DISC Form 68
Rev. 2 1/20/93
7 Pages

DIETARY INTERVENTION STUDY IN CHILDREN
CHILD MEDICAL INFORMATION FOLLOW-UP FORM

Office Use Only

ID ___-___ ___ ___ ___-___

NC ___ ___ ___ ___ ___ ___

VN ___ ___ ___ ___

---

1. What is today's date? .... ________ - ________ - ________
   Month Day Year

2. What is your relationship to your child? (Mark one answer)

   Mother or father .... ☐ 1

   Step-mother or step-father .... ☐ 2

   Legal guardian other than parent .... ☐ 3

   Other relationship .... ☐ 4

   (What is this relationship?)

   ____
   Relationship

---

3. Has a doctor told you in the LAST 12 MONTHS that your child has any of the following medical conditions?

		1 Yes	2 No
A.	Hypothyroidism (or underactive thyroid)	☐	☐
B.	Liver disease (such as jaundice or hepatitis)	☐	☐
C.	Diabetes	☐	☐
D.	Severe long-term intestinal disease (such as colitis requiring long-term medication)	☐	☐
E.	Kidney disease (such as nephrotic syndrome, nephritis or kidney failure)	☐	☐
F.	Hemophilia	☐	☐
G.	Anorexia (extreme undereating leading to weight loss)	☐	☐
H.	Bulimia (binge eating, self-inducted vomiting)	☐	☐
I.	Cancer or other serious disease (describe below)	☐	☐

____

____

4. Has your child ever intentionally gained or lost seven pounds or more over a period of two weeks or less during the past year? ... ☐ Yes 1 ☐ No 2

5. Has your child been admitted to a hospital in the LAST 12 MONTHS? .... ☐ Yes 1 ☐ No 2

IF NO, SKIP TO ITEM 6. If YES, answer Items 5A and 5B.

A. List dates and reasons for hospitalization(s):

____

____

B. Has your child had any operations in in the LAST 12 MONTHS? .... ☐ Yes 1 ☐ No 2

IF NO, SKIP TO ITEM 6. If YES, answer Item C.

C. List dates and names of operations:

____

____

6. Is your child CURRENTLY taking medications prescribed by a doctor? .... ☐ Yes 1 ☐ No 2

IF NO, SKIP TO ITEM 7.

If YES, answer Items 6A-K.

Does your child take:

		1 Yes	2 No
A.	Ritalin	☐	☐
B.	Phenobarbital	☐	☐
C.	Dilantin	☐	☐
D.	Other seizure medications (such as Tegretol or Depakene)	☐	☐
E.	Diuretics (such as Lasix, Diuril or Hydrodiuril)	☐	☐
F.	Retinoids (such as Acutane)	☐	☐
G.	Steroids (such as cortisone, cortisol, prednisone, steroids for asthma or steroids for athletics)	☐	☐
H.	Lipid lowering medications (such as Questran, Colestid or nicotinic acid)	☐	☐
I.	Thyroid (such as Synthroid)	☐	☐
J.	Therapeutic iron (such as Fer-in-sol)	☐	☐
K.	Other medications prescribed by a doctor	☐	☐

If YES, list other medications:

____

____

____

Please being all your child's current medications/ prescriptions to the clinic visit.

7. Has your child taken any medications prescribed by a doctor in the LAST 12 MONTHS? .... ☐ Yes (1) ☐ No (2)

> IF NO, SKIP TO ITEM 8.
>
> If YES, answer Items 7A-K.

Does your child take:

		Yes (1)	No (2)
A.	Ritalin	☐	☐
B.	Phenobarbital	☐	☐
C.	Dilantin	☐	☐
D.	Other seizure medications (such as Tegretol or Depakene)	☐	☐
E.	Diuretics (such as Lasix, Diuril or Hydrodiuril)	☐	☐
F.	Retinoids (such as Acutane)	☐	☐
G.	Steroids (such as cortisone, cortisol, prednisone, steroids for asthma or steroids for athletics)	☐	☐
H.	Lipid lowering medications (such as Questran, Colestid or nicotinic acid)	☐	☐
I.	Thyroid (such as Synthroid)	☐	☐
J.	Therapeutic iron (such as Fer-in-sol)	☐	☐
K.	Other medications prescribed by a doctor	☐	☐

If YES, list other medications:

____

____

____

8. Does your child take any medications prescribed by a doctor occasionally which he/she is currently not taking (such as inhalers for asthma or allergies)? .... ☐ Yes 1 ☐ No 2

If YES, list these medications:

____

____

____

9. Does your child usually take vitamins, minerals or diet supplements? .... ☐ Yes 1 ☐ No 2

IF NO, AND YOUR CHILD IS MALE, SKIP TO END.
IF NO, AND YOUR CHILD IS FEMALE, SKIP TO ITEM 11.
If YES, answer Item 10.

10. What kinds does he/she usually take and how many does he/she usually take each day?

A. Type/Brand Name of Vitamin, Mineral or Diet Supplement	B. No. Each Day
1. ______________________	________
2. ______________________	________
3. ______________________	________
4. ______________________	________
5. ______________________	________

If your child is MALE, skip to END.

11. A. We ask all girls in the DISC study about their periods because menstruation causes changes in the amount of cholesterol in a girl's blood. Has your daughter EVER had a period or any menstrual bleeding? .... ☐ Yes 1 ☐ No 2

If NO, skip to Item 12.

B. When did she have her FIRST period or menstrual bleeding? .... ________ Month - ________ Year

12. A. Now we are going to ask you about some other things that can cause changes in a girl's blood cholesterol. They may not all apply to your child. Is your child taking birth control pills NOW or has she taken them in the last FOUR MONTHS? .... ***BCN4MO*** ☐ Yes 1 ☐ No 2

B. Has she taken them in the last MONTH? .... ***BCLMO*** ☐ Yes 1 ☐ No 2

13. A. Some girls in this age group can become pregnant. Is your child pregnant NOW or has she been pregnant in the last FOUR MONTHS? .... ☐ Yes 1 ☐ No 2

B. Has she been pregnant in the last THREE MONTHS? .... ☐ Yes 1 ☐ No 2

END

Thank you very much for taking the time to complete this questionnaire. Please bring it with you when you bring your child to the DISC Clinical Center.