

Child History Form

Date _____

Name _____ DOB _____ Age _____

Referred by? _____

Child's Current Problems: Please list/describe starting with the most serious.

Treatment: What kinds of things have you tried in order to take care of the problems? Have you seen other professionals? (*please see medication summary form*)

Other Treating Clinicians:

Past Psychiatric Problems: Has your child been evaluated/treated for other psychiatric problems? Medications? Please explain:

School: Please describe your child's functioning at school. Are there any problems? What are his/her likes/dislikes?

Peer Relations: Please describe how your child gets along with other children.

Child History Form

8. Head or Nerve Problems: Has your child had any of the following?
- | | | | |
|--|-----|----|----------|
| a. Severe headaches? | YES | NO | NOT SURE |
| b. Seizures? | YES | NO | NOT SURE |
| With high fever? | YES | NO | NOT SURE |
| Medications for seizures? | YES | NO | NOT SURE |
| c. Loss of consciousness (blackout)? | YES | NO | NOT SURE |
| d. Hit in the head? | YES | NO | NOT SURE |
| e. Dizziness? | YES | NO | NOT SURE |
| f. Double vision? | YES | NO | NOT SURE |
| g. Lack of coordination? | YES | NO | NOT SURE |
| h. Memory problems? | YES | NO | NOT SURE |
| i. History of encephalitis/Meningitis? | YES | NO | NOT SURE |
| j. Momentary lapses of consciousness? | YES | NO | NOT SURE |
| l. Trance-like episodes? | YES | NO | NOT SURE |
| m. Tremor? | YES | NO | NOT SURE |
| n. Trouble walking? | YES | NO | NOT SURE |
9. Sleep issues:
- | | | | |
|--|-----|----|----------|
| a. Problems falling asleep? | YES | NO | NOT SURE |
| b. Problems staying asleep? | YES | NO | NOT SURE |
| c. Problems waking early in the morning? | YES | NO | NOT SURE |
| d. Nightmares? | YES | NO | NOT SURE |
| e. Night terrors? | YES | NO | NOT SURE |
| f. Snoring? | YES | NO | NOT SURE |
| g. Sleep walking? | YES | NO | NOT SURE |
| h. Sleep talking? | YES | NO | NOT SURE |
10. Appetite:
- | | | | |
|---|-----|----|----------|
| a. Has your child ever lost a lot of weight? | YES | NO | NOT SURE |
| b. Has your child ever seemed afraid of eating? | YES | NO | NOT SURE |
| c. Would you describe your child as having a 'poor' appetite? | YES | NO | NOT SURE |
| d. Has your child ever gained a lot of weight? | YES | NO | NOT SURE |
| e. Has your child ever had an excessive interest in eating? | YES | NO | NOT SURE |
11. Heart problems: Has your child had any of the following?
- | | | | |
|---|-----|----|----------|
| a. Hypertension/high blood pressure? | YES | NO | NOT SURE |
| b. Cardiac Conduction Issues | YES | NO | NOT SURE |
| c. Congenital Cardiac Issues (i.e. murmur, etc) | YES | NO | NOT SURE |
| d. Structural Cardiac Issues | YES | NO | NOT SURE |
| e. Shortness of breath on exertion? | YES | NO | NOT SURE |
| f. Syncope/fainting spells | YES | NO | NOT SURE |
| g. EKG/electrocardiogram. | YES | NO | NOT SURE |
| h. Echocardiogram | YES | NO | NOT SURE |
12. Other:
- | | | | |
|---|-----|----|----------|
| a. Has your child had many doctor or emergency room visits? | YES | NO | NOT SURE |
| b. Has there ever been excessive fluid intake? | YES | NO | NOT SURE |
| c. Has there ever been excessive urination? | YES | NO | NOT SURE |
| d. Have there been urinary tract infections? | YES | NO | NOT SURE |
| e. Does this child <u>often</u> mention bodily complaints? | YES | NO | NOT SURE |
13. Has your child:
- | | | | |
|---|-----|----|----------|
| a. Tried alcohol? | YES | NO | NOT SURE |
| b. Gotten into trouble at home, school or community because of alcohol? | YES | NO | NOT SURE |
| c. Tried other drugs? Which ones? _____ | YES | NO | NOT SURE |
| d. Gotten into trouble at home, school or community because of drugs? | YES | NO | NOT SURE |
| e. Used tobacco regularly? | YES | NO | NOT SURE |

Child History Form

DEVELOPMENTAL INFORMATION

A. Pregnancy:

- | | | | |
|--|---------|--------|----------|
| 1. Did the child's mother have any complications of pregnancy with this child, such as: | | | |
| a. Spotting or light bleeding? | YES | NO | NOT SURE |
| b. Heavy bleeding requiring bed rest or special treatment? | YES | NO | NOT SURE |
| c. Excessive nausea/vomiting lasting more than three months? | YES | NO | NOT SURE |
| d. Weight gain over 25 lbs.? | YES | NO | NOT SURE |
| e. Weight loss over 10 lbs.? | YES | NO | NOT SURE |
| f. Infection (like a kidney infection) requiring medical care? | YES | NO | NOT SURE |
| g. High blood pressure and/or excessive fluid in the body? | YES | NO | NOT SURE |
| h. Convulsions during pregnancy? | YES | NO | NOT SURE |
| i. Accidents requiring medical care? | YES | NO | NOT SURE |
| j. Other illness requiring medical care? What? _____ | YES | NO | NOT SURE |
| k. Emotional problems, such as depression, for which she felt concerned? | YES | NO | NOT SURE |
| l. Serious family problems which were upsetting her? | YES | NO | NOT SURE |
| m. Anemia? | YES | NO | NOT SURE |
| n. Heart disease? | YES | NO | NOT SURE |
| o. Kidney disease? | YES | NO | NOT SURE |
| p. Measles/German measles? | YES | NO | NOT SURE |
| q. Flu/other virus? | YES | NO | NOT SURE |
| r. Threatened miscarriage or early contractions? | YES | NO | NOT SURE |
| s. Exposure to X-ray (prior to or during pregnancy)? | YES | NO | NOT SURE |
| | | | |
| 2. Did the mother take any medications during pregnancy (other than vitamins, calcium, or iron.)? What? _____ | YES | NO | NOT SURE |
| 3. Did the mother smoke as much as a pack a day for at least three months? | YES | NO | NOT SURE |
| 4. Did the mother drink the equivalent of a beer or a shot or more of some alcoholic beverage daily, or now and then go out and get very drunk for at least three months of her pregnancy? | YES | NO | NOT SURE |
| 5. Was the mother taking any drugs not prescribed by a doctor, such as marijuana, cocaine, other? _____ | YES | NO | NOT SURE |
| 6. Was this pregnancy planned? | YES | NO | NOT SURE |
| 7. Did the mother have a preference whether she wanted a boy or a girl? | Boy | Girl | None |
| 8. Was the pregnancy shorter or longer than normal? Length? _____ | Shorter | Longer | Normal |
| 9. Did the mother have any problems with toxemia, diabetes, etc.? | YES | NO | NOT SURE |
| 10. Was this the first pregnancy? | YES | NO * | |
| 11. Were there any miscarriages? | YES | NO | |

B. Birth:

- | | | | |
|---|-----|----|------------|
| 1. Did the mother have any problems at delivery of this child? | | | |
| a. Was he/she born breech? (Feet or bottom first?) | YES | NO | NOT SURE |
| b. Did the mother have a Caesarian section? | YES | NO | NOT SURE |
| c. Can the mother recall any other difficulties at the child's birth? | YES | NO | NOT SURE |
| 2. Did labor have to be induced? | YES | NO | NOT SURE |
| How long was the labor? _____ | | | |
| 3. Was the labor unusually difficult? | YES | NO | NOT SURE |
| 4. Did the water break early? | YES | NO | NOT SURE |
| 5. Was an anesthesia used? | YES | NO | NOT SURE * |
| If so, what kind? _____ | | | |
| 6. Were forceps used? | YES | NO | NOT SURE |
| 7. What was the baby's condition at birth? _____ | | | |
| 8. Do you know APGAR scores? _____ | | | |

C. Infancy:

- | | | | |
|---|-----|----|----------|
| 1. After the birth of the child: | | | |
| a. Was he/she in an incubator? If YES, how many days? _____ | YES | NO | NOT SURE |
| b. How much did he/she weigh in lbs.? _____ | | | |
| c. Was he/she small for dates? | YES | NO | NOT SURE |
| Explain: _____ | | | |

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- d. Did the baby stay in the hospital after the mother went home? YES NO NOT SURE
 e. Did he/she have surgery (beyond circumcision/tongue clipping) in first month? YES NO NOT SURE
 Example: Hernia repair, emergency heart surgery, intestinal surgery.
 If YES, describe: _____
2. Were there any of these problems immediately after birth or in the nursery:
- a. Yellow jaundice? YES NO NOT SURE
 - b. Difficulty breathing or a need to help the baby begin to breathe? YES NO NOT SURE
 - c. Blood transfusion? YES NO NOT SURE
 - d. Seizure problem? YES NO NOT SURE
3. Did mother have any post-partum problems ("baby blues" or depression) YES NO NOT SURE
4. Did you notice anything unusual about this child in the first twelve months, such as:
- a. Having to switch formulas three times or more? YES NO NOT SURE
 - b. Did you ever have to switch to non-milk products? YES NO NOT SURE
 - c. Crying day and night, never satisfied? YES NO NOT SURE
 - d. Too quiet, "perfect" baby, didn't respond much to care or attention? YES NO NOT SURE
 - e. Stiffened up when held, seemed to push you away? YES NO NOT SURE
 - f. Floppy or limp when held, didn't cuddle to you? YES NO NOT SURE
 - g. Other? Describe: _____
5. Was your child easy or hard to care for? HARD EASY NOT SURE
 YES NO NOT SURE
6. Was the child colicky? YES NO NOT SURE

D. Early Development:

Motor Milestones

At what month of age did your child:	Age (if known)			
a. Roll over	_____	EARLY	ON TIME	LATE
b. Sit without support?	_____	EARLY	ON TIME	LATE
c. Crawl?	_____	EARLY	ON TIME	LATE
d. Stand holding on?	_____	EARLY	ON TIME	LATE
e. Walk holding on?	_____	EARLY	ON TIME	LATE
f. Walk well?	_____	EARLY	ON TIME	LATE

Language Milestones

At what month of age did your child:	Age (if known)			
a. Make his/her first sounds?	_____	EARLY	ON TIME	LATE
b. Squeal, gurgle and coo?	_____	EARLY	ON TIME	LATE
c. Start babbling?	_____	EARLY	ON TIME	LATE
d. Say MaMa or DaDa?	_____	EARLY	ON TIME	LATE
e. Say first words besides MaMa or DaDa?	_____	EARLY	ON TIME	LATE
f. Say first phrases (e.g. "I want a cookie")	_____	EARLY	ON TIME	LATE
g. Become easily understood by others?	_____	EARLY	ON TIME	LATE

- Did your child have any types of speech impediments growing up? YES NO NOT SURE
 Does your child have any types of speech impediments now? YES NO NOT SURE
 Did the child make any kind of strange sounds or use strange language? YES NO NOT SURE
 Was language development NOT continuous? YES NO NOT SURE
 Was there ever anything unusual about his/her language like:
- a. Often repeating words/phrases he/she had just heard? YES NO NOT SURE
 - b. Often using the wrong pronouns (he, shall, you) to refer to himself/herself/others? YES NO NOT SURE
 - c. Often referring to himself/herself in the third person, such as "He/She wants a cracker"? YES NO NOT SURE
 - d. Seldom started a conversation even though he/she might talk to themselves? YES NO NOT SURE

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Social Milestones

Interactions:

At what month of age did your child:	Age (if known)			
a. Smile in response to another person _____		EARLY	ON TIME	LATE
b. Tell one person apart from another & become anxious/cry with strangers?		EARLY	ON TIME	LATE
c. Become anxious/cry when in strange environment without his/her mother?		EARLY	ON TIME	LATE
d. Play nursery games such as patty cake, bye-bye? _____		EARLY	ON TIME	LATE

Self-help:

At what month of age did your child:	Age (if known)			
a. Drink from a cup? _____		EARLY	ON TIME	LATE
b. Eat from a spoon? _____		EARLY	ON TIME	LATE
c. Dress without assistance? _____		EARLY	ON TIME	LATE
d. Use toilet for urine? _____		EARLY	ON TIME	LATE
e. Use toilet for stool? _____		EARLY	ON TIME	LATE

Play:

At what month of age did your child:	Age (if known)			
a. Play with dolls or stuffed animals? _____		EARLY	ON TIME	LATE
b. Make up and act out stories? _____		EARLY	ON TIME	LATE
c. Play alongside other children without interaction? _____		EARLY	ON TIME	LATE
d. Play together in cooperation with other children? _____		EARLY	ON TIME	LATE

Would you describe him/her as being (having been) an affectionate child (i.e. did he/she (does he/she) like to be held or cuddled, or sit close to you)? YES NO NOT SURE *

Does he/she usually look at or talk to others or interact in a way you would expect

a. Body rocking?	YES	NO	NOT SURE
b. Head-banging?	YES	NO	NOT SURE
c. Hand-flapping?	YES	NO	NOT SURE
d. Toe-walking?	YES	NO	NOT SURE

Were you ever told that your child is mentally handicapped or retarded? YES NO NOT SURE

E. Years 1-5:

1. In the years between one and five did you have any unusual problems with your child (i.e., unusually difficult to raise in the preschool years?) YES NO NOT SURE
2. Did he/she attend: (If NO, skip to next section.)
 - a. Nursery school? YES NO NOT SURE
 - b. Kindergarten? YES NO NOT SURE
3. Did the teacher talk to you about any behavioral/learning problems in either nursery school or kindergarten? YES NO NOT SURE
4. Did you (or his/her teacher) have problems with him/her during preschool years because he/she:
 - a. Frequently ran off, was hard to keep track of? YES NO NOT SURE
 - b. Wouldn't stay at the table to eat or play a game? YES NO NOT SURE
 - c. Was unusually excitable, so that you dreaded to take him/her anywhere? YES NO NOT SURE
 - d. Was unusually impulsive, so that it was very difficult to teach him/her rules of safety, like not running out into the street? YES NO NOT SURE
 - e. Had temper tantrums beyond age 3-1/2? YES NO NOT SURE
 - f. Was destructive of toys or household goods? YES NO NOT SURE
 - g. Set fires or played persistently with matches? YES NO NOT SURE
 - h. Was very demanding(i.e.demands had to be met at once)? YES NO NOT SURE
 - i. Was unusually aggressive, would bite, scratch, hit or kick on slight provocation? YES NO NOT SURE
 - j. Was unusually clumsy, slow to learn to run, jump, skip, or ride a bike? YES NO NOT SURE
 - k. Other problems? Describe _____

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SCHOOL

Current School _____ Grade ____ Class: Regular/Resource/Advanced/SED/OH/Other: _____
Address/Phone _____

Teacher's/Principal's Name: _____

Past School	Grades	Dates	Type of Class	Reason for leaving

- 0= No Problem 5= Severe Problem
1. How would you rank your child's overall attitude towards school? 0 1 2 3 4 5
2. Does your child have behavior problems in school? 0 1 2 3 4 5
3. Does your child have problems with tardiness, cutting classes, truancy? 0 1 2 3 4 5
4. Does your child ever refuse to go to school? 0 1 2 3 4 5
5. Have school authorities reprimanded or punished your child? 0 1 2 3 4 5
6. Achievement
- a. Has your child ever been held back or advanced in a grade? Held back Neither Advanced
- b. What subject does your child like best at school? _____
- c. Is this his/her best subject? _____
- d. What is (are) your child's worst subject(s)? _____
- e. Does your child have any kind of learning problems at school? _____
- f. Are his/her grades better or worse than the past? Better Same Worse
7. Did the child show any of the following?
- a. Right-left confusion? YES NO NOT SURE
- b. Letter reversal? YES NO NOT SURE
- c. Misalignment of rows? YES NO NOT SURE
- d. Lack of spacing between written words? YES NO NOT SURE
- e. Unusual variation of letter size? YES NO NOT SURE
- f. Illegible handwriting? YES NO NOT SURE
8. Is his/her behavior different at school than at home?
 If YES, how?: _____
9. Testing
- a. Has there been intellectual (i.e. IQ) testing done in the past? YES NO NOT SURE
 Results _____
- b. Has your child ever been tested for learning disabilities (i.e. educational testing)? YES NO NOT SURE
 Results _____
10. Has your child ever had an IEP (Individualized Educational Plan)? YES NO NOT SURE
 Results _____

SOCIALIZATION

1. Does your child have some very good friends? YES NO NOT SURE*
- a. The name and age of his/her best friend(s)? _____
- b. What was it about this/these friend(s) that attracted your child to him/her/them? _____
- c. What do they do together? _____
- d. How often during a week are they together? _____
2. Has he/she stayed pretty good friends with someone for as long a time as 6 months? YES NO NOT SURE*

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- | | | | |
|---|--------|----------|-------------|
| 3. Has he/she ever belonged to any club or group, or played on a team? | YES | NO | NOT SURE* |
| 4. Is he/she the kind of person who notices/worries if a friend is in trouble? | YES | NO | NOT SURE* |
| 5. Does your child have any problems: | | | |
| a. Making friends? | YES | NO | NOT SURE |
| b. Keeping friends? | YES | NO | NOT SURE |
| 6. Does your child tell you that he/she: | | | |
| a. Feels lonely a lot? | YES | NO | NOT SURE |
| b. Wishes he/she had more friends? | YES | NO | NOT SURE |
| 7. Would people describe your child as a loner?
Why/Why not? _____ | YES | NO | NOT SURE |
| 8. Spare Time: | | | |
| a. Would your child rather spend his/her spare time alone or with someone? | Alone | Equal * | With others |
| b. Would your child rather spend time inside or outside? | Inside | Equal | Outside |
| c. What would your child most like to do during his/her spare time? _____ | | | |
| 9. Do other kids tease or pick on your child? | YES | NO | NOT SURE |
| a. What does he/she do when they tease him/her? _____ | | | |
| b. Can he/she defend himself/herself? | YES | NO | NOT SURE |
| 10. Does your child tease or bully other children? | YES | NO | NOT SURE |
| 11. Did your child ever run around in a gang of kids? | YES | NO | NOT SURE |
| a. Did he/she ever get into trouble because of a gang? | YES | NO | NOT SURE |
| b. What did they do? _____ | | | |
| 12. Does your child have a preference to play mostly with boys or girls? | BOYS | GIRLS | BOTH SAME* |
| 13. Does your child play with children older or younger than himself/herself? | OLDER | SAME AGE | YOUNGER |
| 14. Any habits/behaviors that seem to get your child into trouble with other children?
What? _____ | YES | NO | NOT SURE |

PERSONALITY

- | | | | |
|--|-------|------------|----------------|
| 1. Does your child tend to approach or withdraw from new situations
(e.g., new people, toys, demands, etc.)? | | Approach | Withdraw |
| 2. Does your child adapt easily to new situations? | YES | NO | NOT SURE |
| 3. Does your child become frustrated easily? | YES | NO | NOT SURE |
| 4. Does he or she seem to underreact or overreact to situations
(e.g., new person, wet diaper, hunger, etc.)? | | Underreact | NO Overreact |
| 5. Was it or is it easy to get a response from your child? | | Hard | Easy |
| 6. Did he/she seem to be overactive or underactive? | | Overactive | NO Underactive |
| 7. How would you describe his/her usual mood? _____ | | | |
| 8. Would you describe your child as: | | | |
| a. "Irritable"? | YES | NO | NOT SURE |
| b. "Hard to manage"? | YES | NO | NOT SURE |
| c. "Fearful"? | YES | NO | NOT SURE |
| d. "Overly cautious"? | YES | NO | NOT SURE |
| e. "Afraid of many things"? | YES | NO | NOT SURE |
| f. "A complainer"? | YES | NO | NOT SURE |
| g. "Self-critical"? | YES | NO | NOT SURE |
| 9. What are your child's interests or hobbies? _____ | | | |
| 10. What is your child good at? _____ | | | |
| 11. What do you like most about your child? _____ | | | |
| 12. What do you like least? _____ | | | |
| 13. Does your child seem to feel remorse or guilt for his/her wrong activities? | LOW 0 | 1 | 2 3 4 5 HIGH |
| 14. Does your child seem to feel guilty even when what he/she has done
isn't all that terrible? | 0 | 1 | 2 3 4 5 |
| 15. Self-Esteem: | | | |
| a. Please rank how much your child "likes" himself/herself. | 0 | 1 | 2 3 4 5 |
| b. Does your child say negative statements about his/her personality/appearance? | 0 | 1 | 2 3 4 5 |
| c. Does your child feel like a "loser" in life? | 0 | 1 | 2 3 4 5 |

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FAMILY

A. Family Information:	Age	Degree Grade	Address/Phone if different
Father: _____ Biological () Step () Foster () Occupation: _____			_____ _____
Mother: _____ Biological () Step () Foster () Occupation: _____			_____ _____
Children (In Chronological Order): _____ _____ _____			_____ _____ _____
Others in Home			

Current Date of: Marriage _____ Separation _____ Divorced _____
 Prior: Mother married to: _____ Date Married: _____ Date Terminated: _____
 Father married to: _____ Date Married: _____ Date Terminated: _____

B. Home Life:

0= No Problem 5= Severe

Problem

- | | | | | | | |
|---|-----|---|----|---|----------|---|
| 1. Is there a problem with quarreling with mother? | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Does your child confide problems with his/her mother? | YES | | NO | | NOT SURE | |
| 3. Does your child have talks or discussions with his/her mother? | YES | | NO | | NOT SURE | |
| 4. Overall, how would you rank your child's relationship to his/her mother? | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Is there a problem with quarreling with father? | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Does your child confide problems with his/her father? | YES | | NO | | NOT SURE | |
| 7. Does your child have talks or discussions with his/her father? | YES | | NO | | NOT SURE | |
| 8. Overall, how would you rank your child's relationship to his/her father? | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. Is there a problem with quarreling with brothers and sisters? | 0 | 1 | 2 | 3 | 4 | 5 |
| 10. Overall, how would you rank your child's relationship with siblings? | 0 | 1 | 2 | 3 | 4 | 5 |

Explanation of above:

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C. Family Background:

Has anyone in the patient's family had:

"Nervous breakdown"?	YES	NO	NOT SURE	WHO? _____
Psychiatric hospitalization?	YES	NO	NOT SURE	WHO? _____
Depression?	YES	NO	NOT SURE	WHO? _____
Manic-depressive	YES	NO	NOT SURE	WHO? _____
Bipolar disorder?	YES	NO	NOT SURE	WHO? _____
Suicide?	YES	NO	NOT SURE	WHO? _____
Alcoholism?	YES	NO	NOT SURE	WHO? _____
Drug abuse?	YES	NO	NOT SURE	WHO? _____
Schizophrenia?	YES	NO	NOT SURE	WHO? _____
Obsessive-compulsive disorder?	YES	NO	NOT SURE	WHO? _____
Panic attacks?	YES	NO	NOT SURE	WHO? _____
Anxiety Disorder	YES	NO	NOT SURE	WHO? _____
Tourette's disease/tics?	YES	NO	NOT SURE	WHO? _____
Anorexia or bulimia?	YES	NO	NOT SURE	WHO? _____
ADD/ADHD?	YES	NO	NOT SURE	WHO? _____
School problems?	YES	NO	NOT SURE	WHO? _____
Learning disabilities?	YES	NO	NOT SURE	WHO? _____
Mental retardation?	YES	NO	NOT SURE	WHO? _____
Autism?	YES	NO	NOT SURE	WHO? _____
Asperger's Syndrome?	YES	NO	NOT SURE	WHO? _____
Epilepsy?	YES	NO	NOT SURE	WHO? _____
Alzheimer's disease?	YES	NO	NOT SURE	WHO? _____
Wilson's disease?	YES	NO	NOT SURE	WHO? _____
Parkinson's disease?	YES	NO	NOT SURE	WHO? _____
Heart attack before the age of 50?	YES	NO	NOT SURE	WHO? _____
Unexplained sudden death?	YES	NO	NOT SURE	WHO? _____
Arrhythmia?	YES	NO	NOT SURE	WHO? _____
Congenital cardiac issues?	YES	NO	NOT SURE	WHO? _____
Structural Cardiac issues?	YES	NO	NOT SURE	WHO? _____
Syncope/fainting?	YES	NO	NOT SURE	WHO? _____

Other Comments

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