditions?

₉₉ Not Applicable / Information not available

| | | <i>If Yes, please indicate which parent had the condition.</i> | | | |
|------------|---|--|---|---|--|
| Conditions | | No / Yes | Biological Mother | Biological Father | |
| 6a. | Anxiety Disorder | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | |
| 6b. | Asthma | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | |
| 6c. | Attention Deficit Hyperactivity Disorder (ADD / ADHD) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | |
| 6d. | Cancer | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | |
| 6e. | Depression | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | |

CHILDHOOD ADENOTONSILLECTOMY STUDY
Family History
BASELINE

[Parent / Guardian Completed]

Participant ID: _____
Participant Initials: _____
Site: _____
Date: ____ / ____ / ____
RC ID: ____ - ____

| | | <i>If Yes, please indicate which parent had the condition.</i> | | | | | |
|---|---|--|---|--------------------------|--------------------------|---|---|
| | Conditions | No / Yes | <table border="1"> <thead> <tr> <th>Biological Mother</th> <th>Biological Father</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</td> <td><input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</td> </tr> </tbody> </table> | Biological Mother | Biological Father | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes |
| Biological Mother | Biological Father | | | | | | |
| <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | | | |
| 6f. | Diabetes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6g. | Eczema | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6h. | Enlarged Tonsils or Adenoids | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6i. | Excessive Sleepiness (3 or more times per week) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6j. | Hay Fever (Nasal Allergies) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6k. | High Blood Pressure (Hypertension) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6l. | High Cholesterol | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6m. | Heart Disease | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6n. | Insomnia | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6o. | Loud Snoring (3 or more times per week) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6p. | Migraine Headache or Chronic Severe Headache | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |
| 6q. | Narcolepsy | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | | | | |

[Parent / Guardian Completed]

| | | <i>If Yes, please indicate which parent had the condition.</i> | | |
|-----|--|--|---|---|
| | Conditions | No / Yes | Biological Mother | Biological Father |
| 6r. | Sleep Apnea | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes |
| 6s. | Emphysema or Chronic Obstructive Lung Disease | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes |
| 6t. | Other Significant Medical Conditions: _____ _____ _____ | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes |

7. What was the mother's height at the time of your child's birth? _____ feet / inches
₈₈ Not Sure

8. What was the mother's weight at the time of your child's birth? _____ lbs / oz
₈₈ Not Sure

9. What is the mother's current height? _____ feet / inches
₈₈ Not Sure

10. What is the mother's current weight? _____ lbs / oz
₈₈ Not Sure

Child's Respiratory History:

11. In the PAST YEAR, did your child:

| | No | Yes | Not Sure |
|----------------------------|---------------------------------------|---------------------------------------|--|
| 11a. Usually have a cough? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

[Parent / Guardian Completed]

| | | No | Yes | Not Sure | |
|------|--|---------------------------------------|---------------------------------------|--|---|
| 11b. | Usually cough on most days for three (3) consecutive months or more? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | |
| 11c. | Usually bring up phlegm from the chest? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | |
| 11d. | Bring up phlegm as much as twice a day, four or more times a week, for three (3) consecutive months or more? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | |
| 11e. | Usually bring up phlegm at all on getting up or first thing in the morning? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | |
| 11f. | Have periods or episodes of increased cough and phlegm lasting three (3) weeks or more? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | |
| 11g. | Have an attack of wheezing that made him or her feel short of breath? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | <p>If Yes, please answer the following:</p> <input type="checkbox"/> ₁ Rarely <input type="checkbox"/> ₂ Sometimes <input type="checkbox"/> ₃ Often <input type="checkbox"/> ₄ Almost Daily |
| 11h. | Been troubled by shortness of breath when hurrying on level ground or walking up a slight hill? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | |
| 11i. | Been troubled by chest tightness? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ | |

12. In the PAST Year, has your child's chest sounded wheezy or whistling?

- ₀ No
- ₁ Yes
- ₈₈ Not Sure

| If Yes, please answer the following: | | |
|---|---------------------------------------|--|
| No | Yes | Not Sure |
| <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

| | |
|------|--------------------------------|
| 12a. | When your child has a cold? |
| 12b. | Occasionally apart from colds? |
| 12c. | Most days or nights? |

| | | <i>If Yes to Question 12, please answer the following:</i> | | |
|------|---------------------------------|--|---------------------------------------|--|
| | | No | Yes | Not Sure |
| 12d. | With exercise? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 12e. | Only during the night? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 12f. | With exposure to dust or fumes? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 12g. | When exposed to pollen? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

13. In the PAST YEAR, did any of the following situations cause your child to have a stuffy or runny nose?

| | | No | Yes | Not Sure |
|------|--------------|---------------------------------------|---------------------------------------|--|
| 13a. | A Smoky Room | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 13b. | A Dusty Room | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 13c. | Cold Weather | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 13d. | Exercise | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

Note – A copy of this form must be submitted to the Vermont Labs with the specimen.

Collection Information:

1. Draw time: _____ : _____
24 Hour Clock

2. Does the participant bleed or bruise easily?
 0 No
 1 Yes
 88 Don't Know

3. Has the participant ever been told that they have a disorder related to blood clotting or coagulation?
 0 No
 1 Yes
 88 Don't Know

4. Has the participant ever experienced fainting spells while having blood drawn?
 0 No
 1 Yes
 88 Don't Know

5. Time at start of venipuncture: _____ : _____
24 Hour Clock

6. Elapsed time until tourniquet released: _____ : _____
24 Hour Clock

7. Time at end of venipuncture: _____ : _____
24 Hour Clock

8. Was any blood drawn?
 1 Yes, full sample
 2 Yes, partial sample
 3 No, refused
 4 No, hard to stick
 98 No, other reason, specify:

8a. If Partial Sample was obtained, please specify:
10 mL Serum Partial Volume ____
10 mL EDTA Partial Volume ____
Note if either of these were not done, write ND in space provided.

9. Quality of venipuncture:
 1 Traumatic
 2 Clean

9a. If Quality is Traumatic, please check all that apply:
 1 Vein collapse
 2 Hematoma
 3 Excessive duration of draw
 4 Vein hard to get
 5 Leakage at venipuncture site
 6 Multiple stick

Processing Information:

10. Processing Start Time: _____ : _____ EDTA _____ : _____ SERUM
24 Hour Clock 24 Hour Clock

11. Vial processing information:

| | Vial # | Type | Color | Vol. (mL) | Done | Comments |
|------|--------|--------------|--------|-----------|--|--|
| 11a. | 1 | SERUM | Clear | 1.0mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11b. | 2 | SERUM | Red | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11c. | 3 | SERUM | Red | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11d. | 4 | SERUM | RED | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11e. | 5 | SERUM | RED | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11f. | 6 | SERUM | RED | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11g. | 7 | SERUM | RED | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11h. | 8 | SERUM | RED | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11i. | 9 | SERUM | RED | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11j. | 10 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11k. | 11 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11l. | 12 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11m. | 13 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11n. | 14 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11o. | 15 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11p. | 16 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11q. | 17 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11r. | 18 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11s. | 19 | EDTA | PURPLE | 0.5mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |
| 11t. | 20 | Packed Cells | WHITE | 5.0mL | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₁ Partial Volume <input type="checkbox"/> ₂ Hemolysis |

12. Were samples frozen? ₀ No ₁ Yes

13. Date samples sent to Vermont Lab: ____ / ____ / ____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Materials Provided
Baseline Visit

Participant ID: _____
Participant Initials: _____
Site: _____
Date: ____ / ____ / _____
RC ID: ____ - ____

- 1. Were educational materials provided to the child?
₀ No
₁ Yes

- 2. Was Nasal Saline Spray provided to the child?
₀ No
₁ Yes

- 2a. If Yes, what was the lot number?

- 2b. Were directions and application uses reviewed with the parent or guardian?
₀ No
₁ Yes

[Parent / Guardian Completed]

1. Has your child ever been diagnosed by a doctor with any of the following?

| | | <i>If YES to "Ever had this condition", answer these questions:</i> | | | |
|-----|---|--|--|--|--|
| | Conditions | Ever had this condition? | Diagnosed or treated by a physician? | Still Present? | Currently taking medication for this condition? |
| 1a. | Acute Life Threatening Episode (ALTE) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1b. | Anxiety Disorder | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1c. | Asthma | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1d. | Attention Deficit Hyperactivity Disorder (ADD / ADHD) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1e. | Cancer | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1f. | Cerebral Palsy | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1g. | Heartburn or acid reflux | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1h. | Depression | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1i. | Diabetes | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1j. | Eating Disorder (Anorexia, Bulimia) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1k. | Eczema (Atopic Dermatitis) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1l. | Hay Fever (Nasal Allergies) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |

[Parent / Guardian Completed]

| | | <i>If YES to "Ever had this condition", answer these questions:</i> | | | |
|-----|---|--|--|--|--|
| | Conditions | Ever had this condition? | Diagnosed or treated by a physician? | Still Present? | Currently taking medication for this condition? |
| 1m. | High Blood Pressure (Hypertension) | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1n. | High Cholesterol | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1o. | Insomnia | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1p. | Migraine Headache or Chronic Severe Headache | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1q. | Autism | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1r. | Aspergers Syndrome | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |
| 1s. | Other Significant Medical Conditions: _____ _____ _____ _____ | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure | <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈₈ Not Sure |

2. Does your child have allergies? ₀ No
₁ Yes
- 2a. If Yes, has your child ever been tested (skin or blood) for allergies? ₀ No
₁ Yes
₈₈ Not Sure
- 2b. If Yes, which of the following tests were positive for allergies (check all that apply):
- ₁ Molds ₂ Trees ₃ Cats ₄ Insects
₅ Dust ₆ Grass or Pollen ₇ Dogs ₈ Food / Drink
₉ Latex ₉₈ Other, specify: _____

[Parent / Guardian Completed]

3. Has your child ever had Surgery requiring an over night stay? ₀ No ₁ Yes

| | Surgery | Date Performed |
|-----|-----------------------|-------------------|
| 3a. | Please specify: _____ | ___ / ___ / _____ |
| 3b. | Please specify: _____ | ___ / ___ / _____ |
| 3c. | Please specify: _____ | ___ / ___ / _____ |
| 3d. | Please specify: _____ | ___ / ___ / _____ |

4. Has your child ever been referred to any of the following specialists?

| | | NO | YES |
|-----|---|---------------------------------------|---------------------------------------|
| 4a. | Cardiologist (Heart Doctor) | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 4b. | Gastroenterologist (Stomach Doctor) | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 4c. | Pulmonologist (Lung Doctor) | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 4d. | Neurologist | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 4e. | Otolaryngologist (Ear, Nose, & Throat Doctor) | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 4f. | Psychiatrist / Psychologist | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 4g. | Sleep Specialist | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |

5. What was your child's weight at birth? _____ lbs / oz ₉₉ Not Sure

6. Was your child born early (prematurely, or 4 or more weeks early)? ₀ No ₁ Yes ₈₈ Not Sure

7. Did your child need oxygen for more than one day after birth? ₀ No ₁ Yes ₈₈ Not Sure

1. Were any sections of the NEPSY performed? ₀ No ₁ Yes

2. Please indicate the child's hand preference: ₁ Right ₂ Left ₃ Ambidextrous ₈₈ Not Established

Please provide the summary scores from the NEPSY for the appropriate subtest

| | Subtest | Raw Score | Attn / Exec Scaled Scores | Language Scaled Scores |
|-----|-------------------------------------|------------------|----------------------------------|-------------------------------|
| 3. | Phonological Processing | | | |
| 4. | Tower | | | |
| 5. | Auditory Attention and Response Set | | | |
| 6. | Speeded Naming | | | |
| 7. | Visual Attention | | | |
| 8. | Comprehension of Instructions | | | |
| 9. | Sum Scaled Scores | | | |
| 10. | Core Domain Scores | | | |
| 11. | Percentile | | | |

* NOTE: For V8, only complete Attn / Exec scores. Please write in ND for the remaining columns for V8. *

12. Please provide the scores for the Arrows sub-section: _____ Raw Score
_____ Scaled Score

1. Were any sections of the NEPSY-II Inhibition subtest performed? No Yes

| 2. | <i>Inhibition Naming</i> | Score |
|-----|---|-------|
| 2a. | Inhibition Naming Total Errors Percentile Rank: | |
| 2b. | Inhibition Naming Total Completion Time Scaled Score: | |
| 2c. | Inhibition Naming Combined Scaled Score: | |

| 3. | <i>Inhibition – Inhibition</i> | Score |
|-----|---|-------|
| 3a. | Inhibition – Inhibition Total Errors Percentile Rank: | |
| 3b. | Inhibition – Inhibition Total Completion Time Scaled Score: | |
| 3c. | Inhibition – Inhibition Combined Scaled Score: | |

| 4. | <i>Inhibition Switching:</i> | Score |
|-----|--|-------|
| 4a. | Inhibition – Switching Total Errors Percentile Rank: | |
| 4b. | Inhibition – Switching Completion Time Scaled Score: | |
| 4c. | Inhibition – Switching Combined Scaled Score: | |

| 5. | <i>Inhibition Contrast:</i> | Score |
|-----|---|-------|
| 5a. | Inhibition Naming vs. Inhibition – Inhibition Contrast Scaled Score:: | |
| 5b. | Inhibition – Inhibition vs. Inhibition – Switching Contrast Scaled Score: | |

6. Inhibition Total Error Scaled Score: _____

1. Were any sections of the NEPSY-II Word Generation subtest performed? ₀ No ₁ Yes

Please provide the scores for the following NEPSY-II Word Generation Subtest Items:

2. Word Generation Semantic Total Score: _____
3. Word Generation Semantic Scaled Score: _____
4. Word Generation Initial Letter Total Score: _____
5. Word Generation Initial Letter Scaled Score: _____
6. Word Generation Semantic vs. Initial Letter Contrast Scaled Score: _____

Please rate each test / questionnaire given for their validity

| | Test / Questionnaire Name | Child | Parent | Teacher |
|-----|---|--|--|--|
| 1. | Beery VMI (VMI) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 2. | DAS - II (DAS2) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 3. | NEPSY (NEPSY) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 4. | NEPSY – II Inhibition Scores (NEPSY2) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 5. | NEPSY – II Word Generation Subtest (NEPWRD) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 6. | WRAML-2 (WRAML2) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 7. | Purdue Pegboard (PUPEG) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 8. | CDI (CDI) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | | |
| 9. | Conners' Parent (CONN) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | |
| 10. | Conners' Teacher (CONNTR) | | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done |
| 11. | BRIEF Parent (BRIEF) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | |
| 12. | BRIEF Teacher (BRITR) | | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done |

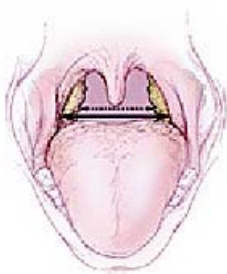
| | Test / Questionnaire Name | Child | Parent | Teacher |
|-----|--|---|---|---------|
| 13. | Child Behavior Checklist (CBCL) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | |
| 14. | Pediatric Sleep Questionnaire (PSLQ) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | |
| 15. | Modified Epworth Sleepiness Scale (SLSC) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | |
| 16. | PedsQL – Child Report (ages 5-7) (CHQL1) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done / Not Applicable | | |
| 17. | PedsQL – Child Report (ages 8-12) (CHQL2) | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done / Not Applicable | | |
| 18. | PedsQL – Parent Report (ages 5-7) (PAQL1) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done / Not Applicable | |
| 19. | PedsQL – Parent Report (ages 8-12) (PAQL2) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done / Not Applicable | |
| 20. | OSA-18 Quality of Life (OSAS) | | <input type="checkbox"/> ₁ Valid <input type="checkbox"/> ₂ Questionable <input type="checkbox"/> ₉₉ Not Done | |

Comments: _____

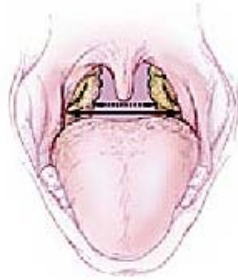
1. Please provide the Surgeon ID: _____ - _____

2. What was the pre-operation Adenoid size?
₁ 0 – 32% of nasopharynx occluded
₂ 33 – 66% of nasopharynx occluded
₃ 67 – 100% of nasopharynx occluded

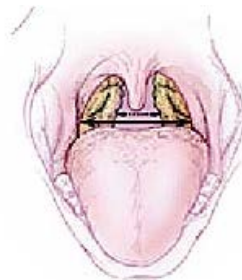
3. What was the pre-operation Tonsil size?
(Please refer to the photos below)



₁ 1+ 0 – 25%



₂ 2+ 26 – 50%



₃ 3+ 51 – 75%



₄ 4+ 76 – 100%

4. What surgical technique was used for Adenoid removal?
₁ Cautery
₂ Cold dissection
₃ Adenoids not removed
₉₈ Other, specify: _____

4a. Were adenoids previously removed? ₀ No ₁ Yes

5. What surgical technique was used for Tonsil removal?
₁ Cautery
₂ Cold dissection
₉₈ Other, specify: _____

6. What was the EBL?
₁ <100 cc
₉₈ Other (_____ cc)

7. What was the post-operation Adenoid size?
₁ 0 – 32% of nasopharynx occluded
₂ 33 – 66% of nasopharynx occluded
₃ 67 – 100% of nasopharynx occluded

8. Were the tonsils removed completely? ₀ No ₁ Yes

9. Were digital photos done? ₀ No ₁ Yes
- 9a. If YES, was the digital photo sent to the Surgical QC group? ₀ No ₁ Yes
- 9b. If digital photo was sent, what was the file name? _____

10. Were there any complications with the surgical procedure? ₀ No ₁ Yes

- 10a. If Yes, please check all that apply:
- ₁ Damage to teeth
 - ₂ Burns to soft tissue
 - ₃ Airway fire *
 - ₄ Excessive blood loss (>250 cc)
 - ₅ Need for blood transfusion
 - ₆ Return to OR (control hemorrhage) *
 - ₇ Re-intubation requiring unanticipated ICU admission *
 - ₈ Death *
 - ₉₈ Other (including atlanto-axial subluxation with neurological deficit*, foreign body aspiration*), specify: _____
- _____
- _____

*** Serious Adverse Event, requires immediate action as outlined in the MOP ***

OSA-18 Quality of Life Survey
Evaluation of Sleep-Disordered Breathing

Instructions. For each question below, please circle the number that best describes how often each symptom or problem has occurred during the past 4 weeks (or since the last survey if sooner). Thank you.

| None of the time | Hardly any of the time | A little of the time | Some of the time | A good bit of the time | Most of the time | All of the time |
|------------------------|------------------------------|----------------------------|------------------------|------------------------------|------------------------|-----------------------|
|------------------------|------------------------------|----------------------------|------------------------|------------------------------|------------------------|-----------------------|

SLEEP DISTURBANCE

During the past 4 weeks, how often has your child had...

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ...loud snoring? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...breath holding spells or pauses in breathing at night? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...choking or gasping sounds while asleep? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...restless sleep or frequent awakenings from sleep? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

PHYSICAL SUFFERING

During the past 4 weeks, how often has your child had...

| | | | | | | | |
|--|---|---|---|---|---|---|---|
| ...mouth breathing because of nasal obstruction? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...frequent colds or upper respiratory infections? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...nasal discharge or runny nose? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...difficulty in swallowing foods? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

EMOTIONAL DISTRESS

During the past 4 weeks, how often has your child had...

| | | | | | | | |
|--|---|---|---|---|---|---|---|
| ...mood swings or temper tantrums? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...aggressive or hyperactive behavior? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...discipline problems? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

DAYTIME PROBLEMS

During the past 4 weeks, how often has your child had...

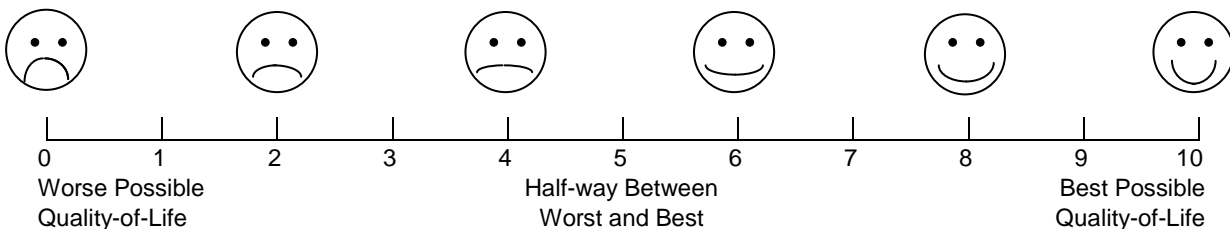
| | | | | | | | |
|--|---|---|---|---|---|---|---|
| ...excessive daytime drowsiness or sleepiness? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...poor attention span or concentration? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...difficulty getting out of bed in the morning? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

CAREGIVER CONCERNS

During the past 4 weeks, how often have the above problems...

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ...caused you to worry about your child's general health? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...created concern that your child is not getting enough air? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...interfered with your ability to perform daily activities? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ...made you frustrated? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

OVERALL, HOW WOULD YOU RATE YOUR CHILD'S QUALITY OF LIFE AS A RESULT OF THE ABOVE PROBLEMS?
(Circle one number)



Please answer all of the following questions:

| | None of the time | Hardly any of the time | A little of the time | Some of the time | A good bit of the time | Most of the time | All of the time |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Sleep Disturbance | | | | | | | |
| 1. During the past 4 weeks, how often has your child had: | | | | | | | |
| 1a. Loud Snoring? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 1b. Breath holding spells or pauses in breathing at night? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 1c. Chocking or gasping sounds while asleep? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 1d. Restless sleep or frequent awakenings from sleep? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |

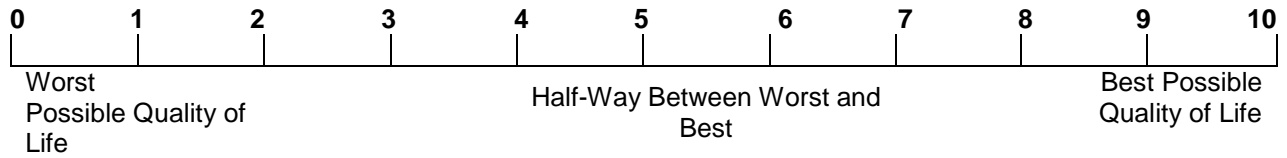
| | | | | | | | |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Physical Suffering | | | | | | | |
| 2. During the past 4 weeks, how often has your child had: | | | | | | | |
| 2a. Mouth breathing because of nasal obstruction? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 2b. Frequent colds or upper respiratory infections? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 2c. Nasal discharge or runny nose? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 2d. Difficulty in swallowing foods? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |

| | | | | | | | |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Emotional Distress | | | | | | | |
| 3. During the past 4 weeks, how often has your child had: | | | | | | | |
| 3a. Mood swings or temper tantrums? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 3b. Aggressive or hyperactive behavior? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 3c. Discipline problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |

| | | | | | | | |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Daytime Problems | | | | | | | |
| 4. During the past 4 weeks, how often has your child had: | | | | | | | |
| 4a. Excessive daytime drowsiness or sleepiness? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 4b. Poor attention span or concentration? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 4c. Difficulty getting out of bed in the morning? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |

| | None of the time | Hardly any of the time | A little of the time | Some of the time | A good bit of the time | Most of the time | All of the time |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Caregiver Concerns | | | | | | | |
| 5. During the past 4 weeks, how often have the above problems: | | | | | | | |
| 5a. Caused you to worry about your child's general health? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 5b. Created concern that your child is not getting enough air? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 5c. Interfered with your ability to perform daily activities? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
| 5d. Made you frustrated? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |

6. Overall, how would you rate your child's quality of life as a result of the above problems?
(Provide number based on chart below) _____



[Parent Completed]

DIRECTIONS:

The following is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for your child during the **past ONE month** by checking the appropriate box below. There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a problem has your child had with...

| 1. | Physical Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 1a. | Walking more than one block? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1b. | Running? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1c. | Participating in sports activity or exercise? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1d. | Lifting something heavy? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1e. | Taking a bath or shower by him or herself? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1f. | Doing chores like picking up his or her toys? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1g. | Having hurts or aches? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1h. | Low energy level? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 2. | Emotional Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 2a. | Feeling afraid or scared? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2b. | Feeling sad or blue? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2c. | Feeling angry? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2d. | Trouble sleeping? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2e. | Worrying about what will happen to him / her? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 3. | Social Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 3a. | Getting along with other children? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3b. | Other kids not wanting to be his or her friend? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3c. | Getting teased by other children? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3d. | Not able to do things that other children his or her age can do? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3e. | Keeping up when playing with other children? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 4. | School Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 4a. | Paying attention in class? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4b. | Forgetting things? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4c. | Keeping up with school activities? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4d. | Missing school because of not feeling well? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4e. | Missing school to go to the doctor or hospital? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

[Parent Completed]

DIRECTIONS:

The following is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for your child during the **past ONE month** by checking the appropriate box below. There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a problem has your child had with...

| 1. | Physical Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 1a. | Walking more than one block? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1b. | Running? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1c. | Participating in sports activity or exercise? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1d. | Lifting something heavy? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1e. | Taking a bath or shower by him or herself? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1f. | Doing chores like picking up his or her toys? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1g. | Having hurts or aches? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 1h. | Low energy level? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 2. | Emotional Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 2a. | Feeling afraid or scared? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2b. | Feeling sad or blue? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2c. | Feeling angry? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2d. | Trouble sleeping? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 2e. | Worrying about what will happen to him / her? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 3. | Social Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 3a. | Getting along with other children? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3b. | Other kids not wanting to be his or her friend? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3c. | Getting teased by other children? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3d. | Not able to do things that other children his or her age can do? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 3e. | Keeping up when playing with other children? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

| 4. | School Functioning (problems with): | Never | Almost Never | Sometimes | Often | Almost Always |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 4a. | Paying attention in class? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4b. | Forgetting things? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4c. | Keeping up with school activities? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4d. | Missing school because of not feeling well? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 4e. | Missing school to go to the doctor or hospital? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

[Parent / Guardian Completed]

Parental Information:

Questions 1 – 4 pertain to the child's birth parents.

- 1. What is the mother's ethnicity?
₁ Hispanic or Latino
₂ Not Hispanic or Latino
₈₈ Not Sure

- 2. What is the mother's race?
₁ American Indian / Native Alaskan
₂ Asian
₃ Native Hawaiian / Other Pacific Islander
₄ Black / African American
₅ White / Caucasian
₆ Multiracial
₈₈ Not Sure
₉₈ Other, specify: _____

- 3. What is the father's ethnicity?
₁ Hispanic or Latino
₂ Not Hispanic or Latino
₈₈ Not Sure

- 4. What is the father's race?
₁ American Indian / Native Alaskan
₂ Asian
₃ Native Hawaiian / Other Pacific Islander
₄ Black / African American
₅ White / Caucasian
₆ Multiracial
₈₈ Not Sure
₉₈ Other, specify: _____

Household Information:

Questions 5 – 9 pertain to the child's current housing situation.

- 5. What is your annual household income before taxes?
₁ Under \$5,000
₂ \$5,000 to \$9,999
₃ \$10,000 to \$19,999
₄ \$20,000 to \$29,999
₅ \$30,000 to \$39,999
₆ \$40,000 to \$49,999
₇ \$50,000 to \$59,999
₈ \$60,000 and above
₉₇ Prefer not to answer

[Parent / Guardian Completed]

6. What is the highest level of education completed by the mother?

- 1 8th grade or less than 8th grade
- 2 9th – 11th grade
- 3 High school diploma or GED
- 4 Vocational, trade school, or Associate's degree
- 5 Courses toward college degree
- 6 Bachelor's Degree or 4-year college degree
- 7 Master's Degree
- 8 Professional Degree (M.D., Ph.D., J.D., etc)
- 88 Not Sure

7. What is the highest level of education completed by the father?

- 1 8th grade or less than 8th grade
- 2 9th – 11th grade
- 3 High school diploma or GED
- 4 Vocational, trade school, or Associate's degree
- 5 Courses toward college degree
- 6 Bachelor's Degree or 4-year college degree
- 7 Master's Degree
- 8 Professional Degree (M.D., Ph.D., J.D., etc)
- 88 Not Sure

8. What is the mother's current employment status?

- 1 Working full-time (35 or more hours per week)
- 2 Working part-time (35 or less hours per week)
- 3 Home keeper
- 4 Unemployed, looking for work
- 5 Unemployed, not looking for work
- 6 Student
- 7 Retired
- 8 Unable to work, specify: _____
- 88 Not Sure

9. What is the father's current employment status?

- 1 Working full-time (35 or more hours per week)
- 2 Working part-time (35 or less hours per week)
- 3 Home keeper
- 4 Unemployed, looking for work
- 5 Unemployed, not looking for work
- 6 Student
- 7 Retired
- 8 Unable to work, specify: _____
- 88 Not Sure

1. Temp: _____ ° C
2. Pulse: _____
3. Resp: _____

| SYSTEM | NORMAL | ABNORMAL (explain) | NOT DONE |
|------------------------------|---------------------------------------|---|--|
| 4. Constitutional | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 5. Skin | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 6. HEENT | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 7. Neck | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 8. Respiratory (Not OSAS) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 9. Cardiovascular | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 10. Abdomen | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 11. Musculoskeletal | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 12. Extremities | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 13. Lymphatics | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 14. Neurologic | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |

15. What is the Friedman palate position? ₉₉ Not Done
(Please refer to the photos below)



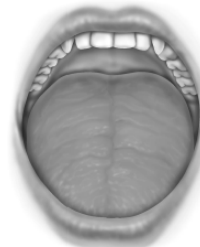
₁ Position I



₂ Position II

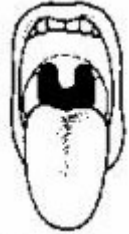


₃ Position III



₄ Position IV

16. What is the Mallampati position? ₉₉ Not Done
(Please refer to the photos below)



₁ Class I



₂ Class II



₃ Class III



₄ Class IV

17. Does the child have any known allergies? ₀ No ₁ Yes

17a. If Yes, what allergies (check all that apply):

- ₁ Molds
- ₅ Dust
- ₉ Latex

- ₂ Trees
- ₆ Grass or Pollen
- ₉₈ Other, specify: _____

- ₃ Cats
- ₇ Dogs

- ₄ Insects
- ₈ Food / Drink

1. Temp: ____ . ____ ° C
2. Pulse: ____
3. Resp: ____

| SYSTEM | NORMAL | ABNORMAL (explain) | NOT DONE |
|------------------------------|---------------------------------------|---|--|
| 4. Constitutional | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 5. Skin | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 6. HEENT | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 7. Neck | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 8. Respiratory (Not OSAS) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 9. Cardiovascular | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 10. Abdomen | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 11. Musculoskeletal | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 12. Extremities | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 13. Lymphatics | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |
| 14. Neurologic | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ _____ | <input type="checkbox"/> ₉₉ |

15. Since the last visit, has the child developed any allergies? ₀ No ₁ Yes

15a. If Yes, what allergies (check all that apply):

- ₁ Molds ₂ Trees ₃ Cats ₄ Insects
₅ Dust ₆ Grass or Pollen ₇ Dogs ₈ Food / Drink
₉ Latex ₉₈ Other, specify: _____

16. Since the last visit, has the child begun any new or alternative medical treatments? ₀ No ₁ Yes

16a. If Yes, what treatment:

- ₁ Nasal Steroids ₂ CPAP or BIPAP ₃ Oxygen Therapy
₄ Oral Device ₅ Surgery (other than TA)
₉₈ Other, specify: _____

1. Since your last visit (____ / ____ / _____), how often has your child snored during sleep?

_0 Never
_1 Rarely (less than once a week)
_2 Sometimes (1 to 2 times per week)
_3 Frequently (3 to 4 times per week)
_4 Always or Almost Always (5 to 7 times per week)
_88 Not Sure

2. Has the child used the nasal spray in the past 30 days? _0 No _1 Yes

2a. If Yes, approximately how many times per week?

_1 More than 7 times
_2 7 – 5 times
_3 4 – 2 times
_4 1 time
_88 Not sure

2b. What time of day does the child use the spray?

_1 Mostly at night
_2 Mostly in the morning
_3 Throughout the day
_88 Not sure

3. Has your child had any new medical problems, hospitalizations, or Emergency Room visits since your last visit (____ / ____ / _____)? _0 No _1 Yes

3a. If Yes, list: _____ Date ____ / ____ / _____
Reason _____

Note – if a condition is recorded above, add it to the AE form

4. Has the child begun any new medications? _0 No _1 Yes

4a. If Yes, list: _____ Date ____ / ____ / _____
Medication _____

Note – these medications will need to be added to the CMED form

5. Since your last visit (____ / ____ / _____), has your child had any of the following during sleep?

| | | Never | Rarely (less than once a week) | Sometimes (1 to 2 times per week) | Frequently (3 to 4 times per week) | Always or Almost Always (5 to 7 times per week) | Not Sure |
|-----|------------------------------|-----------------------------|-----------------------------------|--------------------------------------|---------------------------------------|--|------------------------------|
| 5a. | Chest is wheezy or whistling | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _88 |
| 5b. | Frequent Awakenings | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _88 |
| 5c. | Stop Breathing | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _88 |
| 5d. | Daytime Sleepiness | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _88 |

Comments: _____

1. Please provide the Surgeon ID: _____ - _____

2. After their adenotonsillectomy, did the child require evaluation in the ER, other surgery or admission to the hospital for any reason or did they require evaluation in the ENT clinic for any reason other than a routine post-operative follow-up visit? No Yes

2a. If Yes, what was the reason? Dehydration requiring IV Fluid
 Dehydration requiring Admission *
 Bleeding requiring Admission *
 Bleeding requiring return to OR *
 Other Admission *, specify:

_____ ₉₈ Other, specify: _____

*** Serious Adverse Event, requires immediate action as outline in the MOP ***

3. Did the child have post operative pain requiring pain medication for greater than 3 weeks after surgery? No Yes

4. Are there any current eating or drinking concerns? No Yes

4a. Has this concern required evaluation or care by a medical professional? No Yes

5. Are there any current concerns about the child's voice? No Yes

5a. Has this concern required evaluation or care by a medical professional? No Yes

6. Has the breathing or snoring of the child worsened since surgery? No Yes

7. Are there any other major health concerns? No Yes
If Yes and necessity warrants, please complete an Adverse Event form.

8. Has the child begun any new medications? No Yes
If Yes, please complete the CMED form.

Comments: _____

1. Please provide the Surgeon ID: _____ - _____
2. After their adenotonsillectomy, did the child require evaluation in the ER, other surgery or admission to the hospital for any reason or did they require evaluation in the ENT clinic for any reason other than a routine post-operative follow-up visit? ₀ No ₁ Yes
- 2a. If Yes, what was the reason? ₁ Other Admission*, specify: _____
- ₉₈ Other, specify: _____

*** Serious Adverse Event, requires immediate action as outline in the MOP ***

3. Are there any current eating or drinking concerns? ₀ No ₁ Yes
- 3a. Has this concern required evaluation or care by a medical professional? ₀ No ₁ Yes
4. Are there any current concerns about the child's voice? ₀ No ₁ Yes
- 4a. Has this concern required evaluation or care by a medical professional? ₀ No ₁ Yes
5. Has the breathing or snoring of the child worsened since surgery? ₀ No ₁ Yes
6. In the past 30 days, have there been any other major health concerns? ₀ No ₁ Yes
If Yes and necessity warrants, please complete an Adverse Event form.
7. In the past 30 days, has the child begun any new medications? ₀ No ₁ Yes
If Yes, please complete the CMED form.

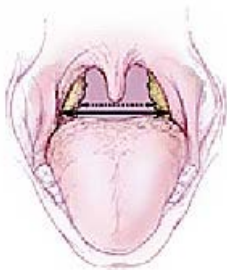
Comments: _____

1. How was this information obtained?

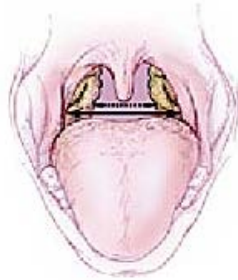
- ₁ Chart Review from previous ENT evaluation
₂ Current ENT evaluation

2. What was the pre-operation Tonsil size?
(Please refer to the photos below)

- ₉₉ Not Done



₁ 1+ 0 – 25%



₂ 2+ 26 – 50%



₃ 3+ 51 – 75%



₄ 4+ 76 – 100%

3. Is the child a candidate for Adenotonsillectomy?

- ₀ No ₁ Yes

4. Are there any known contraindications for surgery?

- ₀ No ₁ Yes

5. What is the Surgeon ID?

____ - ____

[Parent Completed]

-
1. While sleeping, does your child:
 - 1a. Snore more than half the time? ₁ Yes ₀ No ₈₈ Don't Know
 - 1b. Always snore? ₁ Yes ₀ No ₈₈ Don't Know
 - 1c. Snore loudly? ₁ Yes ₀ No ₈₈ Don't Know
 - 1d. Have "heavy" or loud breathing? ₁ Yes ₀ No ₈₈ Don't Know
 - 1e. Have trouble breathing, or struggle to breathe? ₁ Yes ₀ No ₈₈ Don't Know

 2. Have you ever seen your child stop breathing during the night? ₁ Yes ₀ No ₈₈ Don't Know

 3. Does your child:
 - 3a. Tend to breathe through the mouth during the day? ₁ Yes ₀ No ₈₈ Don't Know
 - 3b. Have a dry mouth on waking up in the morning? ₁ Yes ₀ No ₈₈ Don't Know
 - 3c. Occasionally wet the bed? ₁ Yes ₀ No ₈₈ Don't Know

 4. Does your child:
 - 4a. Wake up feeling unrefreshed in the morning? ₁ Yes ₀ No ₈₈ Don't Know
 - 4b. Have a problem with sleepiness during the day? ₁ Yes ₀ No ₈₈ Don't Know

 5. Has a teacher or other supervisor commented that your child appears sleepy during the day? ₁ Yes ₀ No ₈₈ Don't Know

 6. Is it hard to wake your child up in the morning? ₁ Yes ₀ No ₈₈ Don't Know

 7. Does your child wake up with headaches in the morning? ₁ Yes ₀ No ₈₈ Don't Know

 8. Did your child stop growing at a normal rate at any time since birth? ₁ Yes ₀ No ₈₈ Don't Know

 9. Is your child overweight? ₁ Yes ₀ No ₈₈ Don't Know

 10. This child **OFTEN**:
 - 10a. Does not seem to listen when spoken to directly. ₁ Yes ₀ No ₈₈ Don't Know
 - 10b. Has difficulty organizing tasks and activities. ₁ Yes ₀ No ₈₈ Don't Know
 - 10c. Is easily distracted by extraneous stimuli. ₁ Yes ₀ No ₈₈ Don't Know
 - 10d. Fidgets with hands or feet or squirms in seat. ₁ Yes ₀ No ₈₈ Don't Know
 - 10e. Is "on the go" or often acts as if "driven by a motor". ₁ Yes ₀ No ₈₈ Don't Know
 - 10f. Interrupts or intrudes on others (eg: butts into conversations or games). ₁ Yes ₀ No ₈₈ Don't Know

These data should be collected and entered into the Prescreening & Screening Summary Module in the DMS bi-weekly, by the End of Business on Friday. These data will help provide monthly reports on enrollment, recruitment, and retention per site for the duration of the study.

Pre-Screening Data:

1. How many participant contacts were made by site staff this week (please indicate the number for each of the contact methods listed below):
 - 1a. Participants recruited through chart review: _____
 - 1b. Participants recruited through clinic referral (ENT, PSG, sleep lab, etc): _____
 - 1c. Participants recruited through CHAT flyers, brochures, or other media: _____
 - 1d. Participant recruited through other means: _____
Describe other means: _____
 - 1e. Total number of participants contacted: _____

Note: Add columns 1a – 1d.

2. What is the status of the participants contacted above (please indicate the number for each category below):
 - 2a. Participants eligible for screening: _____
 - 2b. Participants **not** eligible for screening: _____
Note: If participant is a screen failure, fill out the SSTOP CRF.
 - 2c. Participants **not** interested in participating: _____
 - 2d. Total number of participants assessed for screening: _____

Note: Add columns 2a – 2c.

Screening Data:

3. How many of the screened participants were eligible for randomization: _____
4. How many of the screened participants were **not** eligible for randomization: _____

1. Was this test performed? ₀ No
₁ Yes

For Question 2, please provide the summary scores from the Purdue Pegboard test

2.

| | | Hand | Number of Pegs |
|-----|--------------------|---|----------------|
| 2a. | Dominant Hand: | <input type="checkbox"/> ₁ Right <input type="checkbox"/> ₂ Left | ___ |
| 2b. | Non-dominant Hand: | <input type="checkbox"/> ₁ Right <input type="checkbox"/> ₂ Left | ___ |
| 2c. | Both Hands: | | ___ |

- 1. Has the participant met all eligibility criteria and signed the consent form; and the PI has reviewed and certified the individual as being eligible?
₀ No
₁ Yes

- 2. Has the participant had an ENT evaluation within 90 days of baseline, and is considered a candidate for surgery?
₀ No
₁ Yes

- 3. Has the participant had an overnight PSG evaluation, and is within the protocol defined limits?
₀ No
₁ Yes

- 4. Was the child able to perform the neurocognitive testing?
₀ No
₁ Yes

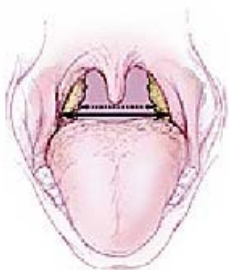
- 5. Date the parent signed the consent form:
____ / ____ / ____

- 6. Date of Randomization:
____ / ____ / ____

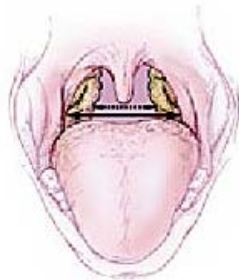
- 7. Randomization Code assigned by DMS:

1. Was reevaluation for surgical candidacy performed? ₀ No ₁ Yes

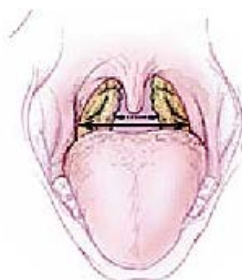
2. What was the current Tonsil size?
(Please refer to the photos below) ₉₉ Not Done



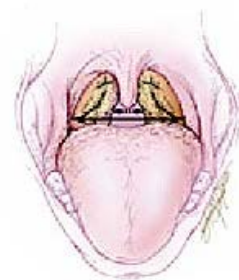
₁ 1+ 0 – 25%



₂ 2+ 26 – 50%



₃ 3+ 51 – 75%



₄ 4+ 76 – 100%

3. Is the child still considered to be a candidate for Adenotonsillectomy? ₀ No ₁ Yes

4. Are there any known contraindications for surgery? ₀ No ₁ Yes

5. What is the Surgeon ID? _____ - _____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Referral Source and Demographics
SCREEN

Participant ID: _____
Participant Initials: _____
Site: _____
Date: ____ / ____ / _____
RC ID: ____ - ____

1. Participant was recruited from which source:

- ₁ OTL
- ₂ Sleep Clinic
- ₃ Sleep Lab
- ₄ Pediatric Clinic
- ₅ Community
- ₆ Advertisement
- ₇ Chart Review
- ₉₈ Other, specify: _____

2. What is the child's Date of Birth?

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

3. What is the Screening PSG date?

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

4. What is the child's race?

- ₁ American Indian / Native Alaskan
- ₂ Asian
- ₃ Native Hawaiian / Other Pacific Islander
- ₄ Black / African American
- ₅ White / Caucasian
- ₆ Multiracial
- ₉₈ Other, specify: _____

5. What is the child's ethnicity?

- ₁ Hispanic or Latino
- ₂ Not Hispanic or Latino

6. What is the child's standing height? *

_____ . ____ cm

7. What is the child's weight? *

_____ . ____ kg

8. What is the child's BMI? *

_____ . ____

*** Indicate measurement at time of PSG screening.**

9. What is the child's gender?

- ₁ Male
- ₂ Female

[Parent / Guardian Completed]

Please maintain this log for 5 consecutive days. Complete these questions first thing in the morning of each day.

1. Please provide the day: _____
Enter a number from 1 - 5
2. What is today's date? _____ / _____ / _____
3. At what time did your child go to bed and try to fall asleep last night? _____ : _____ ₁ AM ₂ PM
4. Did your child wake up during the night? ₀ No ₁ Yes
- 4a. If YES, please provide the times:
- 1) _____ : _____ ₁ AM ₂ PM
- 2) _____ : _____ ₁ AM ₂ PM
- 3) _____ : _____ ₁ AM ₂ PM
5. What time did your child first wake up today? _____ : _____ ₁ AM ₂ PM
6. Did your child go back to sleep after first waking up? ₀ No ₁ Yes
- 6a. If YES, what time did they get up and out of bed? _____ : _____ ₁ AM ₂ PM
7. Did your child take any naps yesterday? ₀ No ₁ Yes

If YES, please provide the times:

| | Nap Begin | Nap End |
|-----|---|---|
| 7a. | _____ : _____ <input type="checkbox"/> ₁ AM <input type="checkbox"/> ₂ PM | _____ : _____ <input type="checkbox"/> ₁ AM <input type="checkbox"/> ₂ PM |
| 7b. | _____ : _____ <input type="checkbox"/> ₁ AM <input type="checkbox"/> ₂ PM | _____ : _____ <input type="checkbox"/> ₁ AM <input type="checkbox"/> ₂ PM |

8. Did your child go to school yesterday? ₀ No ₁ Yes
₉₉ Not Applicable / Child not in school
9. Was your child sick yesterday? ₀ No ₁ Yes
- 9a. If YES, with what? _____
10. Did your child take any medication(s) yesterday? ₀ No ₁ Yes
- 10a. If YES, list medication(s): _____
11. How many 8oz (1 cup) caffeinated beverages did your child drink yesterday? _____

[Parent / Guardian Completed]

1. During the past 6 months, at what time, on average has your child:

| | | Weekdays: | Weekends: |
|-----|---|---|---|
| 1a. | Gone to bed? (first closed the eyes in attempt to fall asleep) | <input type="checkbox"/> _1_ AM : <input type="checkbox"/> _2_ PM | <input type="checkbox"/> _1_ AM : <input type="checkbox"/> _2_ PM |
| 1b. | Fallen asleep? | <input type="checkbox"/> _1_ AM : <input type="checkbox"/> _2_ PM | <input type="checkbox"/> _1_ AM : <input type="checkbox"/> _2_ PM |
| 1c. | Woken up? (after the sleep period) | <input type="checkbox"/> _1_ AM : <input type="checkbox"/> _2_ PM | <input type="checkbox"/> _1_ AM : <input type="checkbox"/> _2_ PM |

2. Has your child snored in the **last month**?
0 No
1 Yes
88 Not sure

If Yes, answer 2a – 2d; referring to your child’s snoring in the last month:

2a. How often has your child experienced loud snoring during sleep?
0 Never
1 Rarely (less than once a week)
2 Sometimes (1 to 2 times per week)
3 Frequently (3 to 4 times per week)
4 Always or Almost Always (5 to 7 times per week)
88 Not Sure

2b. Has your child’s snoring usually been:
1 Only slightly louder than heavy breathing
2 About as loud as mumbling or talking
3 Louder than talking
4 Extremely loud – can be heard through closed doors
88 Not Sure

2c. Has the snoring sounded:
1 The same with each breath (snore)
2 Sometimes loud, sometimes soft
88 Not Sure

2d. Was your child’s snoring so loud it disturbed others?
0 No
1 Yes
88 Not sure

3. How old was your child when he / she first started snoring? _____ years _88_ Not sure

[Parent / Guardian Completed]

3a. During the entire time your child has snored, has his / her snoring usually been? ₁ Only slightly louder than heavy breathing
₂ About as loud as mumbling or talking
₃ Louder than talking
₄ Extremely loud – can be heard through closed doors
₈₈ Not Sure

3b. Has your child's snoring EVER been so loud it disturbed others? ₀ No
₁ Yes
₈₈ Not sure

If Yes, answer 3c:

3c. Approximately how many years has the snoring been this loud? _____ years ₈₈ Not sure

4. Do you watch your child while he / she is asleep at night because you are afraid about his / her breathing? ₀ No
₁ Yes
₂ Only when child was younger than 5 years old

5. In the **PAST YEAR**, has your child had the following:

| | | No | Yes | Not Sure |
|-----|--------------------------|---------------------------------------|---------------------------------------|--|
| 5a. | Frequent colds or flu? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 5b. | Frequent ear infections? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 5c. | Difficulty swallowing? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 5d. | Speech problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

| | | No | Yes | Not In School | Not Sure |
|-----|--|---------------------------------------|---------------------------------------|---------------------------------------|--|
| 5e. | Difficulties with school work related to attention problems or sleepiness? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₈₈ |
| 5f. | Difficulties with school work related to behavior problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₈₈ |
| 5g. | Difficulties interacting with others or in a group setting because of behavior problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₈₈ |

CHILDHOOD ADENOTONSILLECTOMY STUDY
Sleep and Health Questionnaire
BASELINE

[Parent / Guardian Completed]

Participant ID: _____
Participant Initials: _____
Site: _____
Date: ____ / ____ / _____
RC ID: ____ - ____

| | | No | Yes | Not Sure |
|-----|--|---------------------------------------|---------------------------------------|--|
| 5h. | Extreme irritability or mood problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 5i. | Has your child been professionally counseled for a behavior problem? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 5j. | Has your child been referred for special help in school? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

6. Over the **PAST MONTH**, has your child had any of the following during sleep?

| | | Never | Rarely (less than once a week) | Sometime s (1 to 2 times per week) | Frequently (3 to 4 times per week) | Always or Almost Always (5 to 7 times per week) | Not Sure |
|-----|---|---------------------------------------|---|---|--|---|--|
| 6a. | Breathing difficulty | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6b. | Chest is wheezy or whistling | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6c. | Frequent Awakenings | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6d. | Frequent tossing, turning, or thrashing? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6e. | Heartburn | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6f. | Legs are jumpy or jerky | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6g. | Restlessness | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6h. | Talk during sleep | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 6i. | Walk during sleep | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |

7. At what time of day does your child function best?
₁ Morning
₂ Afternoon
₃ Evening
₄ No best time

8. In the **PAST 3 Months**, on average, how much time has your child spent doing the following:
Note: Enter 0 if you did not do any of the activities below

| | | Amount of Time Per Day | Number of Days Per Week |
|-----|--|---------------------------|----------------------------|
| 8a. | Walking for exercise or to school | ___ H ___ M | __ D |
| 8b. | Jogging or running | ___ H ___ M | __ D |
| 8c. | Bicycling | ___ H ___ M | __ D |
| 8d. | Basketball, volley ball or other sports involving running or jumping | ___ H ___ M | __ D |
| 8e. | Swimming | ___ H ___ M | __ D |
| 8f. | Jump rope | ___ H ___ M | __ D |
| 8g. | In gym class or PE, being active | ___ H ___ M | __ D |
| 8h. | Other activity (specify): _____ | ___ H ___ M | __ D |

9. On average how many beverages containing caffeine (cola, coffee, tea, etc.) does your child drink per day?
**** One can of soda = 1.5 cups; 1 20oz bottle = 2.5 cups ****

- ₀ None
- ₁ Less than one cup per day
- ₂ Approximately one cup (8oz) per day
- ₃ More than one cup, but not more than three cups per day
- ₄ More than three cups per day

[Parent / Guardian Completed]

1. Since your last visit, at what time, on average has your child:

| | | Weekdays: | Weekends: |
|-----|---|---|---|
| 1a. | Gone to bed? (first closed the eyes in attempt to fall asleep) | <input type="text"/> _1_ AM : <input type="text"/> _2_ PM | <input type="text"/> _1_ AM : <input type="text"/> _2_ PM |
| 1b. | Fallen asleep? | <input type="text"/> _1_ AM : <input type="text"/> _2_ PM | <input type="text"/> _1_ AM : <input type="text"/> _2_ PM |
| 1c. | Woken up? (after the sleep period) | <input type="text"/> _1_ AM : <input type="text"/> _2_ PM | <input type="text"/> _1_ AM : <input type="text"/> _2_ PM |

2. Has your child snored in the **last month**?
0 No
1 Yes
88 Not sure

If Yes, answer 2a – 2d; referring to your child’s snoring in the last month:

2a. In the last month, how often has your child experienced loud snoring during sleep?
0 Never
1 Rarely (less than once a week)
2 Sometimes (1 to 2 times per week)
3 Frequently (3 to 4 times per week)
4 Always or Almost Always (5 to 7 times per week)
88 Not Sure

2b. In the last month, has your child’s snoring usually been:
1 Only slightly louder than heavy breathing
2 About as loud as mumbling or talking
3 Louder than talking
4 Extremely loud – can be heard through closed doors
88 Not Sure

2c. In the last month, has the snoring sounded:
1 The same with each breath (snore)
2 Sometimes loud, sometimes soft
88 Not Sure

2d. In the last month, was your child’s snoring so loud it disturbed others?
0 No
1 Yes
88 Not sure

3. Do you watch your child while he / she is asleep at night because you are afraid about his / her breathing?
0 No
1 Yes
2 Only when child was younger than 5 years old

4. In the **PAST 6 MONTHS**, has your child had the following:

| | | No | Yes | Not Sure |
|-----|--------------------------|---------------------------------------|---------------------------------------|--|
| 4a. | Frequent colds or flu? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 4b. | Frequent ear infections? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 4c. | Difficulty swallowing? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 4d. | Speech problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

| | | No | Yes | Not In School | Not Sure |
|-----|--|---------------------------------------|---------------------------------------|---------------------------------------|--|
| 4e. | Difficulties with school work related to attention problems or sleepiness? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₈₈ |
| 4f. | Difficulties with school work related to behavior problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₈₈ |
| 4g. | Difficulties interacting with others or in a group setting because of behavior problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₈₈ |

| | | No | Yes | Not Sure |
|-----|--|---------------------------------------|---------------------------------------|--|
| 4h. | Extreme irritability or mood problems? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 4i. | Has your child been professionally counseled for a behavior problem? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |
| 4j. | Has your child been referred for special help in school? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₈₈ |

[Parent / Guardian Completed]

5. Over the **PAST MONTH**, has your child had any of the following during sleep?

| | | Never | Rarely (less than once a week) | Sometimes (1 to 2 times per week) | Frequently (3 to 4 times per week) | Always or Almost Always (5 to 7 times per week) | Not Sure |
|-----|--|---------------------------------------|---|--|---|---|--|
| 5a. | Breathing difficulty | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5b. | Chest is wheezy or whistling | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5c. | Frequent Awakenings | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5d. | Frequent tossing, turning, or thrashing? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5e. | Heartburn | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5f. | Legs are jumpy or jerky | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5g. | Restlessness | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5h. | Talk during sleep | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |
| 5i. | Walk during sleep | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₈₈ |

6. At what time of day does your child function best?
₁ Morning
₂ Afternoon
₃ Evening
₄ No best time

7. In the **PAST 3 Months**, on average, how much time has your child spent doing the following:
Note: Enter 0 if you did not do any of the activities below

| | | Amount of Time Per Day | Number of Days Per Week |
|-----|--|---------------------------|----------------------------|
| 7a. | Walking for exercise or to school | ___ H ___ M | __ D |
| 7b. | Jogging or running | ___ H ___ M | __ D |
| 7c. | Bicycling | ___ H ___ M | __ D |
| 7d. | Basketball, volley ball or other sports involving running or jumping | ___ H ___ M | __ D |
| 7e. | Swimming | ___ H ___ M | __ D |
| 7f. | Jump rope | ___ H ___ M | __ D |
| 7g. | In gym class or PE, being active | ___ H ___ M | __ D |
| 7h. | Other activity (specify): _____ | ___ H ___ M | __ D |

8. On average how many beverages containing caffeine (cola, coffee, tea, etc.) does your child drink per day?
**** One can of soda = 1.5 cups; 1 20oz bottle = 2.5 cups ****

- 0 None
- 1 Less than one cup per day
- 2 Approximately one cup (8oz) per day
- 3 More than one cup, but not more than three cups per day
- 4 More than three cups per day

[Parent Completed]

How likely is your child to actually doze off or fall asleep in the following situations, *in contrast to feeling just tired?* This refers to his / her usual way of life in recent times. Even if he / she has not done some of these things recently, think about how they would have affected your child. Use the following scale to choose the *most appropriate number* for each situation:

It is important that you check ONE box (0 to 3) for each of the 10 questions:

| | | Chance of Dozing or Falling Asleep | | | |
|-----|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| | | No Chance | Slight Chance | Moderate Chance | High Chance |
| 1. | Sitting and reading | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 2. | Watching TV | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 3. | Sitting, inactive in a public place (ergo: a class room or a movie theater) | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 4. | As a passenger in a car for an hour without a break | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 5. | Lying down to rest in the afternoon when circumstances permit | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 6. | Sitting and talking to someone | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 7. | Sitting quietly after lunch | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 8. | In a car, while stopped for a few minutes in traffic | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 9. | Doing homework or taking a test | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 10. | Playing a videogame | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |

1. Were the parent completed sleep journals returned? ₀ No
₁ Yes
2. Were the journals recorded for 5 days? ₀ No
₁ Yes
- 2a. If No, how many days were recorded? _____

-
1. Did the participant complete the study, as per protocol? ₀ No ₁ Yes
- 1a. If No, what was the last study visit the participant completed? _____
2. Date the participant stopped: _____ / _____ / _____
3. What was the primary reason that the participant stopped?
- ₁ Participant successfully completed all required study visits
 - ₂ Participant lost to follow-up
 - ₃ Participant withdrew consent
 - ₄ Protocol defined stopping rules, decrease in DASII performance
 - ₅ Screen failure as defined in MOP
 - ₆ New medical problem determined to make continued participation unsafe
 - ₇ New behavioral or learning problem determined to make continued participation unsafe
 - ₈ Participant declined their assigned randomization arm
 - ₉ Death
 - ₉₈ Other, specify: _____
- _____

Comments: _____

NOTE: This form should only be completed after a participant has been **RANDOMIZED**.

1. Date the participant's treatment stopped:

__ M __ / __ D __ / __ Y __ Y __ Y __

2. What is the primary reason that the participant's treatment was stopped?

- ₁ Child's physician has identified a change in signs or symptoms that warrants alternative treatment for OSA (Initiation of CPAP for example)
- ₂ Child has developed new academic or behavioral problems resulting in a recommendation for grade retention
- ₃ Child has begun special education
- ₄ Child has begun counseling or placement on medications for behavior or emotional problems
- ₅ Recurrent bacterial tonsillitis (3 or more episodes of streptococcal culture positive infection occurring over a 3 month period)
- ₆ New clinical diagnosis of cor pulmonale
- ₇ Development of "failure to thrive" defined by weight loss during the course of follow-up
- ₈ New onset Stage 2 Hypertension, which is not better explained by another medical condition
- ₉ New onset hypersomnolence defined as reports of falling asleep on average > 3 times per week, which is not better explained by other factors unrelated to OSA
- ₁₀ Parent / Caregiver decision to have Adenotonsillectomy Surgery (WWSC group)
- ₁₁ Parent / Caregiver decision to not have Adenotonsillectomy Surgery (EAT group)
- ₉₈ Other medical or neuropsychological necessitated reason, specify: _____

3. Has the Medical Monitor confirmed this to be a treatment failure? ₀ No ₁ Yes

4. Did this participant crossover? ₀ No ₁ Yes

4a. If yes, please indicate the primary reason:

- ₁ Crossover due to confirmed treatment failure
- ₂ Crossover due to parent / caregiver decision

5. Will the participant be continuing with follow-up visits? ₀ No ₁ Yes

Comments: _____

**Research Coordinator completes this form if the participant needs to be unblinded.
Photocopies of this form with signatures must be faxed to the DCC.**

1. Date participant was unblinded: _____
M M / D D / Y Y Y Y
2. What was the participant's randomization arm?
₁ Early Adenotonsillectomy (EAT)
₂ Watchful Waiting with Supportive Care (WWSC)
3. Why was the participant unblinded?
₁ Neuropsychological scores fell outside the accepted range
₂ Participant experienced an SAE related to medical intervention
₃ Parent or child inadvertently disclosed their treatment arm
₉₈ Other, specify: _____

4. Was the DCC contacted within 24 hours of unblinding?
₀ No
₁ Yes
- 4a. If **YES**, name of the person contacted: _____
- 4b. If **NO**, state the reason why: _____

PI Signature: _____

Date: M M / D D / Y Y Y Y

Directions: Fax this form to the DCC at (215) 573-6262

1. Was the Beery VMI performed? ₀ No
₁ Yes

2. Please indicate the neuropsychological battery performed: ₁ Version 1
₂ Version 2

3. Please indicate the child's hand preference: ₁ Right
₂ Left
₃ Alternated Hands

Please provide the summary scores from the Beery VMI

| | | Beery VMI |
|----|-----------------|-----------|
| 4. | Raw Score: | |
| 5. | Standard Score: | |
| 6. | Percentile: | |

1. Were any of the sections of the WRAML-2 administered? ₀ No ₁ Yes

Please provide the summary data from the WRAML2

| | | Raw Score | Scaled Score |
|----|------------------------------|-----------|--------------|
| 2. | Verbal Learning: | | |
| 3. | Verbal Learning Recall: | | |
| 4. | Verbal Learning Recognition: | | |