The Raine Study 20 - 21 year follow-up

Thank you for taking the time to fill in this questionnaire.

Please read each question carefully and answer ALL of the questions by following the completion instructions provided below.

All information will be strictly confidential

HOW TO COMPLETE THIS FORM

Please use a BLACK pen.

Please take your time in answering all of the questions.

If you make a mistake, or want to change any of your shaded responses, please place a cross through the incorrect response and shade the correct response.

For written responses, please cross out your incorrect response and write your new response just above or below the one you have crossed out.

Medical History Questionnaire

1. BACKGROUND

The purpose of this 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. This questionnaire also asks for information regarding your alcohol intake.

2. CONFIDENTIAL

Q1. 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 **only** one response for each item***)**

	No 0	Yes, in the past 1	Yes, Now 2	Yes, now and in the past 3	
Acne	☐	☐	☐	☐	G220_CH22
Anxiety problems	☐	☐	☐	☐	G220_CH1
Arthritis or joint problems	☐	☐	☐	☐	G220_CH2
Asthma	☐	☐	☐	☐	G220_CH3
Attentional problems	☐	☐	☐	☐	G220_CH4
Back pain	☐	☐	☐	☐	G220_CH20
Behavioural problems	☐	☐	☐	☐	G220_CH5
Bladder control problems	☐	☐	☐	☐	G220_CH23
Chronic respiratory or breathing problems (other than asthma)	☐	☐	☐	☐	G220_CH6
Co-ordination or clumsiness difficulties	☐	☐	☐	☐	G220_CH7
Coeliac disease	☐	☐	☐	☐	G220_CH27
Depression	☐	☐	☐	☐	G220_CH8
Diabetes	☐	☐	☐	☐	G220_CH24
Eating disorder/Weight problems	☐	☐	☐	☐	G220_CH25
Hayfever or some other allergy	☐	☐	☐	☐	G220_CH9
Hearing impairment or deafness	☐	☐	☐	☐	G220_CH10
Heart condition	☐	☐	☐	☐	G220_CH11
Hemochromatosis (iron overload disease)	☐	☐	☐	☐	G220_CH28
Intellectual disability	☐	☐	☐	☐	G220_CH12
Learning problems	☐	☐	☐	☐	G220_CH13

	No 0	Yes, in the past 1	Yes, Now 2	Yes, now and in the past 3	
Menstrual problems	☐	☐	☐	☐	G220_CH26
Migraine or severe headache	☐	☐	☐	☐	G220_CH14
Neck pain	☐	☐	☐	☐	G220_CH21
Sleep disturbance	☐	☐	☐	☐	G220_CH15
Speech and/or language problems	☐	☐	☐	☐	G220_CH16
Thyroid gland problems	☐	☐	☐	☐	G220_CH29
Vision problems	☐	☐	☐	☐	G220_CH17
Any other medical condition or health	☐	☐	☐	☐	G220_CH18

Q2. 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 requiring medication).*
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*

Pre-coded illnesses:
G220_MD1
.
.
.
G220_MD19

Condition of pre-coded illnesses:
G220_MD20
.
.
.
G220_MD35
0 = No more conditions
1 = Yes, in the past
2 = Yes, now
3 = Yes, now and in the past
8 = NA

Q3. In the last 12 months, have you attended any of the following?

0 ○ No (*Please go to Q4*)
1 ○ Yes

G220_AT1

(*Please mark **only** one response for each item***)**

		No 0	Yes Now completed 2	Yes Still attending regularly or occasionally 3	NA 8
GP or family doctor	G220_AT8	☐	☐	☐	☐
Accident and Emergency	G220_AT19	☐	☐	☐	☐
Hospital outpatient (department or clinic)	G220_AT13	☐	☐	☐	☐
Private medical specialist	G220_AT20	☐	☐	☐	☐
Dentist, dental therapist, orthodontist	G220_AT11	☐	☐	☐	☐
School nurse	G220_AT16	☐	☐	☐	☐
Optician/Optometrist	G220_AT15	☐	☐	☐	☐
Dietician/Nutritionist	G220_AT12	☐	☐	☐	☐
Physiotherapist	G220_AT2	☐	☐	☐	☐
Occupational therapist (OT)	G220_AT3	☐	☐	☐	☐
Speech therapist	G220_AT4	☐	☐	☐	☐
Psychologist/Psychiatrist	G220_AT5	☐	☐	☐	☐
Podiatrist	G220_AT17	☐	☐	☐	☐
Chiropractor	G220_AT6	☐	☐	☐	☐
Alternative therapist (eg iridologist)	G220_AT7	☐	☐	☐	☐

Q4. In the last 6 months, have you taken/used any prescription medication(s)?

0 ○ No (*Please go to Q5*)
1 ○ Yes

G220_PMED

Which medication(s)?

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

Pre-defined medications		
G220_PM1	Prescription medication - antihistamine	0 = No 1 = Yes 2 = Yes taking it 8 = NA
G220_PM2	Prescription medication - antibiotics (prophylactic)	
G220_PM3	Prescription medication - anticonvulsants	
G220_PM4	Prescription medication - oral steroids	
G220_PM5	Prescription medication - cytotoxic/immuno therapy	
G220_PM6	Prescription medication - topical corticosteroids	
G220_PM7	Prescription medication - amphetamines	
G220_PM8	Prescription medication - antifungal medication	
G220_PM9	Prescription medication - intestinal motility	
G220_PM10	Prescription medication - acne cream	
G220_PM11	Prescription medication - other medications	
G220_PM12	Prescription medication - enzymes	
G220_PM13	Prescription medication - hormones	
G220_PM14	Prescription medication - non steroidal antiinflammatories	
G220_PM15	Prescription medication - cardiac medication	
G220_PM16	Prescription medication - vitamins/minerals	
G220_PM17	Prescription medication - asthma relievers	
G220_PM18	Prescription medication - asthma preventers	
G220_PM19	Prescription medication - asthma symptom controllers	
G220_PM20	Prescription medication - asthma combined	
G220_PM21	Prescription medication - other asthma medications	
G220_PM22	Prescription medication - oral steroids (not asthma related)	
G220_PM23	Prescription medication - topical creams (nonsteroid/nonantibiotic)	
G220_PM24	Prescription medication - steroid nasal sprays	
G220_PM25	Prescription medication - insulin	
G220_PM26	Prescription medication - clonidine	
G220_PM27	Prescription medication - steroid eye drops	
G220_PM28	Prescription medication - prescription analgesics	
G220_PM29	Prescription medication - antispasmodic/anticholoinergic (bladder dysfunction)	
G220_PM30	Prescription medication - sedative	
G220_PM31	Prescription medication - antibiotic (nonprophylactic)	
G220_PM32	Prescription medication - prescription antiemetics	
G220_PM33	Prescription medication - beta blockers	
G220_PM34	Prescription medication - oral contraceptives	
G220_PM35	Prescription medication - lipid agent	
G220_PM36	Prescription medication - roaccutane	
G220_PM37	Prescription medication - morning after pill	
G220_PM38	Prescription medication - hyperacidity, reflux and ulcer medications	
G220_PM39	Prescription medication - antihypertensives/diuretics	
G220_PM40	Prescription medication - hypoglycaemic agents other than insulin	

Q5. <u>In the last 6 months</u>, have you taken/used any 'over the counter' medication(s) *(including vitamins, minerals and health food products)***?**

0	○ No (*Please go to Q6*)	G220_CMED
1	○ Yes	

Which medication(s)?

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

Pre-defined medications		
G220_CM1	Non prescription medication - vitamins	
G220_CM2	Non prescription medication - analgesics/antipyretics	
G220_CM3	Non prescription medication - decongestants	
G220_CM4	Non prescription medication - antihistamines	
G220_CM5	Non prescription medication - naturopathic products	
G220_CM6	Non prescription medication - skin lotions/creams	
G220_CM7	Non prescription medication - laxatives	
G220_CM8	Non prescription medication - fluoride tablets	
G220_CM9	Non prescription medication - antispasmodic	
G220_CM10	Non prescription medication - topical antifungal cream	
G220_CM11	Non prescription medication - other medications	
G220_CM12	Non prescription medication - antiemetics	
G220_CM13	Non prescription medication - antacids	
G220_CM14	Non prescription medication - self prescribed bronchodilator	**0 = No**
G220_CM15	Non prescription medication - urinary alkaliser	**1 = Yes**
G220_CM16	Non prescription medication - non steroid antiinflammatory	**2 = Yes taking it**
G220_CM17	Non prescription medication - self prescribed asthma reliever	**8 = NA**
G220_CM18	Non prescription medication - sedative	
G220_CM19	Non-prescription medication - morning after pill (non-prescription)	
G220_CM20	Non-prescription medication -	
G220_CM21	Non-prescription medication -	
G220_CM22	Non-prescription medication -	
G220_CM23	Non-prescription medication -	
G220_CM24	Non-prescription medication -	
G220_CM25	Non-prescription medication -	
G220_CM26	Non-prescription medication -	
G220_CM27	Non-prescription medication -	
G220_CM28	Non-prescription medication -	
G220_CM29	Non-prescription medication -	
G220_CM30	Non prescription medication -	

Q6. <u>Since the last follow-up</u> at 17 years of age, have you had any accidents or injuries which required you to go to a doctor (GP), hospital or clinic?

0	○ No (*Please go to Q7*)
1	○ Yes

G220_INJ

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*

Pre-coded injuries:
G220_INC1
.
.
G220_INC5

Injury number of items:
G220_INF1
.
.
G220_INF5

Q7. <u>Since the last follow-up</u> at 17 years of age, have you been admitted to a hospital/day surgery?

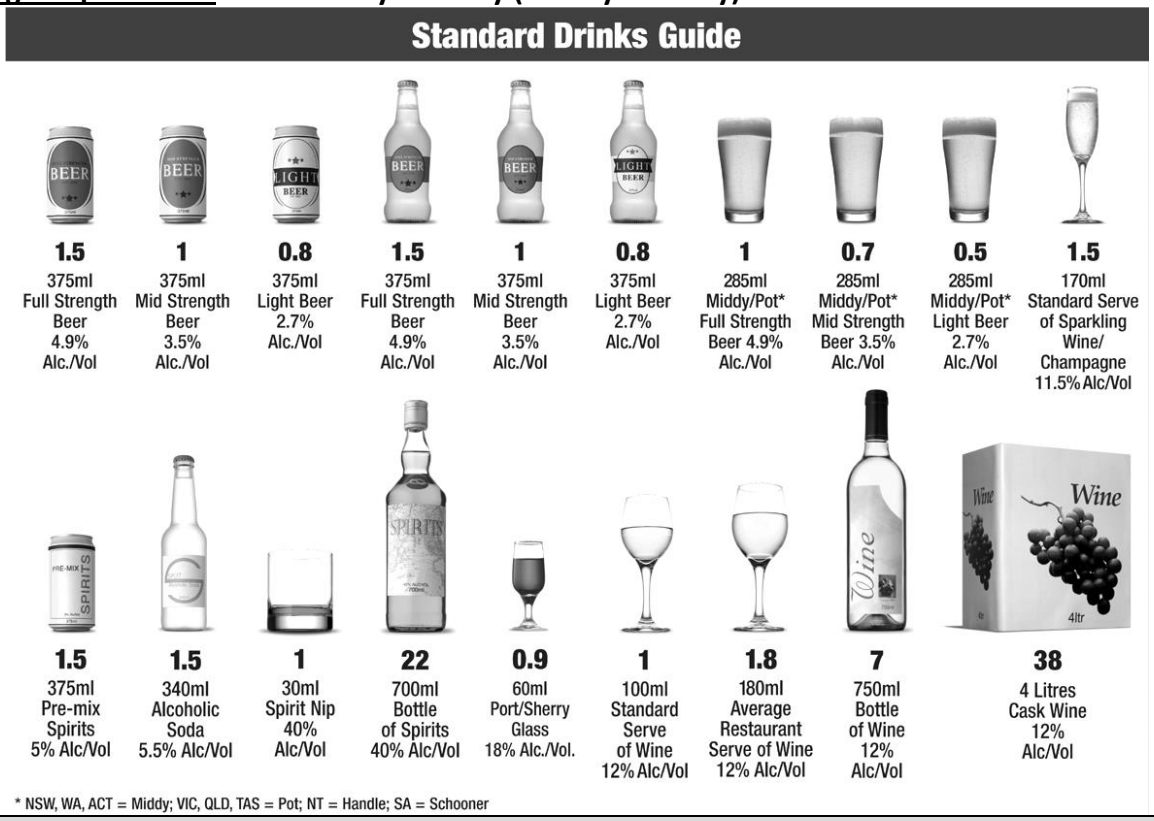
0	○ No (*Please go to Q8*)
1	○ Yes

G220_HO

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

Date	Hospital	Reason for admission
eg. October 2005 G220_HOD1 . . G220_HOD5	*McCourt St Day Surgery* **Pre-defined hospital:** G220_ HOH1 . . G220_ HOH5	*Removal of impacted wisdom teeth* **Pre-Coded admission:** G220_ HOC1 . . G220_ HOC5

Q7. Please indicate as accurately as possible, the type and amount of alcohol you consumed each day <u>during the past week</u>. Start from yesterday (circle yesterday)



Type and Amount of Alcohol drank	
Eg. Friday - 2 cans mid strength beer, 1 can pre-mix spirits and 1 glass cask wine	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

	Beer	Wine	Sprit	Total Drinks
Monday	G220_AH19	G220_AH20	G220_AH21	G220_AH5
Tuesday	G220_AH22	G220_AH23	G220_AH24	G220_AH7
Wednesday	G220_AH25	G220_AH26	G220_AH27	G220_AH9
Thursday	G220_AH28	G220_AH29	G220_AH30	G220_AH11
Friday	G220_AH31	G220_AH32	G220_AH33	G220_AH13
Saturday	G220_AH34	G220_AH35	G220_AH36	G220_AH15
Sunday	G220_AH37	G220_AH38	G220_AH39	G220_AH17
	0 = No 1 = Yes 8 = NA			88 = NA

Q9. Does this level of consumption reflect a typical week?

G220_AH18

0	○	No
1	○	Yes

Q10. Have you drunk so much alcohol that you threw up (vomited?)

G220_AH43

0	○	Never
1	○	Yes, only once
2	○	Yes, more than once

Q11. Please write below any comments concerning this questionnaire, the research, or anything else you would like to tell us about.

G220_QCO2

0 = No
1 = Yes, positive
2 = Yes, negative
3 = Both

Q12. Date questionnaire completed:

G220_MQ_DNWN

DD	MM	YYYY