RDN Participant ID:		Date of Registration: (dd mmm yyyy)	
Local Subject ID:		Status	
Site ID:		Date of Visit	

Hospitalizations/Surgeries:

Has your child ever been hospitalized for any of the following?			# of hospitalizations and approx. ages(years)
Psychological or behavioral problems	O Yes	O No	#_____/__ __.__ __ years
Problems with diabetes	O Yes	O No	#_____/__ __.__ __ years
Problems with obesity	O Yes	O No	#_____/__ __.__ __ years
Problems with high blood pressure	O Yes	O No	#_____/__ __.__ __ years
Deep vein thrombosis (blood clot in vein)	O Yes	O No	#_____/_____ years
Heart problems	O Yes	O No	#_____/_____ years
Gastrointestinal problems:	O Yes	O No	#_____/_____ years
Reflux	O Yes	O No	#_____/_____ years
Constipation	O Yes	O No	#_____/_____ years
Diarrhea	O Yes	O No	#_____/_____ years
Irritable bowel syndrome	O Yes	O No	#_____/_____ years
Inflammatory bowel	O Yes	O No	#_____/_____ years
Respiratory problems:	O Yes	O No	#_____/_____ years
Asthma	O Yes	O No	#_____/_____ years
Apnea	O Yes	O No	#_____/_____ years
ALTE (acute life-threatening event)/ (near-SIDS)	O Yes	O No	#_____/_____ years
Pneumonia	O Yes	O No	#_____/_____ years

Hip dysplasia/dislocation	O Yes O No	#_____/_____ years
Scoliosis	O Yes O No	#_____/_____ years
Seizures	O Yes O No	#_____/_____ years
Cellulitis	O Yes O No	#_____/_____ years

Other (please list) _____
_____

Has your child ever had surgery for any of the following reasons?		Approx. age(s) (years)
Undescended testes	O Yes O No	_____ years
Strabismus (crossed eyes)	O Yes O No	_____ years
Removal of tonsils and/or adenoids	O Yes O No	_____ years
Placement of ear tubes	O Yes O No	_____ years
Scoliosis	O Yes O No	_____ years
SCFE (Slipped capital femoral epiphysis)	O Yes O No	_____ years
Gastrostomy tube (G-tube)	O Yes O No	_____ years
Nissen fundoplication (for reflux)	O Yes O No	_____ years
Muscle biopsy	O Yes O No	_____ years
Tracheostomy tube	O Yes O No	_____ years

Other (please list) _____
_____

Illnesses/Medical problems:

Does your child have a history of the following?		If yes, requiring medication?	If yes, at what age?
High blood pressure	O Yes O No	O Yes O No	from _____ to _____ (years)
Varicose veins	O Yes O No	O Yes O No	from _____ to _____ (years)
Type 1 Diabetes (autoimmune / insulin dependent)	O Yes O No	O Yes O No	from _____ to _____ (years)
Type 2 Diabetes (2' to overweight / takes pills and/or insulin)	O Yes O No	O Yes O No	from _____ to _____ (years)
Skin infection	O Yes O No	O Yes O No	from _____ to _____ (years)

Cellulitis	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Asthma	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Seizures	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Hypothermia (low body temperature)	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Hyperthermia (high body temperature)	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Hypothyroidism	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Hyperthyroidism	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Polycystic ovaries (PCOS)	O Yes	O No	O Yes	O No	from _____ to _____ (years)
High cholesterol	O Yes	O No	O Yes	O No	from _____ to _____ (years)
High triglycerides	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Gastroesophageal reflux	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Gallstones	O Yes	O No	O Yes	O No	from _____ to _____ (years)
Pancreatitis	O Yes	O No	O Yes	O No	from _____ to _____ (years)

Other (please describe) _____

Does your child have any orthopedic (bone) problems not listed on the previous pages? O Yes O NO
If yes, please describe _____

Has your child ever had a sleep study?

O Yes O No O Not sure
Results of sleep study (if applicable) _____

Does your child have sleep apnea (stops breathing for short episodes [greater than 5 seconds] while he/she sleeps)? O Yes O No O Not sure

If your child currently does <u>not</u> have sleep apnea, did they ever have it in the past?
O Yes O No O Not sure
If yes, how long did they have sleep apnea? _____months _____years
What intervention or treatment was done: _____

Describe your child's typical sleep pattern: (indicate one)
O Never wakes O Wakes once/night O Wakes more than once/night

If applicable, why does your child wake up at night? (Indicate all that apply)
☐ Snoring/stops breathing ☐ To seek food ☐ To urinate ☐ To drink ☐ Don't know

Does your child get excessively sleepy during the day compared to other children of a similar age?
O YES O NO

Describe your child's pain threshold: (indicate one)
O Much lower than average
O Lower than average
O Average
O Higher than average
O Much higher than average

Describe your child's vomit occurrence: (indicate one)

- O Much lower than average
- O Lower than average
- O Average
- O Higher than average
- O Much higher than average