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

Growth Hormone:

Is your child currently on growth hormone? O Yes O No

If applicable, what type of growth hormone?

- O Genotropin
- O Norditropin
- O Nutropin
- O Humatrope
- O Saizen, and Tevtropin
- O Other _____

Current dose _____ mg per day

If not currently, has your child ever been on growth hormone in the past? O Yes O 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? O Yes O No

If not on currently, has your child ever been on testosterone in the past? O Yes O 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)

Type:	Drug name:	Dose
☐ Injection:	OTestosterone Cypionate	mg IM q2-4 weeks_____
☐ Patch:	O Androderm	mg per day_____
☐ Gel:	O Androgel O Testim	grams per day _____
☐ Other:	O_____O_____	grams per day_____

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? _____ yea7rs

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 Cryselle	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			Age from/to (years)			
Prozac(fluoxetine)	O Yes	O No	Dose _____	from _____	to _____	O Ongoing
Zoloft (sertraline)	O Yes	O No	Dose _____	from _____	to _____	O Ongoing
Paxil (paroxetine)	O Yes	O No	Dose _____	from _____	to _____	O Ongoing

Other: please specify_____

O Yes O No Dose _____ from _____ to _____ O Ongoing

Antidepressants Age from/to (years)

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 Age from/to (years)

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 Age from/to (years)

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 Age from/to (years)

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)

			Age from/to (years)		
Thyroid medication	O Yes O No	Dose _____	from _____	to _____	O Ongoing
CoQ10	O Yes O No	Dose _____	from _____	to _____	O Ongoing
Narcan (naloxone)	O Yes O No	Dose _____	from _____	to _____	O Ongoing
Camitine (carnitor)	O Yes O No	Dose _____	from _____	to _____	O Ongoing
Carnitine (fumarate)	O Yes O No	Dose _____	from _____	to _____	O Ongoing

Age from/to (years)

Saliva stimulants (e.g.biotene) O Yes O No Dose _____from _____ to _____ O Ongoing

describe: _____

Age from/to (years)

DDAVP (desmopressin)	O Yes O No	Dose _____	from _____	to _____	O Ongoing
Metformin (glucophage)	O Yes O No	Dose _____	from _____	to _____	O Ongoing
Avandia/Actos (pioglitazone, rosiglitazone)	O Yes O No	Dose _____	from _____	to _____	O Ongoing

Age from/to (years)

Insulin O Yes O No Dose _____ from _____ to _____ O Ongoing

describe: _____

Age from/to (years)

Other diabetes medication O Yes O No Dose _____from _____ to _____ O Ongoing

describe: _____

Albuterol	O Yes O No	Dose _____	from _____	to _____	O Ongoing
Inhaled steroids (Flovent [fluticasone], Advair, etc.)	O Yes O No	Dose _____	from _____	to ____	O Ongoing

Age from/to (years)

Other asthma medication O Yes O No Dose _____ from _____ to _____ O Ongoing

describe: _____

Calcium	O Yes O No	Dose _____	from _____	to _____	O Ongoing
Multivitamin	O Yes O No	Dose _____	from _____	to _____	O Ongoing

Bisphosphonate (Actonel/Fosamax)	O Yes	O No	Dose _____ from _____ to _____	O Ongoing
Melatonin	O Yes	O No	Dose _____ from _____ to _____	O Ongoing
Other medication	O Yes	O No	Dose _____ from _____ to _____	O Ongoing

describe: _____