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THE RAINE SLEEPOVER STUDY
23 year follow-up

THE RAINE STUDY

Medical History Questionnaire

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 shade the circles completely	Please write clearly within the boxes	Please write clearly within the space
●	A B C 1 2 3	PLEASE WRITE IN CAPITAL LETTERS

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.

Questionnaire

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.

If you require further information please contact:
The Raine Study on 9489 7794 or 0447 863 944

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Q2 1

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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 **one** response for each item)*	No	Yes, in the past	Yes, now	Yes, now and in the past
Acne	○	○	○	○
Anxiety problems	○	○	○	○
Arthritis or joint problems	○	○	○	○
Asthma	○	○	○	○
Attentional problems	○	○	○	○
Back pain	○	○	○	○
Behavioural problems	○	○	○	○
Bladder control problems	○	○	○	○
Chronic respiratory or breathing problems (other than asthma)	○	○	○	○
Co-ordination or clumsiness difficulties	○	○	○	○
Coeliac disease	○	○	○	○
Depression	○	○	○	○
Diabetes	○	○	○	○
Eating disorder/Weight problems	○	○	○	○
Hayfever or some other allergy	○	○	○	○
Hearing impairment or deafness	○	○	○	○
Heart conditon	○	○	○	○
Hemochromatosis (iron overload disease)	○	○	○	○
Intellectual disability	○	○	○	○
Learning problems	○	○	○	○
Menstrual problems	○	○	○	○
Migraine or severe headache	○	○	○	○
Neck pain	○	○	○	○
Sleep disturbance	○	○	○	○
Speech and/or language problems	○	○	○	○
Thyroid gland problems	○	○	○	○
Vision problems	○	○	○	○
Any other medical condition or health problem not mentioned above	○	○	○	○

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*

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

O No (go to Q4)

O Yes

*(Please mark **one** response for each item)*	No	Yes Now completed	Yes Still attending regularly or occasionally
GP or family doctor	O	O	O
Accident and emergency	O	O	O
Hospital outpatient (department or clinic)	O	O	O
Private medical specialist	O	O	O
Dentist/Dental therapist/Orthodontist	O	O	O
School nurse	O	O	O
Optician/Optometrist	O	O	O
Dietician/Nutritionist	O	O	O
Physiotherapist	O	O	O
Occupational therapist (OT)	O	O	O
Speech therapist	O	O	O
Psychologist/Psychiatrist	O	O	O
Podiatrist	O	O	O
Chiropractor	O	O	O
Alternative therapist (eg iridologist)	O	O	O

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

O No (go to Q5)

O Yes

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*

Q5. 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 Q6)

O 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*

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Q4 10 20

Q5 10 20

Q6. Since the last follow-up at 20 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 Q7)

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*

Q7. Since the last follow-up at 20 years of age, have you been admitted to a hospital/day surgery?

O No (go to Q8)

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*

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Q6

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Q7

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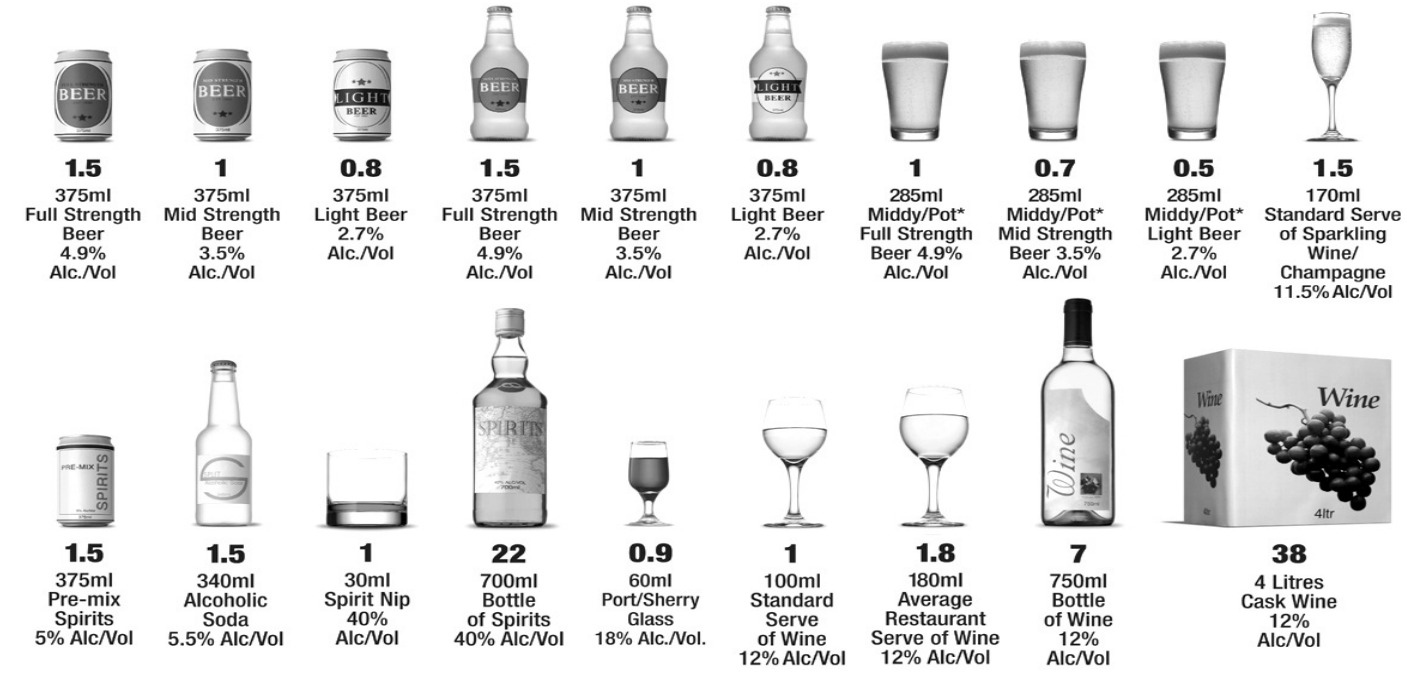
Q8. Please indicate as accurately as possible, the type and amount of alcohol you consumed each day during the past week. Start from yesterday (circle yesterday)

Standard Drinks Guide



* NSW, WA, ACT = Middy; VIC, QLD, TAS = Pot; NT = Handle; SA = Schooner

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	

Q9. Does this level of consumption reflect a typical week? O Yes O No

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

O Never O Yes, once only O Yes, more than once

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Mon Tues Wed Thu

Sat Sun

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

Q12. Date questionnaire completed: ☐☐ / ☐☐ / ☐☐☐☐

Thank you very much for your time and effort!

WE APPRECIATE THE TIME THAT YOU HAVE SPENT COMPLETING THIS QUESTIONNAIRE

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