THE CHILDREN'S MEMORIAL HOSPITAL
Division of Immunology/Rheumatology
INITIAL PHONE INTERVIEW

Family Member Interviewed: (Relationship: mom, dad, grandparent, guardian, self, other)

Interview Date: ___/___/___

OFFICIAL USE ONLY

When did your child first have the JDMS rash (face, hands, elbows, knees, etc)? Date: ____________

When did your child first have the JDMS weakness (unable to get up, falls, trouble getting dress, hoarseness, trouble climbing stairs, or keeping up with other children during physical activity / play, etc)? Date: ____________

When was your child diagnosed with JDMS Date: ____________?

1. During the three months prior to [the onset of JDMS / Onset date] did your child have any illness(es)?
   0 = NO  1 = YES  8 = Don't Know

   If YES continue and begin in order of occurrence. If NO, skip to questions # 10

2. Illness #1: If yes, which of the following symptoms / illness episodes did the child have?

   (A) Fever
   (B) Cough
   (C) Sore Throat
   (D) Runny Nose
   (E) Headache
   (F) Tiredness
   (G) Nausea or upset stomach
   (H) Vomiting
   (I) Diarrhea (>=3 loose or watery stools/ day)
   (J) Rash
   (K) Earache
   (L) Cold or Flu
   (M) Respiratory illnesses (Pneumonia, Asthma, Bronchitis)
   (N) Weight Loss
   (O) Other Illnesses (Please Specify) __________________________
   (P) Weakness
      (1 = am, 2 = pm, 3 = All Day, 8 = don't know, 9 = Miss)

   A
   B

1
(Q) Muscle Pain
(R) Arthritis (joint swelling / pain)
(S) Abdominal pain
(T) Blood in the stool
(U) Difficulty swallowing
(V) Difficulty speaking or "nasal-sounding" speech
(W) Lumps or calcification, e.g. under the skin
(X) Shortness of breath
(Y) Tightness in joints
(Z) Pits (depressions) in tips of fingers
(AA) Coldness of hands
(BB) Change in color of hands or feet
(CC) Stiffness
(DD) Paronychia (having nail/cuticle infection
(EE) UTI (pain upon urination)
(FF) Otitis Media (ear infection)
(GG) Strep Throat (with positive culture)

3. Did you contact or visit a physician for this illness?
   0 = No    1 = Yes    8 = Don't Know

4. If YES, what was the physician's diagnosis?
   (0 = No, 1 = Yes, 8 = Don't Know )
   a. Myositis
   b. A "flu" syndrome or cold
   c. A virus
   d. Pneumonia
   e. Strep infection w/ culture positive
   f. Hand/foot/mouth disease
   g. Other - Specify______________________

5. Did your child receive any medications for this illness including:
   (0 = No, 1 =Yes, 8 = Don't Know )
   a. Cough/Cold preparations
   b. NSAIDS (Ibuprofen Advil, etc.)
   c. Prednisone/Solumedrol
   d. Antibiotic
   e. Other (please specify__________________________)

If no other illnesses, skip to Question #10.
6. **Illness #2** If yes, which of the following symptoms / illness episodes did the child have?

   (A) Fever
   (B) Cough
   (C) Sore Throat
   (D) Runny Nose
   (E) Headache
   (F) Tiredness
   (G) Nausea or upset stomach
   (H) Vomiting
   (I) Diarrhea (>=3 loose or watery stools/ day)
   (J) Rash
   (K) Earache
   (L) Cold or Flu
   (M) Respiratory illnesses (Pneumonia, Asthma, Bronchitis)
   (N) Weight Loss
   (O) Other Illnesses (Please Specify)______________________________
   (P) Weakness
      \(^{1=am, 2=pm, 3=AllDay, 8=don't know, 9=Miss}\)
   (Q) Muscle Pain
   (R) Arthritis (joint swelling / pain)
   (S) Abdominal pain
   (T) Blood in the stool
   (U) Difficulty swallowing
   (V) Difficulty speaking or "nasal-sounding" speech
   (W) Lumps or calcification, e.g. under the skin
   (X) Shortness of breath
   (Y) Tightness in joints
   (Z) Pits (depressions) in tips of fingers
   (AA) Coldness of hands
6. Illness #2 continued...

(BB) Change in color of hands or feet

(CC) Stiffness

-DD Paronychia (having nail/cuticle infection

(EE) UTI (pain upon urination)

(FF) Otitis Media (ear infection)

(GG) Strep Throat (with positive culture)

7. Did you contact or visit a physician for this illness #2?
   0 = No  1 = Yes  8 = Don't Know

8. If YES, what was the physician's diagnosis?
   (0 = No, 1 = Yes, 8 = Don't Know )
   a. Myositis
   b. A "flu" syndrome or cold
   c. A virus
   d. Pneumonia
   e. Strep infection w/ culture positive
   f. Hand/foot/mouth disease
   g. Other - Specify __________________________

9. Did your child receive any medications for this illness including:
   (0 = No, 1 = Yes, 8 = Don't Know )
   a. Cough/Cold preparations
   b. NSAIDS (Ibuprofen Advil, etc.)
   c. Prednisone/Solumedrol
   d. Antibiotic
   e. Other (please specify __________________________)

10. Did your child take any other medications for any reason, during the 3
    months prior to [the onset of JDM5 / Onset date]?
    0 = No  1 = Yes  8 = Don't Know

    If YES, please specify:

    Drug: __________________________
    Purpose: __________________________

    a. __________________________
    b. __________________________
    c. __________________________

8 Onset
a.____
b.____
c.____
d.____
e.____
f.____
9.____
**Patient Code: __________**

11. Did any individuals living in the home or friends/playmates of the child have an illness during the 3 months prior to [the onset of JDMS / Onset date]?
   
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
<td>Don't Know</td>
</tr>
</tbody>
</table>

If YES, Please specify below:

<table>
<thead>
<tr>
<th>Relationship to child</th>
<th>Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>e.</td>
</tr>
<tr>
<td>b.</td>
<td>f.</td>
</tr>
<tr>
<td>c.</td>
<td>g.</td>
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<tr>
<td>d.</td>
<td>h.</td>
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</tbody>
</table>

Please enter 11a-h

B. HISTORY OF THE JDMS CASE

12. After the symptoms of rash and/or weakness first began, did you see family doctor, pediatrician, etc.?
   
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If YES, what type(s) of doctor(s):

<table>
<thead>
<tr>
<th>Name of doctor</th>
<th>Specialty</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a.</td>
<td>e.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
<td>f.</td>
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<tr>
<td></td>
<td>c.</td>
<td>g.</td>
</tr>
<tr>
<td></td>
<td>d.</td>
<td>h.</td>
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</table>

Please enter doctor’s name, specialty and date (questions 12a-h)

13. Were any medications prescribed for your child for JDMS?
   
<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If YES, please comment:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Rx by MD? (Yes/No)</th>
<th>Dose (ml/kg/day)</th>
<th>Date Started</th>
<th>Date Ended</th>
<th>MD Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
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<tr>
<td>b.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
14A. Has your child been evaluated by a Physical Therapist?
    0 = No  1 = Yes  8 = Don't know

14B. Has your child been evaluated by an Occupational Therapist?
    0 = No  1 = Yes  8 = Don't know

If NO, skip to Question 18.

15. ________

15. Were exercises prescribed?
    0 = No  1 = Yes  8 = Don't know

   If YES, how often:
    1 = Daily  2 = 3x weekly  3 = other -- please specify ____________
    8 = Don't know

16. ________

16. Are you performing these exercises?
    0 = No  1 = Yes

   If YES, how often:
    1 = Daily  2 = 3x daily  3 = other -- please specify__________
    8 = Don't Know

17. ________

17. Are you currently being followed by a therapist?
    0 = No  1 = Yes

18. Which of the following statements describes your child's strength and activity status:

18a. ________ a) At Onset of Symptoms?_____ b) At Diagnosis?_____

18b. ________ c) Now (today)?_____

18c. ________ I will read 4 descriptions:
    1 = Normal strength, participates in all activities, keeps up with friends/playmates
    2 = Some weakness obvious, participates in all activities, can't keep up with friend completely
    3 = Weakness obvious, activity limited but able to attend school and/or interact with friends/playmates
    4 = Significantly weak, unable to attend school and/or interact with friends/playmates on a full-time basis

18d. ________ d) What level (1-4 above) describes the weakest you have ever seen your child?

18e. ___/___/___ e) When?_____/_____/_____

19. What symptoms has the child with the JDMS had?
    (0 = Never present, 1 = Present in the past but not now
    2 = Present now, 8 = Don't know)

   a. Weakness
   b. Muscle pain
   c. Fever
   d. Rash
   e. Arthritis (joint swelling / pain)
   f. Abdominal pain
   g. Blood in the stool
   h. Difficulty swallowing
   i. Difficulty speaking or "nasal-sounding" speech
   j. Lumps or calcification, e.g. under the skin
   k. Shortness of breath
   l. Tightness in joints
   m. Pits (depressions) in tips of fingers.
   n. Coldness of hands
   o. Change in color of hands or feet
   p. Stiffness

   Please Specify:  1=AM  2=PM  3= All day  8= Don't know
C. FAMILY BACKGROUND

20. In what town was your child born?

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>COUNTRY</th>
<th>DATES (MM/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>____</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
</tbody>
</table>

21. Where has he/she lived since birth?

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>COUNTRY</th>
<th>DATES (MM/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
<tr>
<td>b.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
<tr>
<td>c.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
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<tr>
<td>d.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
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<tr>
<td>e.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
</tbody>
</table>

22. List other places your child and family have visited since your child’s birth, starting with the most recent:

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>COUNTRY</th>
<th>DATES (MM/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
<tr>
<td>b.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
<tr>
<td>c.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
<tr>
<td>d.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___ to ___</td>
</tr>
</tbody>
</table>

23. Please list any health related issues that arose during these trips. Please include any illnesses, insect bites, reactions to food or insect bite or any reason for seeking medical treatment.

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>COUNTRY</th>
<th>OCCURRENCE</th>
<th>DATES (MM/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___</td>
<td>___ to ___</td>
</tr>
<tr>
<td>b.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___</td>
<td>___ to ___</td>
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<tr>
<td>c.</td>
<td>____</td>
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<td>___ to ___</td>
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<tr>
<td>d.</td>
<td>____</td>
<td>____</td>
<td>____</td>
<td>___</td>
<td>___ to ___</td>
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</tbody>
</table>

24. List the adults with whom your child was living [at the onset of JDMS/during ____].

<table>
<thead>
<tr>
<th>Relationship to Child</th>
<th>Birth Date</th>
<th>Occupation</th>
<th>Highest grade Completed</th>
<th>FT/PT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Mom</td>
<td>f. <em><strong>/</strong></em></td>
<td>k. _______</td>
<td>p. _______</td>
<td></td>
</tr>
<tr>
<td>b. Dad</td>
<td>g. <em><strong>/</strong></em></td>
<td>l. _______</td>
<td>q. _______</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>h. <em><strong>/</strong></em></td>
<td>m. _______</td>
<td>r. _______</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>i. <em><strong>/</strong></em></td>
<td>n. _______</td>
<td>s. _______</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>j. <em><strong>/</strong></em></td>
<td>o. _______</td>
<td>t. _______</td>
<td></td>
</tr>
</tbody>
</table>
25. List the total number of adults living in the household:

26. List the total number of children living in the household:

27. Is the child adopted?  
   0 = No  1 = Yes  

   If YES, skip to 63  

   If NO, continue . . .

Has anyone in the family been told by a doctor that he/she has ever had any of the following medical conditions? (Think of the following relatives of the child: mother, father, grandmother, grandfather, aunt, uncle, sister, brother, cousin).

28. Lupus/SLE  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

29. Scleroderma  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

30. Dermatomyositis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

31. Polymyositis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

32. Rheumatoid Arthritis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

33. Osteoarthritis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

34. Hyperthyroidism  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

35. Hypothyroidism  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

36. Sjogren's Syndrome  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

37. Raynaud's Syndrome  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

38a. Diabetes (with insulin)  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

38b. NIDDM (without insulin)  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

39. Myasthenia gravis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

40. Multiple sclerosis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

41. Epilepsy/seizures  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

42. Ulcerative colitis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

43. Crohn's disease  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

44. Addison's disease  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

45. Pernicious anemia  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

46. Vasculitis  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

47. Cancer  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

48. Premature ovarian failure  (0=No, 1=Yes, 8=Don't Know) Who?_____________________

48a. Miscarriages  (0=No, 1=Yes, 8=Don't Know) Who?_____________________
49. Is there a history of the miscarriages, stillbirths, or malformed infants in the mother?
   0 = No  1 = Yes  8 = Don't Know
   a. Total number of miscarriages ________
   b. Total number of stillbirths ________
   c. Total number of malformed infants ________

50. Is there any history of psychological problems in the family?
    0 = No  1 = Yes  8 = Don't Know
    If YES please specify who and why ________________________

51. Any history of alcohol abuse in the family?
    0 = No  1 = Yes  8 = Don't Know
    If YES please specify who ________________________

52. Any history of substance abuse?
    0 = No  1 = Yes  8 = Don't Know
    If YES please specify who ________________________

53. Any history of schizophrenia?
    0 = No  1 = Yes  8 = Don't Know
    If YES please specify who ________________________

54. Any history of depression or manic bipolar disorder?
    0 = No  1 = Yes  8 = Don't Know
    If YES please specify who ________________________

55. Any history of anyone receiving counseling or therapy?
    0 = No  1 = Yes  8 = Don't Know
    If YES please specify who and why ________________________
D. THE CHILD'S MEDICAL BACKGROUND

60. Did the mother have difficulty becoming pregnant or carrying the pregnancy?
   0 = No    1 = Yes    8 = Don't know

61. Did your child have any problem(s) which caused him/her to remain in the hospital more than five
days after birth?
   0 = No    1 = Yes    8 = Don't Know

   If YES, please specify ________________________________________________________________

62. Has the mother ever had breast implant?
   0 = No    1 = Yes    8 = Don't Know

63. How was _____________ (name) fed as a baby?
   1 = Breast     2 = Formula     3 = Breast & formula (milk)
   8 = Don't know

64. Wks ______
    Mons ______
    If exclusively breast-fed OR with supplement, until what age?
    Weeks _______ OR Months ________

65. If bottled-fed OR breast-fed and supplemented, what kind of milk did ___________ (name)
    receive? (0 = No, 1 = Yes, 8 = Don't Know)
    a. Cow's milk formula (Similac, Enfamil)
    b. Cow's milk
    c. ____________
    d. Soy bean formula (Isomil, Prosobee)
    d. Other

66. Wks ______
    Mons ______
    At what age was solid food introduced?
    Weeks ________ OR Months ________

(Question 67 was deleted)
68. Has your child ever been hospitalized or had surgery?
   0 = No  1 = Yes  8 = Don't Know

   Please enter question 68 a-d.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Name of Hospital, City, State</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
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<tr>
<td>b.</td>
<td></td>
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<tr>
<td>c.</td>
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<tr>
<td>d.</td>
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</tbody>
</table>

69. Has your child had any fractures?
   0 = No  1 = Yes  8 = Don't Know

   If YES, specify:

<table>
<thead>
<tr>
<th>LOCATION OF FX</th>
<th>NUMBER OF FX</th>
<th>DATE OF FX</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
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<tr>
<td>b.</td>
<td></td>
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<tr>
<td>c.</td>
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</tbody>
</table>

70. Has a physician ever diagnosed the following conditions in your child?
   (0 = No, 1 = Yes, 8 = Don't Know)
   a. Asthma
   b. Hay Fever
   c. Hives
   d. Insect Allergy
   e. Food Allergy
   f. Animal Allergy
   g. Drug Allergy
   h. Latex Allergy or Sensitivity

71. Has a physician ever diagnosed any other major medical conditions or psychological
    Condition in your child?  0 = No  1 = Yes  8 = Don't Know

   Please enter question 71a-d

   If YES, please specify (include dates)

   | a.                         | to         |
   | b.                         | to         |
   | c.                         | to         |
   | d.                         | to         |

72. Has the child received the following immunizations?
   (0 = No, 1 = Yes, 8 = Don't Know)
   a. Measles
   b. Mumps (also Known as MMR)
   c. Rubella
   d. Diphtheria
   e. Pertussis (also Known as DPT)
   f. Tetanus
   g. Polio (also Known as OPV)
   h. Hib (Hemophilus Influenza Type B)
   i. Pneumovax (Pneumococcal Vaccine)
   j. Hepatitis Vaccine
   k. Smallpox
   l. Vercella (Chicken Pox)
   m. Other (such as "flu shots", typhoid, etc.) -- specify __________________________
73. Did your child receive any of these immunizations within three months of [the onset of JDMS/?]

   (0 = No, 1 = Yes, 8 = Don't Know)

   a. Measles
   b. Mumps
   c. Rubella
   d. Diphtheria
   e. Pertussis
   f. Tetanus
   g. Polio
   h. HIB
   i. Pneumovax
   j. Hepatitis Vaccine
   k. Smallpox
   l. Varicella (Chicken Pox)
   m. Other. Please specify ________________

If NO, skip to Question #75

74. Has your child ever had an unusual reaction to any immunization?

   0 = No       1 = Yes       8 = Don't Know

If YES, continue:

<table>
<thead>
<tr>
<th>Type of Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. High Fever</td>
</tr>
<tr>
<td>b. Seizures</td>
</tr>
<tr>
<td>c. Rash</td>
</tr>
<tr>
<td>d. Arthritis</td>
</tr>
<tr>
<td>e. Other</td>
</tr>
</tbody>
</table>

75. Has your child ever had a case of the following illnesses?

   (0 = No, 1 = Yes, 8 = Don't Know)

   a. Measles ("Hard Measles", "Red Measles")
   b. Mumps
   c. Rubella ("German Measles")
   d. Diphtheria
   e. Pertussis ("Whooping Cough")
   f. Tetanus
   g. Polio
   h. Hepatitis
   i. Smallpox
   j. Varicella ("Chicken Pox")
E. ENVIRONMENT

76. Did any of the following personal/family events (considered by some to be stressful) happen in your child's life [three months before onset of JDMS/during_________]?
   0 = No  1 = Yes  8 = Don't Know
   (0 = No, 1 = Yes, 8 = Don't Know)
   a. Hospitalization of brother or sister?
   b. Marital separation or divorce of parents?
   c. Death of parent?
   d. Addition of person(s) to family not by birth? (e.g. grandparent(s)/cousin moving in)
   e. Birth of brother or sister?
   f. Jail sentence of parent?
   g. Death of brother or sister?
   h. Serious illness requiring hospitalization of parent?
   i. Brother or sister leaving home?
   j. Marriage of parent to step parent?
   k. Death of a close friend?
   l. Change in parents employment?
   m. Death of a grandparent?
   n. Loss of a job by a parent?
   o. Move to a new residence?
   p. Acquiring a visible deformity or handicap (Includes getting eyeglasses)?
   q. Failure of a grade in school?
   r. Move to a new school district or change of school?
   s. Becoming involved in drugs or alcohol?
   t. Discovery of being adopted
   u. Suspension from school?
   v. Beginning to go on dates?
   w. Other (specify)

77. During the three months before onset of JDMS did your child go to school, preschool or day care?
   0 = No  1 = Yes

77. If YES, please complete:
   Name of School ____________________________
   City, State ________________________________
   a. Number of hours/week attended ________
   b. Number of children in classroom ________

78. How many days of school has your child missed in the last year which related to:
   a) this illness? ________________  b) other illnesses? ________________

79. During the three months before onset of JDMS, did your child have any insect bites?
   0 = No  1 = Yes  8 = Don't Know

79. If YES, please complete (0=No, 1=Yes, 8=Don't know):
   a. Tick bites
   b. Mosquito bites
   c. Flea bites
   d. Bee/wasp/hornet stings
   e. Other
80. During the three months before onset of JDMS did your child experience sunburn on any part of their body? 0 = No 1 = Yes 8 = Don’t know
   a) ____________
      a) Did this exposure result in a reaction greater than normal/expected? 0 = No 1 = Yes 8 = Don’t know
   b) ____________
      b) If YES, did the disease change? 0 = Same 1 = Better 2 = Worse 8 = Don’t Know

81. ____________
   During the three months before onset of JDMS did your child experience extensive or prolonged exposure to the sun? 0 = No 1 = Yes 8 = Don’t know
   a) ____________
      a) Did this exposure result in a reaction greater than normal/expected? 0 = No 1 = Yes 8 = Don’t know
   b) ____________
      b) If YES, did the disease change? 0 = Same 1 = Better 2 = Worse 8 = Don’t Know

82. _________
   How would you describe the neighborhood of the child’s home?
      1 = City 2 = Suburban 3 = Edge of town 4 = Farm or rural

83. ____________
   What is the population of your town?
      1 = < 1,000 2 = 1,000 - 2,500 3 = 2,500 - 5,000
      4 = 5,000 - 10,000 5 = 10,000 - 25,000 6 = 25,000 - 50,000
      7 = 50,000 - 100,000 8 = > 100,000

84. ____________
   What type of dwelling does your child live in?
      1 = House 2 = Trailer 3 = Apartment
      4 = Townhome/Condominium 5 = Shelter/homeless

85. ____________
   How old is the current residence?
      1 = 0-10 years 2 = 11-20 years 3 = 21-40 years
      4 = > 40 years 8 = Don’t know

86. Yrs ____________
    Mos ____________
   How long has your child lived at this address? Yrs. _______ Mos. _______

87. ____________
   Does your family live near water within a 5 mile radius? (0 = No, 1 = Yes, 8 = Don’t know)
   a. ________
      a. Retention pond
   b. ________
      b. Stream
   c. ________
      c. Lake
   d. ________
      d. Ocean
   e. ________
      e. River
   f. ________
      f. Swimming pool
   g. ________
      g. Other________

88. ____________
   Has your child ever lived near water? When? (0 = No, 1 = Yes, 8 = Don’t know)
   a. ________
      a. Retention pond
   b. ________
      b. Stream
   c. ________
      c. Lake
   d. ________
      d. Ocean
   e. ________
      e. River
   f. ________
      f. Swimming pool
   g. ________
      g. Other________
89. Has your child ever vacationed near water?
   (0=No, 1=Yes, 8=Don’t know)
   a. Retention pond
   b. Stream
   c. Lake
   d. Ocean
   e. River
   f. Swimming pool
   g. Other________________

90. Does your child frequently go swimming?
   (0=No, 1=Yes, 8=Don’t know)
   a. Pool
   b. Lake
   c. Ocean
   d. Other________________

91. What kind of drinking water supply do you have?
   (0=No, 1=Yes, 8=Don’t know)
   a. Well Water
   b. City
   c. Bottled water
   d. Spring water
   e. Other________________

92. Are there any factories, industrial plants, business, landfills, garbage dumps or toxic waste sites near the child’s home (within a five mile radius) that emit fumes, gases or particles of any kind?
   Please enter 92 a-c
   0 = No   1 = Yes   8 = Don’t Know

   If YES, please indicate type of Industry:
   a. ________________________________
   b. ________________________________
   c. ________________________________

93. Is your child exposed to animals or pets on a regular basis?
   0 = No  1 = Yes  8 = Don’t know

   If YES, continue (0 = No, 1 = Yes, 8=Don’t Know)
   Domestic
   a. Dogs
   b. Cats
   c. Gerbils
   d. Hamsters
   e. Birds
   f. Other domestic __________________

   Farm
   g. Cows
   h. Pigs
   i. Sheep
   j. Chickens
   k. Other farm ____________________

   Wild
   l. Rabbits
   m. Squirrels
   n. Deer
   o. Other wild______________________
94. If animals are present, have any been ill recently?
   0 = No  1 = Yes  8 = Don't know

95. Does anyone living in the child's home smoke regularly?
   0 = No  1 = Yes  8 = Don't know
   If YES, please specify:
   1 = Cigarettes  2 = Cigar  3 = Pipes
   4 = Other

   a. Mother  # of packs/day
      # of years
   b. Father  # of packs/day
      # of years
   c. The child
      # of packs/day
      # of years
   d. Siblings
      # of packs/day
      # of years
   e. Other    # of packs/day
      # of years
   f. Other    # of packs/day
      # of years

96. Are any of the following products used in the home (or are carried home via clothing etc.) more
    than once per year?
   0 = No, 1 = Yes, 8 = Don't Know

   a. Paint
   b. Turpentine
   c. Glue
   d. Linseed Oil
   e. Clay
   f. Solvents
   g. Other chemicals

97. Is there anything that you feel might have contributed this illness in your child?
   0 = No  1 = Yes  8 = Don't Know

   __________________________________________________________

   Was your child taking any traditional/ethnic/home remedies for his/her symptoms:
   A) Before Dx:
   __________________________________________________________
   ___________________________________________________________________
   B) After Dx:
   __________________________________________________________
   ___________________________________________________________________

THAT CONCLUDES THE QUESTIONNAIRE. THANK YOU VERY MUCH FOR GIVING US THIS INFORMATION. IF
YOU HAVE ANY QUESTIONS FOR ME, I WOULD BE HAPPY TO TRY TO ANSWER THEM.