Growth Hormone:
Is your child currently on growth hormone?  ○ Yes  ○ No
If applicable, what type of growth hormone?
  ○ Genotropin
  ○ Norditropin
  ○ Nutropin
  ○ Humatrope
  ○ Saizen, and Tevtropin
  ○ Other ___________________
Current dose _______ mg per day
If not currently, has your child ever been on growth hormone in the past?  ○ Yes  ○ No
If applicable, how old was your child when he/she started growth hormone? ________ years
If applicable, how old was your child when he/she stopped growth hormone? ________ years
If growth hormone was stopped, why was it discontinued? (Indicate all that apply)
  □ Side effects (describe) __________________________________________
  □ Due to age/ had stopped growing
  □ Child’s decision
  □ Behavioral problems
  □ Insurance would not pay
  □ Research study completed
  □ Other (describe) _____________________

Sex Hormones:
Males Only:
Is your child currently on testosterone?  ○ Yes  ○ No
If not on currently, has your child ever been on testosterone in the past?  ○ Yes  ○ No
If applicable, how old was your child when he started testosterone? ________ years
If applicable, how old was your child when he stopped testosterone? ________ years
What type of administration of the testosterone? (check box)

<table>
<thead>
<tr>
<th>Type</th>
<th>Drug name:</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Injection:</td>
<td>OTestosterone Cypionate</td>
<td>mg IM q2-4 weeks___________</td>
</tr>
<tr>
<td>□ Patch:</td>
<td>O Androderm</td>
<td>mg per day_______________</td>
</tr>
<tr>
<td>□ Gel:</td>
<td>O Androgel O Testim</td>
<td>grams per day ___________</td>
</tr>
<tr>
<td>□ Other:</td>
<td>O__________O___________</td>
<td>grams per day_____________</td>
</tr>
</tbody>
</table>

If testosterone was stopped, why was it discontinued? (Indicate all that apply)

□ Behavioral problems

□ Other side effects (describe) __________________________________________

□ Child’s decision

□ Other (describe) ______________________________________________________

Females Only:
Is your child currently on estrogen?   O Yes   O No
If not on currently, has your child ever been on estrogen in the past?   O Yes   O No
If applicable, how old was your child when she started estrogen? ________ years
If applicable, how old was your child when she stopped estrogen? ________ years
What type of estrogen?

□ Oral contraceptives (type):   Dose___________

O Monophasic-Alesse  O Junel (1-1.5/20-30)  O Modicon  O Portia
O Apri               O Junel FE (1-1.5/20/30)  O Mononessa  O Seasonale
O Aviane             O Kelnor               O Necon (0.5-1/35-50)  O Sprintec
O Balziva            O Levlen               O Nordette  O Yasmin
O Brevicon           O Levlite              O Norethin  O Zovia.
O Cryssel             O Levora               O Ortho-cept  O Other:____
O Demulen (1/35)      O Loestrin(1-1.5-20-30)  O Ortho-Cyclen
O Demulen (1/50)      O Lo-Ovral            O OrthoNovum
O Desogen            O Low-Ogestrel        O Ovcon
O Genora (0.5-1/35-50) O Lutera O Ovral

☐ Premarin/provera: Dose ______mg per day
   O Prempro

☐ Premarin only: Dose ______mg per day
   O Cenestin
   O Enjuvia
   OMenest

☐ Depo-provera: Dose ______ mg/ml

☐ Progesterone only: Dose_______ mg
   O Camila O Nor-QD
   O Errin O Ortho-Micronor
   O Jovilette O Ovrette

☐ Patch: Dose _______mg per day
   O Alora O Estraderm
   O Climara OMenostar
   O Esclim OVivelle

☐ Other (please list name and dose) __________________________

If estrogen was stopped, why was it discontinued?
   ☐ Behavioral problems

   ☐ Other side effects (describe) ________________________________

   ☐ Child’s decision

   ☐ Other (describe) ___________________________________________

**Psychotropic medications:**
Is your child currently on or have they ever been on any of the following medications? (indicate all that apply – leave dose blank if you do not know)

**SSRI’s**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
<th>Dose</th>
<th>Age from/to (years)</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prozac (fluoxetine)</td>
<td>O Yes O No</td>
<td>Dose</td>
<td>from _____ to _____</td>
<td>O Ongoing</td>
<td></td>
</tr>
<tr>
<td>Zoloft (sertraline)</td>
<td>O Yes O No</td>
<td>Dose</td>
<td>from _____ to _____</td>
<td>O Ongoing</td>
<td></td>
</tr>
<tr>
<td>Paxil (paroxetine)</td>
<td>O Yes O No</td>
<td>Dose</td>
<td>from _____ to _____</td>
<td>O Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
Other: please specify__________________
   O Yes  O No  Dose ___________  from _____ to _____  O Ongoing

**Antidepressants**

Wellbutrin (bupropion)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Remeron (mirtazapine)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Other: please specify__________________
   O Yes  O No  Dose ___________  from _____ to _____  O Ongoing

**Antiepileptics**

Topamax (topiramate)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Tegretol (carbamazepine)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Depakote (valproic acid)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Other: please specify__________________
   O Yes  O No  Dose ___________  from _____ to _____  O Ongoing

**Stimulants**

Provigil (modafanil)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Ritalin (methylphenidate)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Other __ please specify__________________
   O Yes  O No  Dose ___________  from _____ to _____  O Ongoing

**Antipsychotics**

Risperdal (risperidone)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Seroquel (quetiapine)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Abilify (aripiprazole)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Haldol (haloperidol)  O Yes  O No  Dose ___________  from _____ to _____  O Ongoing
Other __ please specify__________________
   O Yes  O No  Dose ___________  from _____ to _____  O Ongoing

How would you rate the effectiveness of the psychotropic medication(s) your child is currently on?

☐ not effective  ☐ somewhat effective  ☐ effective  ☐ very effective

Do you have any comments on past psychotropic medications your child has been on?
________________________________________________________________________________
________________________________________________________________________________
Other medications

Is your child currently on or have they ever been on any of the following medications? (indicate all that apply – leave dose blank if you do not know)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
<th>Dose</th>
<th>Age from/to (years)</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid medication</td>
<td></td>
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<tr>
<td>CoQ10</td>
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<tr>
<td>Narcan (naloxone)</td>
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<tr>
<td>Camitine (carnitor)</td>
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<tr>
<td>Carnitine (fumarate)</td>
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<tr>
<td>Saliva stimulants (e.g. biotene)</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>DDAVP (desmopressin)</td>
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<tr>
<td>Metformin (glucophage)</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Avandia/Actos (pioglitazone, rosiglitazone)</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Insulin</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other diabetes medication</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Albuterol</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Inhaled steroids</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other asthma medication</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Calcium</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Multivitamin</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>
Bisphosphonate O Yes O No Dose ___________ from _____ to _____ O Ongoing (Actonel/Fosamax)
Melatonin O Yes O No Dose ___________ from _____ to _____ O Ongoing
Other medication O Yes O No Dose ___________ from _____ to _____ O Ongoing
describe: ___________________