## 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.