## History by System

### Ophthalmology

1. Strabismus: [ ]  Yes [ ]  No [ ]  Unknown
2. Glaucoma: [ ]  Yes [ ]  No [ ]  Unknown
3. Myopia: [ ]  Yes [ ]  No [ ]  Unknown
4. Retinal detachment: [ ]  Yes [ ]  No [ ]  Unknown
5. Cataracts: [ ]  Yes [ ]  No [ ]  Unknown

### Auditory

1. Any history of deafness? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date first detected (yyyy-mm):

### Pulmonary

1. Any difficulty breathing? [ ]  Yes [ ]  No [ ]  Sometimes
2. If Yes, is difficulty breathing related to meal times? [ ]  Yes [ ]  No [ ]  Unknown
3. History of aspiration? [ ]  Yes [ ]  No [ ]  Unknown
4. Any swallowing study done? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date swallowing study done (yyyy-mm):

1. Any pulmonary function tests done? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date done (yyyy-mm):

1. Any snoring? [ ]  Yes [ ]  No
2. Any sleep study done? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date sleep study done (yyyy-mm):

1. Wheezing? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, how often do you use nebulizer? [ ]  Daily [ ]  Monthly [ ]  As needed

1. History of asthma? [ ]  Yes [ ]  No
	1. If Yes, steroid pills or liquid medication for asthma? [ ]  Yes [ ]  No
	2. If Yes, steroid inhalers (Qvar, Flovent)? [ ]  Yes [ ]  No

If Yes, how often? [ ]  Daily [ ]  Monthly [ ]  As needed

1. BiPAP currently? [ ]  Yes [ ]  No [ ]  Unknown
2. If Yes, how many hours a day? [ ]  0-4 hours/day [ ]  5-16 hours/day [ ]  > 16 hours/day
3. If Yes, when started (yyyy-mm)
4. BiPAP only with hospitalization or illness: [ ]  Yes [ ]  No [ ]  Unknown
5. Ventilator: [ ]  Yes [ ]  No [ ]  Unknown

If Yes, how many hours a day? :hours/day

1. Mechanical In/Ex-sufflation (cough assist):

[ ]  Daily

[ ]  Only when ill

[ ]  Don’t Use

[ ]  Unknown

1. Are you currently using IPPB?

[ ]  Daily [ ]  Only when ill [ ]  Don’t Use [ ]  Unknown

1. How many times have you required antibiotics for a cold or pneumonia in the last year?

[ ]  None [ ]  Once [ ]  2 times [ ]  3 times [ ]  4 times [ ]  > 5 times

### Cardiovascular

1. Is there a history of heart arrhythmia? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date first detected (yyyy-mm):

1. Is there a history of an enlarged heart? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date first detected (yyyy-mm):

If Yes, how detected: [ ]  Chest X-ray [ ]  Echocardiogram

### Endocrine

1. Any history of early puberty? [ ]  Yes [ ]  No
2. If female, at what age did you notice breast bud formation? years [ ]  N/A
3. If female, start of her period (menarche)? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date of onset (yyyy-mm):

1. Any history of vitamin D deficiency? [ ]  Yes [ ]  No
2. Any DEXA scan performed? [ ]  Yes [ ]  No

If Yes, date performed (yyyy-mm):

Any history of osteoporosis? [ ]  Yes [ ]  No

 Ever have diabetes? [ ]  Yes [ ]  No

### Abdominal/GI

1. History of difficulty eating?[ ]  Yes [ ]  No [ ]  Unknown
2. History of difficulty swallowing? [ ]  Yes [ ]  No [ ]  Unknown
3. History of constipation? [ ]  Yes [ ]  No [ ]  Unknown
4. Ever have a kidney problem? [ ]  Yes [ ]  No
5. Ever have a liver problem? [ ]  Yes [ ]  No

If Yes, was this an elevation in the liver enzyme (AST/ALT) only? [ ]  Yes [ ]  No

### Genito-Urinary

1. Frequent urinary tract infections? [ ]  Yes [ ]  No [ ]  Unknown

### Musculoskeletal

1. Broken bones? [ ]  Yes [ ]  No [ ]  Unknown
	1. If Yes, total number of broken bones:
	2. If Yes, specify bones broken and mechanism broken:

[ ]  Femur, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Tibia/Fibula, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Radius/Ulna, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Vetebral body, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Humerus, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Carpal, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

1. Joint dislocation? [ ]  Yes [ ]  No [ ]  Unknown
	1. If Yes, total number of joint dislocations:
	2. If Yes, specify joints dislocated and mechanism:

[ ]  Elbow, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Patella (knee cap), mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Wrist, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

[ ]  Shoulder, mechanism:

[ ]  Major Trauma

[ ]  Minor Trauma (slip and fall)

1. Scoliosis: [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date first detected (yyyy-mm):

### Neurologic

1. Seizure: [ ]  Yes [ ]  No [ ]  Unknown
	* 1. If Yes, date of onset (yyyy-mm):
		2. What kind of seizure:

[ ]  Grand mal

[ ]  Partial complex

[ ]  Absence

[ ]  Febrile

[ ]  Don’t know

1. Attention deficit disorder: [ ]  Yes [ ]  No [ ]  Unknown
2. Is there a learning disability? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, is the learning disability characterized as mental retardation (IQ <70) either through formal IQ testing or exam? [ ]  Yes [ ]  No

1. Behavioral issues? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date of onset (yyyy-mm):

### Psychiatric

1. Anxiety: [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date of onset (yyyy-mm):

1. Depression: [ ]  Yes [ ]  No [ ]  Unknown

If Yes, date of onset (yyyy-mm):

### Pain

1. Pain? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, area of body:

1. Pain with certain position? [ ]  Yes [ ]  No [ ]  Unknown

If Yes, specify

1. Pain with exercise? [ ]  Yes [ ]  No [ ]  Unknown

## General Instructions

Medical History data are collected to verify the inclusion and exclusion criteria (e.g., no history of psychiatric disabilities) and to describe the study population. Typically, the Medical History Form captures conditions that EVER occurred at some point in time within a protocol-defined period (e.g., the last 12 months).

## Specific Instructions

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.

The CRF includes all instructions available for the data elements at this time. More detailed instructions will be added in Version 1.0 of this CRF Module.