33737

THE RAINE STUDY

Teenager Medical History Questionnaire

16 year Follow-up

33737

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

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 

CONFIDENTIAL

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

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**
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

Office use only

MD

1 5 9 13

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
Acne	O	O	O	O
Anxiety problems	O	O	O	O
Arthritis or joint problems	O	O	O	O
Asthma	O	O	O	O
Attentional problems	O	O	O	O
Back pain	O	O	O	O
Behavioural problems	O	O	O	O
Bladder control problems	O	O	O	O
Chronic respiratory or breathing problems (other than asthma)	O	O	O	O
Co-ordination or clumsiness difficulties	O	O	O	O
Coeliac disease	O	O	O	O
Depression	O	O	O	O
Diabetes	O	O	O	O
Eating disorder/Weight problems	O	O	O	O
Hayfever or some other allergy	O	O	O	O
Hearing impairment or deafness	O	O	O	O
Heart conditon	O	O	O	O
Hemochromatosis (iron overload disease)	O	O	O	O
Intellectual disability	O	O	O	O
Learning problems	O	O	O	O
Menstrual problems	O	O	O	O
Migraine or severe headache	O	O	O	O
Neck pain	O	O	O	O
Sleep disturbance	O	O	O	O
Speech and/or language problems	O	O	O	O
Thyroid gland problems	O	O	O	O
Vision problems	O	O	O	O
Any other medical condition or health problem not mentioned above	O	O	O	O

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

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

○ No **Go to Q6**

○ 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

Office use only

PMD1 10 20

Q5

CMD1 10 20

Q6

Q6. 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 Q7**

○ 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

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?

○ No **Go to Q8**

○ 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

Office use only

Q7 Q8

I1 H1 / / I2 H2 / / I3 H3 / / I4 H4 / / I5 H5 / /

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

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...					
Coeliac disease	O	O	O	O	O
Hemochromatosis (iron overload)	O	O	O	O	O
Does your father have...					
Coeliac disease	O	O	O	O	O
Hemochromatosis (iron overload)	O	O	O	O	O
Do any of your biological brothers or sisters (siblings) have...					
Sibling 1					
Coeliac disease	O	O	O	O	O
Hemochromatosis (iron overload)	O	O	O	O	O
Sibling 2					
Coeliac disease	O	O	O	O	O
Hemochromatosis (iron overload)	O	O	O	O	O
Sibling 3					
Coeliac disease	O	O	O	O	O
Hemochromatosis (iron overload)	O	O	O	O	O
Sibling 4					
Coeliac disease	O	O	O	O	O
Hemochromatosis (iron overload)	O	O	O	O	O
Sibling 5					
Coeliac disease	O	O	O	O	O
Hemochromatosis (iron overload)	O	O	O	O	O

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:

☐☐ / ☐☐ / ☐☐☐☐

THANK YOU

WE APPRECIATE THE TIME THAT YOU HAVE SPENT COMPLETING THIS QUESTIONNAIRE

Office use only

DAT ☐ QCOM ☐ WI ☐