(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

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 you 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? _____

(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

_____

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 (*e.g., hitting/biting*)	○ YES ○ NO
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? _____

(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

---

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: _____
_____
_____

(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

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: _____
_____
_____

(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.

Medication Name	***Dose***	***Dates***	***Reason for taking***	***New since last visit?***