Current History

Please fill out this questionnaire regarding your child with regards to the past year (since your last study visit).

Food History:

How would you describe your child’s appetite? (Circle one)
- Much less than average
- Less than average
- Average
- More than average
- Much more than average

Approximately how many calories does your child eat per day? _____ calories

How would you describe your child’s thirst? (Circle one)
- Much less than average
- Less than average
- Average
- More than average
- Much more than average

How many ounces of fluid does your child drink per day? ________ ounces

Does your child food seek?  ○ YES  ○ NO
Does your child hoard/hide food?  ○ YES  ○ NO
Has your child eaten pet food?  ○ YES  ○ NO
Has your child eaten garbage?  ○ YES  ○ NO

Has your child’s behavior regarding food changed over the past year?  ○ YES  ○ NO
If yes, please describe: ____________________________________________________________

Behavior History:

1. Does your child currently exhibit any of the following obsessive-compulsive (OC) behaviors?

   Skin picking  ○ YES  ○ NO
   Nail picking  ○ YES  ○ NO
   Nail biting  ○ YES  ○ NO
   Self-mutilation  ○ YES  ○ NO
   Compulsive ordering/arranging  ○ YES  ○ NO
   Compulsive counting  ○ YES  ○ NO
   Plays with strings  ○ YES  ○ NO
   Other (OC) behaviors?  ○ YES  ○ NO

   (If Yes, please describe) __________________________________________________________

1a. Have these behaviors changed over the past year?  ○ YES  ○ NO
1b. If yes, how has the behavior changed? ____________________________________________

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2. Please describe your child’s temper and describe what he/she does when angry:

________________________________________________________________________________________
________________________________________________________________________________________

Does your child currently exhibit any of the following behaviors?

Screaming/yelling ○ YES ○ NO
Throwing objects ○ YES ○ NO
Aggressive/violent actions ○ YES ○ NO
(e.g., hitting/biting)
Foul language ○ YES ○ NO
Destructive behavior ○ YES ○ NO
Threatens to hurt others ○ YES ○ NO
Tantrums ○ YES ○ NO
Sexual acting out ○ YES ○ NO
Inappropriate sexual behaviors ○ YES ○ NO

2a. Have these behaviors and/or your child’s temperament changed over the past year? ○ YES ○ NO
2b. If yes, how? __________________________________________________________
____________________________________________________________________________________

3. Does your child currently exhibit any of the following psychiatric behaviors?

Depressed mood ○ YES ○ NO
Anxiety ○ YES ○ NO
Thoughts of hurting him/herself ○ YES ○ NO
Cries easily ○ YES ○ NO
Visual hallucinations (seeing things not there) ○ YES ○ NO
Auditory hallucinations (hearing voices) ○ YES ○ NO
Delusions ○ YES ○ NO

3a. Have these behaviors changed over the past year? ○ YES ○ NO
3b. If yes, how has the behavior changed? _____________________________________________
___________________________________________________________________________________

4. Describe your child’s skin picking: (Circle one)

None Until the skin is red/irritated Until the skin bleeds It takes longer than 2 months for lesions to heal

4a. Has this behavior changed over the past year? ○ YES ○ NO
4b. If yes, how? ____________________________________________
Patient Name ___________________________________________             Study Date ____________________
ID # ________________________________ Age _____ yrs _____ mo
Type: ○ PWS ○ Obesity ○ Other______________ Visit # 1 2 3 4 5 6

5. Does your child have sleep apnea (stops breathing for short episode while he/she sleeps)?  ○ YES  ○ NO
   5a. If yes, have your child’s sleep patterns changed over the past year?  ○ YES  ○ NO
       How? ________________________________________________________________
   5b. If no, has your child had sleep apnea in the past?  ○ YES  ○ NO  ○ Not Sure
       What intervention or treatment was done?
   5c. Does your child get sleepy during the day?  ○ YES  ○ NO
   5d. If yes, how does this behavior compare to last year?  ○ BETTER  ○ UNCHANGED  ○ WORSE
   5e. If changed for the better or worse, please describe: ______________________________________
       ______________________________________________________________________

6. Describe your child’s pain threshold: (Circle one)
   Much lower than average  Lower than average  Average  Higher than average  Much higher than average
   6a. Has his/her pain threshold changed over the past year?  ○ YES  ○ NO
   6b. If yes, how? ____________________________________________________________
       ______________________________________________________________________

Medical History:
Has your child had any new medical problems diagnosed in the past year?  ○ YES  ○ NO
   If yes, please describe: ______________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Did your child have medical problems last year that are no longer a concern?  ○ YES  ○ NO
   If yes, please describe: ______________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Has your child had any new surgical problems in the past year?  ○ YES  ○ NO
   If yes, please describe: ______________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Has your child had any hospitalizations in the past year?  ○ YES  ○ NO
   If yes, please describe: ______________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
Related Services:
In the past year, has your child started or ended any of these therapies:

**Occupational Therapy:**  ○ YES  ○ NO  ○ Continues to receive
  If yes, when: ____/____/_____ dd/mmm/yyyy
  If ended in the past year, when: ____/____/_____ dd/mmm/yyyy
  How long did the therapy last: ____.____ years

**Physical Therapy:**  ○ YES  ○ NO  ○ Continues to receive
  If yes, when: ____/____/_____ dd/mmm/yyyy
  If ended in the past year, when: ____/____/_____ dd/mmm/yyyy
  How long did the therapy last: ____.____ years

**Speech Therapy:**  ○ YES  ○ NO  ○ Continues to receive
  If yes, when: ____/____/_____ dd/mmm/yyyy
  If ended in the past year, when: ____/____/_____ dd/mmm/yyyy
  How long did the therapy last: ____.____ years

**Language Therapy:**  ○ YES  ○ NO  ○ Continues to receive
  If yes, when: ____/____/_____ dd/mmm/yyyy
  If ended in the past year, when: ____/____/_____ dd/mmm/yyyy
  How long did the therapy last: ____.____ years

**Sensory Integration Therapy:**  ○ YES  ○ NO  ○ Continues to receive
  If yes, when: ____/____/_____ dd/mmm/yyyy
  If ended in the past year, when: ____/____/_____ dd/mmm/yyyy
  How long did the therapy last: ____.____ years

**Family History:**
Are there any new medical problems in your family since last year? Have there been any significant changes with your family over the past year (ie: new family member, new pet, new medical issues, changes in home setting, etc). If yes, please describe which family member affected and identify medical condition:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Social History:**
Has anything changed about your child’s home environment over the past year?  ○ YES  ○ NO
If yes, please describe: ________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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(Note: This section for the Study Coordinator to complete)

Patient Name ___________________________________________ Study Date ____________________
ID # _______________________________ Age _____ yrs _____ mo
Type: ○ PWS ○ Obesity ○ Other_________________________ Visit # 1 2 3 4 5 6

Education History:
Grade: _______________________
Special classes/therapies: ________________________________________________________________
Please describe your child’s current school situation:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Education History:
Please describe your child’s current school situation (e.g., grade, special classes, etc.):
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Medication History: Please include all medications that your child is currently taking or took for a substantial amount of time (i.e., more than 2 months), since the last visit even if your child is no longer taking this medication.

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<th>Medication Name</th>
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<th>Dates</th>
<th>Reason for taking</th>
<th>New since last visit?</th>
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