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ID

THE RAINE EYE STUDY 20 - 21 year follow-up



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

A	B	C		1	2	3
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Please write clearly within the space

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**

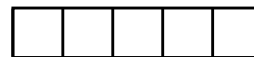
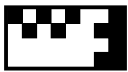


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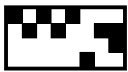
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**CONFIDENTIAL**

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 one response for each item)

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



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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
<i>eg. Impacted wisdom teeth</i>	<i>Dentist</i>	<i>6 months ago</i>	<i>Referral to dental surgeon, antibiotics</i>

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

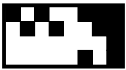
No - **Go to Q4**

Yes



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

	No	Yes Now completed	Yes Still attending regularly or occasionally
GP or family doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accident and emergency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital outpatient (department or clinic)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Private medical specialist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dentist/Dental therapist/Orthodontist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Optician/Optomtrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dietician/Nutritionist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physiotherapist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Occupational therapist (OT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Speech therapist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychologist/Psychiatrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Podiatrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chiropractor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternative therapist (eg iridologist)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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

No - **Go to Q5**

Yes



Which medication(s)?

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

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

No - **Go to Q6**

Yes

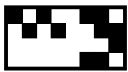


Which medication(s)?

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

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Q4																							
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Q6. **Since the last follow-up** at 17 years of age, have you had any accidents or injuries which required you to go to a doctor (GP), hospital or clinic?

No - **Go to Q7**

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
<i>eg. Sprained wrist</i>	<i>Fell down stairs</i>	<i>3 months ago</i>	<i>Physiotherapy/bandage</i>

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

No - **Go to Q8**

Yes

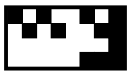


Please list each admission separately, giving as much detail as possible.

Date	Which hospital?	Reason for admission
<i>eg. October 2005</i>	<i>McCourt St Day Surgery</i>	<i>Removal of impacted wisdom teeth</i>

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Q6	1							Q7	1			/			/								
	2								2			/			/								
	3								3			/			/								
	4								4			/			/								
	5								5			/			/								



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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

 1.5 375ml Full Strength Beer 4.9% Alc./Vol	 1 375ml Mid Strength Beer 3.5% Alc./Vol	 0.8 375ml Light Beer 2.7% Alc./Vol	 1.5 375ml Full Strength Beer 4.9% Alc./Vol	 1 375ml Mid Strength Beer 3.5% Alc./Vol	 0.8 375ml Light Beer 2.7% Alc./Vol	 1 285ml Middy/Pot* Full Strength Beer 4.9% Alc./Vol	 0.7 285ml Middy/Pot* Mid Strength Beer 3.5% Alc./Vol	 0.5 285ml Middy/Pot* Light Beer 2.7% Alc./Vol	 1.5 170ml Standard Serve of Sparkling Wine/ Champagne 11.5% Alc/Vol
 1.5 375ml Pre-mix Spirits 5% Alc/Vol	 1.5 340ml Alcoholic Soda 5.5% Alc/Vol	 1 30ml Spirit Nip 40% Alc/Vol	 22 700ml Bottle of Spirits 40% Alc/Vol	 0.9 60ml Port/Sherry Glass 18% Alc./Vol.	 1 100ml Standard Serve of Wine 12% Alc/Vol	 1.8 180ml Average Restaurant Serve of Wine 12% Alc/Vol	 7 750ml Bottle of Wine 12% Alc/Vol	 38 4 Litres Cask Wine 12% Alc/Vol	

* 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	

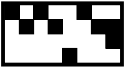
Q9. Does this level of consumption reflect a typical week? Yes No

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

Never Yes, once only Yes, more than once

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Mon	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Tues	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Wed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Thu	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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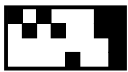
Q11. Please write below any comments concerning this questionnaire, the research, or anything else you would like to tell us about.

Q12. Date questionnaire completed:

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Thank you very much for your time and effort!

**WE APPRECIATE THE TIME THAT YOU HAVE SPENT
COMPLETING THIS QUESTIONNAIRE**