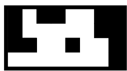
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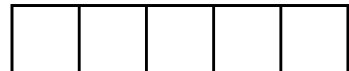

THE RAINE STUDY

Teenager Medical History Questionnaire

16 year Follow-up

Not for completion

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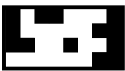
Not for completion



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Medical History Questionnaire

The purpose of this teenager medical history questionnaire is to obtain information about any diagnosed conditions and health problems you may have now or experienced in the past, as well as your health service utilisation and use of any prescription or over the counter medications.

Terms of Reference

For the purpose of this questionnaire the following terms apply:

Health professional diagnosed	A medical doctor, specialist, physiotherapist, chiropractor, optometrist or any other health professional told you that you had a health problem.
Prescription medications	Medication for which a medical doctor wrote a prescription for you to take to a pharmacy
Non-prescription medications	Medications that you don't need a doctors written prescription to buy

Please take your time

If you are uncomfortable about a question or unsure of an answer, please leave it blank and discuss it with one of the Raine Study staff while you are here, or if you are unable to attend an appointment then phone us on 9489 7937 or 9489 7796.

Remember ALL answers are confidential

If you are unable to attend an appointment, please use the Reply Paid envelope enclosed to return your completed questionnaire to us.

Please return your completed questionnaire to us by:

_ _ / _ _ / _ _ _ _

Western Australian Pregnancy Cohort (RAINE) Study
Telethon Institute for Child Health Research
100 Roberts Road, Subiaco WA 6008
(PO Box 855, West Perth WA 6872)
Tel +61 8 9489 7794
Fax +61 8 9489 7700
Web www.rainestudy.org.au

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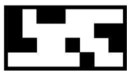
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Completion Instructions

Please use a black or a blue pen to complete the questionnaire

Please print clearly within the boxes

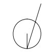
1	2	3	4	5	6	7	8	9	0

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

Please make marks that fill the circle

Please shade the circle completely

Please **do not** use crosses

Please **do not** use ticks 

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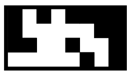

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CONFIDENTIAL

G17_AT23 Q1. Have you **ever** attended the School Dental Service in Western Australia (this includes dental vans visiting schools)?

- O No
- O Yes
- O Don't know

G17_AT1 Q2. In the **last 12 months**, have you attended any of the following?

- O No **Go to Q3**
- O Yes

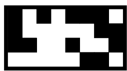
	*(Please mark **all** responses applicable to the study teenager)*	No	Yes Now completed	Yes Still attending regularly or occasionally
G17_AT8	GP or family doctor	O	O	O
G17_AT19	Accident and emergency	O	O	O
G17_AT13	Hospital outpatient (department or clinic)	O	O	O
G17_AT20	Private medical specialist	O	O	O
G17_AT11	Dentist/Dental therapist/Orthodontist	O	O	O
G17_AT16	School nurse	O	O	O
G17_AT15	Optician/Optometrist	O	O	O
G17_AT12	Dietician/Nutritionist	O	O	O
G17_AT2	Physiotherapist	O	O	O
G17_AT3	Occupational therapist (OT)	O	O	O
G17_AT4	Speech therapist	O	O	O
G17_AT5	Psychologist/Psychiatrist	O	O	O
G17_AT17	Podiatrist	O	O	O
G17_AT6	Chiropractor	O	O	O
G17_AT7	Alternative therapist (eg iridologist)	O	O	O

Office use only

G17_MD?? MD

1	20	1 - - - -	21	2 - - - -	22	3 - - - -	23	4 - - - -
5	24	5 - - - -	25	6 - - - -	26	7 - - - -	27	8 - - - -
9	28	9 - - - -	29	10 - - - -	30	14 - - - -	31	15 - - - -
13	32	16 - - - -	33	17 - - - -	34	18 - - - -	35	19 - - - -

Not for completion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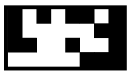
Q3. Do you have now, or have you had in the past, **any** of the following **health professional diagnosed** medical conditions or health problems?

	(Please mark **one** *response for each item)*	No	Yes, in the past	Yes, now	Yes, now and in the past
G17_CH22	Acne	○	○	○	○
G17_CH1	Anxiety problems	○	○	○	○
G17_CH2	Arthritis or joint problems	○	○	○	○
G17_CH3	Asthma	○	○	○	○
G17_CH4	Attentional problems	○	○	○	○
G17_CH20	Back pain	○	○	○	○
G17_CH5	Behavioural problems	○	○	○	○
G17_CH23	Bladder control problems	○	○	○	○
G17_CH6	Chronic respiratory or breathing problems (other than asthma)	○	○	○	○
G17_CH7	Co-ordination or clumsiness difficulties	○	○	○	○
G17_CH27	Coeliac disease	○	○	○	○
G17_CH8	Depression	○	○	○	○
G17_CH24	Diabetes	○	○	○	○
G17_CH25	Eating disorder/Weight problems	○	○	○	○
G17_CH9	Hayfever or some other allergy	○	○	○	○
G17_CH10	Hearing impairment or deafness	○	○	○	○
G17_CH11	Heart conditon	○	○	○	○
G17_CH28	Hemochromatosis (iron overload disease)	○	○	○	○
G17_CH12	Intellectual disability	○	○	○	○
G17_CH13	Learning problems	○	○	○	○
G17_CH26	Menstrual problems	○	○	○	○
G17_CH14	Migraine or severe headache	○	○	○	○
G17_CH21	Neck pain	○	○	○	○
G17_CH15	Sleep disturbance	○	○	○	○
G17_CH16	Speech and/or language problems	○	○	○	○
G17_CH29	Thyroid gland problems	○	○	○	○
G17_CH17	Vision problems	○	○	○	○
G17_CH18	Any other medical condition or health problem not mentioned above	○	○	○	○

Not for completion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Q4. If you have answered "Yes..." to any of the health problems in the previous question, or have any other health professional diagnosed problem or condition, please describe the condition or problem in more detail below.
(eg. long sighted - wear glasses for reading; diagnosed with attention deficit disorder; asthma

Please list every medical condition/health problem separately - otherwise leave this blank.

What condition/problem?	Who diagnosed it?	When was it diagnosed?	Treatment
eg. Impacted wisdom teeth	Dentist	6 months ago	Referral to dental surgeon, antibiotics

G17_PMED

Q5. In the **last 6 months**, have you taken/used any prescription medication(s)?

O No **Go to Q6**

O Yes

Which medication(s)?

Name	Reason for taking it	Are you still taking it?
eg. Antibiotics Ventolin Cortisone cream The Pill or Depo-Provera	For acne For asthma For eczema For acne, menstrual disorders or contraception	Yes Yes No Yes

Not for Completion

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PMD1 10 20

Q5 G17_PM1 ---------------->---------------->----------------> G17_PM20

G17_PM21 ---------------->---------------->----------------> G17_PM40

CMD1 10 20

Q6 G17_CM1 ---------------->---------------->----------------> G17_CM20

no longer used

33737

G17_CMED Q6. In the **last 6 months,** have you taken/used any 'over the counter' medication(s) *(including vitamins, minerals and health food products)*?

O No **Go to Q7**

O Yes

Which medication(s)?

Name	Reason for taking it	Are you still taking it?
eg. Neurofen Antihistamine Fish oil capsules	For period pain For hayfever For ADD	Yes No Yes

G17_INJ Q7. **Since the last follow-up** at 14 years of age, have you had any accidents or injuries which required you to go to a doctor (GP), hospital or clinic?

O No **Go to Q8**

O Yes

Please describe the accident, the injury and any treatment (eg. fell off bike, cut arm, 3 stitches), and list every accident/injury separately, giving as much detail as possible.

Injury	How did it happen?	When did it happen?	Treatment
eg. Sprained wrist	Fell down stairs	3 months ago	Physiotherapy/bandage

Not for Completion

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G17_INF? G17_INC? G17_HOD? G17_HOH? G17_HOC?

	G17_INF?	G17_INC?		G17_HOD?	G17_HOH?	G17_HOC?
I1	1	1	H1	1 / /	1	1
I2	2	2	H2	2 / /	2	2
I3	3	3	H3	3 / /	3	3
I4	4	4	H4	4 / /	4	4
I5	5	5	H5	5 / /	5	5

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G17_HO Q8. **Since the last follow-up** at 14 years of age, have you been admitted to a hospital ?

O No **Go to Q9**

O Yes

Please list each admission separately, giving as much detail as possible.

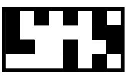
Date	Which hospital?	Reason for admission
eg. October 2005	McCourt St Day Surgery	Removal of impacted wisdom teeth
G17_HOD1	G17_HOH1	G17_HOC1
G17_HOD0	G17_HOH0	G17_HOC0

Q9. This question asks about your **biological family's history** of coeliac disease and hemochromatosis (iron overload disease) **and** whether or not it was diagnosed by a doctor. *(Please include half-brothers and half-sisters but not step-brothers or step-sisters)*

(Please mark ***all*** *applicable responses)*	No	Yes	Don't Know	Diagnosed by a doctor No	Diagnosed by a doctor Yes
Does your mother have...					
G17_H1W Coeliac disease	O	O	O	O	O G17_H1X
G17_H1Y Hemochromatosis (iron overload)	O	O	O	O	O G17_H1Z
Does your father have...					
G17_H2W Coeliac disease	O	O	O	O	O G17_H2X
G17_H2Y Hemochromatosis (iron overload)	O	O	O	O	O G17_H2Z
Do any of your biological brothers or sisters (siblings) have...					
Sibling 1					
G17_H4W Coeliac disease	O	O	O	O	O G17_H4X
G17_H4Y Hemochromatosis (iron overload)	O	O	O	O	O G17_H4Z
Sibling 2					
G17_H5W Coeliac disease	O	O	O	O	O G17_H5X
G17_H5Y Hemochromatosis (iron overload)	O	O	O	O	O G17_H5Z
Sibling 3					
G17_H6W Coeliac disease	O	O	O	O	O G17_H6X
G17_H6Y Hemochromatosis (iron overload)	O	O	O	O	O G17_H6Z
Sibling 4					
G17_H7W Coeliac disease	O	O	O	O	O G17_H7X
G17_H7Y Hemochromatosis (iron overload)	O	O	O	O	O G17_H7Z
Sibling 5					
G17_H8W Coeliac disease	O	O	O	O	O G17_H8X
G17_H8Y Hemochromatosis (iron overload)	O	O	O	O	O G17_H8Z

Same pattern through to sibling 7

Not for completion



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Q10. Please write below any comments concerning this questionnaire, the research, or anything else you would like to tell us about.

Q11. Please indicate the date you completed this questionnaire:

/ /

Not for completion

THANK YOU

WE APPRECIATE THE TIME THAT YOU HAVE SPENT COMPLETING THIS QUESTIONNAIRE

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Not for completion