

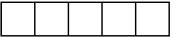


Teenager Medical History Questionnaire

16 year Follow-up







Medical History Questionnaire

The purpose of this teenager medical history questionnaire is to obtain information about any diagnosed conditions and health problems you may have now or experienced in the past, as well as your health service utilisation and use of any prescription or over the counter medications.

Terms of Reference

For the purpose of this questionnaire the following terms apply:

Health professional diagnosed A medical doctor, specialist, physiotherapist, chiropractor,

optometrist or any other health professional told you that you had

a health problem.

Prescription medications Medication for which a medical doctor wrote a prescription for you to

take to a pharmacy

Non-prescription medications Medications that you don't need a doctors written prescription to buy

Please take your time

If you are uncomfortable about a question or unsure of an answer, please leave it blank and discuss it with one of the Raine Study staff while you are here, or if you are unable to attend an appointment then phone us on 9489 7937 or 9489 7796.

Remember ALL answers are confidential

If you are unable to attend an appointment, please use the Reply Paid envelope enclosed to return your completed questionnaire to us.

Please return your completed questionnaire to us by:

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Completion Instructions

Please use a black or a blue pen to complete the questionnaire

1 2 3 4 5 6 7 8 9 0

A B C D E F G H I J K L M

I O P Q R S T U V W X Y Z

Please print clearly within the boxes

Please make marks that fill the circle

Please shade the circle completely

Please do not use crosses

Please do not use ticks



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CONFIDENTIAL

Q1. Have you **ever** attended the School Dental Service in Western Australia (this includes dental vans visiting schools)?

O No

O NO

O Yes

O Don't know

G217 AT1 Q2. In the last 12 months, have you attended any of the following?

O No

Go to Q3

O Yes

	(Please mark all responses applicable to the study teenager)	No	Yes Now completed	Still attending regularly or occasionally
G217 AT8	GP or family doctor	0	0	0
G217_AT1	Accident and emergency	0	0	0
G217_AT1	Hospital outpatient (department or clinic)	0	0	0
G217 AT2	Private medical specialist	0	0	0
G217 AT1	Dentist/Dental therapist/Orthodontist	0	0	0
G217 AT1	School nurse	0	0	0
G217 AT1	Optician/Optometrist	0	0	0
G217 AT1	2 Dietician/Nutritionist	0	0	0
G217 AT2	Physiotherapist	0	0	0
G217 AT3	Occupational therapist (OT)	0	0	0
G217_AT4	Speech therapist	0	0	0
G217_AT5	Psychologist/Psychiatrist	0	0	0
G217_AT1	7 Podiatrist	0	0	0
G217_AT6	Chiropractor	0	0	0
G217 AT7	Alternative therapist (eg iridologist)	0	0	0
1				

Office use only **G217_MD??** MD 20 21 22 1----2 - - - -3 - - - -23 4 - - - -25 26 27 24 7 - - - -30 28 9 - - - -29 10 - - - -14 - - - -31 15 - - - -32 33 17 -34 35 18 -19 -



Do you have now, or have you had in the past, **any** of the following **health professional diagnosed** medical conditions or health problems? Q3.

		(Please mark one response for each item)	No	Yes, in the past	Yes, now	Yes, now and in the past
G217 C	CH22	Acne	0	0	0	0
G217_C	<u>CH1</u>	Anxiety problems	0	0	0	0
G217_C	CH2	Arthritis or joint problems	0	0	0	0
G217 C	CH3	Asthma	0	0	0	0
G217_C	CH4	Attentional problems	0	0	0	0
G217_C		Back pain	0	0	0	0
G217 C		Behavioural problems	0	0	0	0
G217_C		Bladder control problems	0	0	0	0
G217_C		Chronic respiratory or breathing problems (other than asthma)	0	0	0	0
G217_C	CH7	Co-ordination or clumsiness difficulties	0	0	0	0
G217_C	CH27	Coeliac disease	0	0	0	0
G217 C	CH8	Depression	0	0	0	0
G217_C	CH24	Diabetes	0	0	0	0
G217_C	CH25	Eating disorder/Weight problems	0	0	0	0
G217_C	<u>CH9</u>	Hayfever or some other allergy	0	0	0	0
G217_C	CH10	Hearing impairment or deafness	0	0	0	0
G217 C	CH11	Heart conditon	0	0	0	0
G217_C	CH28	Hemochromatosis (iron overload disease)	0	0	0	0
G217_C	CH12	Intellectual disability	0	0	0	0
G217 C	CH13	Learning problems	0	0	0	0
G217_C	CH26	Menstrual problems	0	0	0	0
G217_C	CH14	Migraine or severe headache	0	0	0	0
G217 C	CH21	Neck pain	0	0	0	0
G217_C	CH15	Sleep disturbance	0	0	0	0
G217_C	CH16	Speech and/or language problems	0	0	0	0
G217 C	CH29	Thyroid gland problems	0	0	0	0
G217_C	CH17	Vision problems	0	0	0	0
G217 C		Any other medical condition or health problem not mentioned above	0	0	0	0



Q4. If you have answered "Yes..." to any of the health problems in the previous question, or have any other health professional diagnosed problem or condition, please describe the condition or problem in more detail below.

(eg. long sighted - wear glasses for reading; diagnosed with attention deficit disorder; asthma

Please list every medical condition/health problem separately - otherwise leave this blank.						
What condition/problem?	Who diagnosed it?	When was it diagnosed?	Treatment			
eg. Impacted wisdom teeth	Dentist	6 months ago	Referral to dental surgeon, antibiotics			

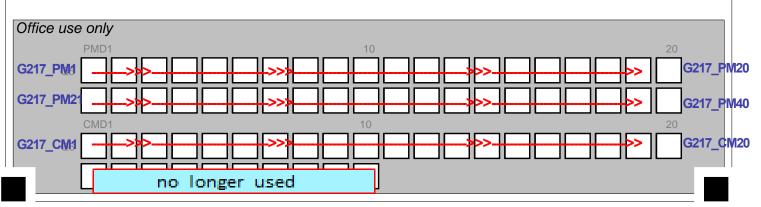
G217 PMED Q5. In the last 6 months, have you taken/used any prescription medication(s)?

O No Go to Q6

O Yes



W	Which medication(s)?					
	Name	Reason for taking it	Are you still taking it?			
eg.	Antibiotics Ventolin Cortisone cream The Pill or Depo-Provera	For acne For asthma For eczema For acne, menstrual disorders or contraception	Yes Yes No Yes			





G217 INJ

G217 CMED Q6. In the **last 6 months**, have you taken/used any 'over the counter' medication(s) (including vitamins, minerals and health food products)?

O No Go to Q7

O Yes



W	hich medication(s)?		
	Name	Reason for taking it	Are you still taking it?
eg.	Neurofen Antihistamine Fish oil capsules	For period pain For hayfever For ADD	Yes No Yes

Q7. **Since the last follow-up** at 14 years of age, have you had any accidents or injuries which required you to go to a doctor (GP), hospital or clinic?

O No Go to Q8

O Yes



Please describe the accident, the injury and any treatment (eg. fell off bike, cut arm, 3 stitches), and list every accident/injury separately, giving as much detail as possible.

Injury	How did it happen?	When did it happen?	Treatment
eg. Sprained wrist	Fell down stairs	3 months ago	Physiotherapy/bandage

	Office use only G217_INF? G217_INC? G217_HOD? ————> G217_HOH? G217_HOC?						
I1	1	1	H1 1]/ [] /	1		
12	2	2	H2 2] / [] /	2	2	
13	3	3	нз 3]/ [] / [3	3	
14	4	4	H4 4		4	4	
5	5	5	H5_5		5	5	



G217_HO Q8. Since the last follow-up at 14 years of age, have you been admitted to a hospital?

O No Go to Q9

O Yes



Please list each admission separately, giving as much detail as possible.						
Date	Which hospital?	Reason for admission				
eg. October 2005	McCourt St Day Surgery	Removal of impacted wisdom teeth				
G217_HOD1	G217_HOH1	G217_HOC1				
G217_HOD0	G217_HOH0	G217_HOC0				

Q9. This question asks about your **biological family's history** of coeliac disease and hemochromatosis (iron overload disease) **and** whether or not it was diagnosed by a doctor. (*Please include half-brothers and half-sisters but not step-brothers or step-sisters*)

	(Please mark all applicable responses)	No	Yes	Don't Know	Diagnosed I No	y a doctor Yes		
	Does your mother have							
G217_H1W	Coeliac disease	0	0	0	0	O G217_H		
G217_H1Y	Hemochromatosis (iron overload)	0	0	0	0	O G217_H		
	Does your father have							
G217_H2W	Coeliac disease	0	0	0	0	O G217_H		
G217_H2Y	Hemochromatosis (iron overload)	0	0	0	0	O G217_H		
	Do any of your biological brothers or sisters (siblings) have							
	Sibling 1							
G217_H4W	Coeliac disease	0	0	0	0	O G217 H4		
G217_H4Y	Hemochromatosis (iron overload)	0	0	0	0	O _{G217} H42		
	Sibling 2							
G217_H5W	Coeliac disease	0	0	0	0	O G217_H		
G217_H5Y	Hemochromatosis (iron overload)	0	0	0	0	O G217_H		
	Sibling 3							
G217_H6W	Coeliac disease	0	O	0	0	O G217_H		
G217_H6Y	Hemochromatosis (iron overload)	0	0	0	0	O G217_H		
	Sibling 4							
G217_H7W	Coeliac disease	0	0	0	0	O G217_H		
G217_H7Y	Hemochromatosis (iron overload)	0	0	0	0	O G217_H7		
	Sibling 5							
G217_H8W	Coeliac disease	0	0	0	0	O G2 7_H		
G217_H8Y	Hemochromatosis (iron overload)	0	0	0	0	O G217_H		

