

DOCUMENT R

An Initiative of the International Centre for Child Studies

A national study of all children born 5th-11th April 1970 in England, Wales and Scotland originating from the 1970 Birth Cohort of the National Birthday Trust Fund

MEDICAL EXAMINATION FORM

STRICTLY CONFIDENTIAL



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PLEASE USE BLOCK CAPITALS

Teenager's Surname

Teenager's Forename(s) (SEX86) Sex: M F

Teenager's Home Address

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Telephone Number Postcode

Date of Birth 0 4 7 0 (DOB86)

Health District Today's date (RDOC-MT)
(RDOC-YR)

Name of Examining Medical Officer: Status: e.g. SCMO, CMO, etc. MOSTAT*

INTRODUCTORY NOTES

May we take this opportunity to thank you for carrying out this examination on behalf of Youthscan UK. For your assistance, a short instruction manual for health personnel is provided with this examination form. This includes an outline of the historical background of the Study, a near-vision test sheet and some procedural details.

You will need the following equipment for the medical examination:

PROCEDURE:	EQUIPMENT RECOMMENDED:
Height	Steel/wooden measuring rod or steel tape measure. If not available, stadiometer on back of weighing machine should be used.
Weight	Beam balance, or other accurate apparatus. Please calibrate this to zero initially.
Head Circumference	Paper or plastic-covered tape measure.
Distant Vision	Standard Snellen Chart (or equivalent).
Near Vision	Near Vision card of Sheridan-Gardiner type, reproduced in instruction manual, by kind permission of the authors.
Blood Pressure	Mercury sphygmomanometer. Please use an adult-size cuff and not small cuff designed for children. The bladder within the cuff should be deep enough to cover about two-thirds of the length of upper arm and long enough to circle the arm completely.
Motor Co-ordination Tests	Tennis or rubber ball; a piece of chalk; stop-watch or a watch with second hand.
Audiogram	Audiometer for sweep audiogram. An audiogram form is provided on this form for recording result of sweep or pure-tone audiogram.

KEY: * indicates ALPHANUMERIC (TEXT) VARIABLE.

In addition, access to all the following will be needed for completion of medical examination form.

Completed Parental Interview Form

This will contain some medical and family details.

Health Records etc.

School medical record cards(s); any available screening records, assessment results, hospital reports, etc.; health file on any children with handicap or disability.

NOTE: IF ONE OR MORE OF THE ABOVE ITEMS IS NOT AVAILBLE PLEASE COMPLETE THE MEDICAL EXAMINATION AS FAR AS POSSIBLE.

Introduction

Most, but not all, of the cohort and their parents have already participated in this Study, either in the perinatal period, intermediately, or at five or ten years.

At five and ten years, health visitors of your DHA carried out an extensive review of the health, development and pre-school care.

At ten years we were able, through your DHA, to identify members of the cohort who had health problems, disabilities and handicaps. Health Visitors and Community Medical Officers kindly conducted interviews and examinations.

Parents of the teenagers have this time received a letter explaining the 16 year Study, inviting their co-operation and ensuring them of confidentiality.

This time some of the mothers will already have been interviewed at home by a health visitor/school nurse; for the remainder, the home interview could be done subsequently, or accomplished at the same time as the medical examination provided that the mother agrees to attend at that time. The documents needed for the maternal interview consist of The Parental Interview Form (Document O), The Maternal Self-Completion Form (Document P) and The Teenage Leisure Diary (Document S). For the medical examination the following documents are needed (i) The Medical Examination Form (Document R), (ii) The Teenage Health Self-Completion Questionnaire, which should be completed by the teenager at the time of attendance for the medical examination (iii) The Information Manual for Health Personnel (Document N), includes the necessary instructions and contains a Sheridan-Gardiner Near Vision sheet for testing near vision.

Your Local Education Authority has kindly traced the whereabouts of the cohort in your DHA and has arranged a separate school educational assessment of each teenager, including tests of reading, vocabulary, mathematics, matrices and spelling; from this, it will be possible to identify slow learners and teenagers with educational as well as health problems.

THE MEDICAL EXAMINATION FORM IS IN THREE SECTIONS

Section 1. (A) Use of Service, (B) Disabilities (pages 3 and 4)

In order to complete this section fully, you will need to assemble all the teenager's school medical records and all other relevant school health and educational documents. You are asked to pay particular attention to assembling complete records of any teenager who is handicapped, receiving special education, or who has been assessed for special educational needs. You will be asked to provide a summary from the notes of the progress and current status of each such teenager. Even if only partial records are accessible to you, please complete all Sections of this questionnaire as far as possible at the time of the medical examination.

Section 2. (A) Morbidity and Special Senses, (B) Medical Examination (pages 4-9)

Please make sure that the recommended equipment is available. Please read in advance if you have time, the medical history from the Parental Interview Form if already completed. Please read through the medical questions carefully before the examination. If you have time, please try out the co-ordination tests. The medical examination is structured to provide the maximum information while leaving you free to conduct the clinical examination in any way you find optimal. Tests such as distant and near vision and measurements of height, weight, head circumference and blood pressure have been aggregated in the medical examination form, in case it proves expedient to carry these out just prior to the actual clinical examination. Please feel free to undertake the necessary measurements, in the order which best suits the facilities available to you and anyone helping you with the examination.

Section 3: Medical Summary. This is self-explanatory (pages 10 and 11)

Section 4: The Audiogram (page 12)

An Audiogram form is on the last sheet of the examination form. It is presumed that this will be done by sweep audiometry. The form also contains space in case pure-tone audiometry is used. You are asked to record whether the results of sweep audiometry are normal or abnormal and if sweep results are abnormal, to arrange to let us have details of pure-tone audiometry. In instance where sweep audiometry is impossible to arrange, or is delayed unavoidably, the remainder of completed health documents should be sent on to us in advance of the audiogram.

EXAMPLE OF HOW TO COMPLETE QUESTIONS

Has colour vision ever been tested?		Tick one box	
YES	<input checked="" type="checkbox"/>	If YES, what was the outcome?	Tick one box
NO	<input type="checkbox"/>		
NOT KNOWN	<input type="checkbox"/>		
		Colour vision normal	<input type="checkbox"/>
		Red/green vision impaired	<input type="checkbox"/>
		Other colour loss	<input checked="" type="checkbox"/>
		(please describe _____	

<i>This means that colour vision has been tested and that there is blue/green imperment.</i>			

SECTION 1A. USE OF SERVICES

A1. Where is this medical examination taking place?

(RA1) Tick one box

School

Child Health Clinic

GP Surgery/Health Centre

Young person's home

Elsewhere

Please specify (RA1.1)*



A2. Has this study teenager ever had school medical examination/developmental checks/vision or hearing tests)?

(RA2)

YES

NO

NOT KNOWN

If YES, at what age(s) were procedures carried out Tick all that apply on each line
SEE SEPARATE LIST

	5	6	7	8	9	10	11	12	13	14	15
Examinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development Checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Screenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(What? **(RA2F)***)

A3. What screening or preventive procedures have been carried out since study teenager was 10 years old? (include tests, immunisations, screening, check ups)

Screening/Other Procedures	Reason	Venue	Age
1 (RA3A.1)*	(RA3A4.1) (RA3A4.2) (RA3A4.3) (RA3A4.4) (RA3A4.5) (RA3A4.6)		
2 (RA3B.1)*	(RA3B4.1) (RA3B4.2) (RA3B4.3) (RA3B4.4) (RA3B4.5) (RA3B4.6)		
3 (RA3C.1)*	(RA3C4.1) (RA3C4.2) (RA3C4.3) (RA3C4.4) (RA3C4.5) (RA3C4.6)		
4 (RA3D.1)*	(RA3D4.1) (RA3D4.2) (RA3D4.3) (RA3D4.4) (RA3D4.5) (RA3D4.6)		
5 (RA3E.1)*	(RA3E4.1) (RA3E4.2) (RA3E4.3) (RA3E4.4) (RA3E4.5) (RA3E4.6)		

A4. Is there any evidence that the study teenager has attended any of the following since 10 years old?

Answer (a) - (f) and tick one box on each line	Yes	No	Don't know	
a) Hearing clinic/consultant audiologist (RA4A.1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES, why? (RA4A.2)*
b) Eye clinic/consultant ophthalmologist (RA4B.1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES, why? (RA4B.2)*
c) Speech therapy (RA4C.1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES, why? (RA4C.2)*
d) Physiotherapy (RA4D.1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e) Child and Family Guidance Service (RA4E.1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES, why (RA4G.1)*
f) Other psychological or psychiatric opinion or treatment (RA4F.1) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(RA4G.2)*

A5. Where does this study teenager live and what type of school does he/she attend?

(RAS) Tick one box only

At home and attends ordinary school

At home and attends special unit attached to ordinary school

At home and attends day special school

In a residential special school

In a hostel and attends day special school

In a hospital for the subnormal

In any other situation

(What? **(RASA)***)

If attends other than ordinary school, please give name, address and designation of school institutions.
(RASB)*



A6. Has a decision been reached by a local education authority that the teenager is in need of special education help/provision?

(RA6) Tick one box

No, and not likely to be required

No, but likely to be required

No, but decision pending

Yes, waiting for a place

Yes, receiving special educational help

Yes, received special educational help in past, but no longer

Not known

If receiving/received special educational help, please answer 6(a) below.

6(a). What help was given, why, when and what has been the result? **(RA6A.1)***
(RA6A.2)*

SECTION 1B. DISABILITIES

B1. Is there any evidence that the study teenager has had any emotional or behavioural problem since 10 years?

(RB1) Tick one box

YES

NO

DON'T KNOW

If YES, please describe problem(s) and give age(s) when occurred

(RB1A.1) *

(RB1A.2) *

B2. Is there any evidence that this teenager has now or has had in the past any significant illness, developmental problem, defect or handicap?

(RB2) Tick one box

YES

NO

Insufficient information

If YES, please list conditions in chronological order of appearance on records, starting with earliest illness, developmental problem or handicap diagnosed.

	Diagnosis		Age first recorded	Disposal
1.	(RB2A.1) *	(RB2A.2) *	(RB2A.3)	(RB2A.4) *
2.	(RB2B.1) *	(RB2B.2) *	(RB2B.3)	(RB2B.4) *
3.	(RB2C.1) *	(RB2C.2) *	(RB2C.3)	(RB2C.4) *
4.	(RB2D.1) *	(RB2D.2) *	(RB2D.3)	(RB2D.4) *
5.	(RB2E.1) *	(RB2E.2) *	(RB2E.3)	(RB2E.4) *

B3. If the teenager has any disability or handicap for which he/she has had assessment for special educational help, please summarise the major findings, clinical progress and present state, from records and all other sources. Please include copies of relevant documentation, reports etc.

(RB3.1) *

(RB3.2) *

(RB3.3) *

(RB3.4) *

(if necessary, please continue on page 11).

SECTION 2A. MORBIDITY AND SPECIAL SENSES

C1. In the light of your clinical examination and the records you have seen, do you consider that there is evidence of any current hearing loss?

(RC1) Tick one box only

	Unilateral	Bilateral
YES, minimal	<input type="checkbox"/>	<input type="checkbox"/>
YES, moderate	<input type="checkbox"/>	<input type="checkbox"/>
YES, marked	<input type="checkbox"/>	<input type="checkbox"/>
NO		<input type="checkbox"/>
Uncertain		<input type="checkbox"/>
Not known		<input type="checkbox"/>

If YES, i.e. unilateral or bilateral loss, answer 1(a), 1(b) and 1(c) below

1(a) What is the probable cause?

(RC1.1) *

1(b) Do you consider that the hearing loss will interfere with normal schooling or everyday functioning? Tick one box

YES, severely (RC1.2)

YES, somewhat

NO

Unable to assess

1(c) Does the teenager wear a hearing aid?

YES (RC1.3)

NO

C2. How intelligible have you found the teenager's speech?

(RC2) Tick one box only

Fully intelligible

Almost all words are intelligible

Many words unintelligible

All, or nearly all, words unintelligible

Unable to assess

(please give reason (RC2.1) *)

C3. Has this teenager ever had any of the following conditions?

Answer (a) - (r) and tick all that apply on each line	Yes, in past 12 months	Yes, previous to past 12 months	Yes, but age not known	No, never	Not known
(a) Recurrent sore throats (3 or more in past year) (RC3.1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Middle ear infection/glue ear (RC3.2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Any hearing loss, perceptive or conductive (RC3.3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Eczema (RC3.4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Hay Fever (RC3.5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Asthma (RC3.6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Wheezy bronchitis (RC3.7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Bronchitis (RC3.8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Pneumonia (RC3.9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Pathological heart condition (RC3.10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Recurrent abdominal pain (RC3.11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Inguinal hernia (RC3.12)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Urinary infection (RC3.13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Wet bed more than occasionally since 10 years of age (RC3.14)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(o) Wet pants in daytime more than occasionally since 10 years of age (RC3.15)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(p) Soiled pants at any time since 10 years of age (RC3.16)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(q) Mental or educational retardation (RC3.17) (please specify (RC3.19)*)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(r) Any other significant illness or disability (RC3.18) (please specify (i) (RC3.20)*) (ii) _____ (iii) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. In your opinion is there any evidence of any of the following psychological/psychiatric problems?

Tick each line (a) - (f), and tick one box on each line	No	Yes	Don't Know
(a) Maladjustment/behaviour disturbance (RC4.1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Depression (RC4.2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Aggression (RC4.3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Appetite problems (e.g. Anorexia, Bulimia etc.) (RC4.4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Psychosis (RC4.5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Neurosis (RC4.6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Suicide attempt(s)/threats (RC4.7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any, please answer 4(a).

4(a). If YES to any of above, please describe (RC4A.1)*
(RC4A.2)*

C5. DISTANT VISION TEST

Test at exactly 20 feet with a standard Snellen Chart of block capitals. Hang chart in good light level with teenager's eyes and free from glare. Occlude opposite eye in usual way. Test all teenagers (without glasses) first and record result separately for Right Eye and Left Eye. Then re-test only teenagers with glasses/lens, wearing them.

		DISTANT VISUAL ACUITY						Worse than	Unable to test
1. Crude distant vision without glasses (test all teenagers)		6	9	12	18	24	36	60	60
(i) Right eye (RC5A.1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Left eye (RC5A.2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Distant vision, wearing glasses/contacts									
(i) Right eye (RC5B.1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Left eye (RC5B.2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C6. NEAR-VISION TEST

A Sheridan-Gardiner near-vision chart is provided in the instruction manual. The teenager should hold it in a good light at a distance of approximately 10 inches away from the eyes. Please occlude the other eye efficiently without pressure on the eyeball. If the teenager cannot read, ask him/her to draw the letters in the air. Test near vision in all teenagers and then retest only teenagers with glasses/lenses, wearing them.

		6	9	12	18	24	36	60	Worse than 60	Unable to test
Near Vision without glasses (all teenagers)										
(i)	Right eye ... (RC6A.1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii)	Left eye ... (RC6A.2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near vision wearing glasses/contacts										
(i)	Right eye ... (RC6B.1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii)	Left eye ... (RC6B.2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C7. In the light of your examination and the records you have seen, would you consider that there is any current visual defect, and does it result in interference with normal schooling or everyday functioning?

(RCT)

Tick one box only

No visual defect	<input type="checkbox"/>	If visual defect, please describe below (RCT.2) * (RCT.3) * _____ _____ _____ _____
Visual defect – but no interference	<input type="checkbox"/>	
with some interference	<input type="checkbox"/>	
manages school books with difficulty	<input type="checkbox"/>	
requires special school books/visual aids	<input type="checkbox"/>	
vision insufficient for special books	<input type="checkbox"/>	
Unable to assess	<input type="checkbox"/>	
(please give reason (RCT.1) *)	<input type="checkbox"/>	
Not examined	<input type="checkbox"/>	

SECTION 2B. MEDICAL EXAMINATION

D1. INITIAL PULSE RATE

Before starting the Medical Examination, please settle the teenager for 2 minutes and take the pulse (over 1 minute) whilst the teenager is sitting.

Pulse rate (RD1) beats in 1 minute



D2. HEIGHT

Recommended technique:

Please position the teenager upright against a flat wall or a door. Encourage him/her to stretch to full height, keeping heels on the floor. Heels and buttocks should be flush against wall or door. Place a hardboard/book on the teenager's head. Mark the position of the lower edge with a pencil and then measure the height from the ground with a wood or steel measuring rod or steel tape measure. Alternatively, use measuring device on the back of a weighing machine and observe precautions as above. NB. Remove shoes before height is measured.



(a) Height in cm, to nearest 0.5 cm	= (RD2.1)	cms.
<i>If centimetre measure not available, please record height in feet and inches.</i>		
(b) Height in feet and inches, to nearest 1/4 inch	=	feet inches

D3. HEAD CIRCUMFERENCE

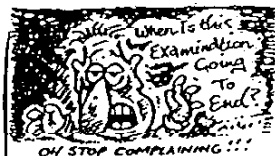
Measure with a paper or plastic tape measure, fitted closely and horizontally around the head just above the eyebrows so as to obtain a maximum circumference.



(a) Head circumference in cm, to nearest 0.5 cm	= (RD3.1)	cms.
	or =	inches

D4. WEIGHT (IN UNDERCLOTHES)

Please weigh on a beam balance, if possible. Please check that the balance is set at zero before weighing.



(a) Weight in kilograms, to nearest 0.1 kg	= (RD4.1)	kg.
<i>If kilogram scale not available, please record in pounds and ounces to nearest 1/4 ounce.</i>		
(b) Weight in pounds and ounces	=	pounds ounces

D5. BLOOD PRESSURE

Please postpone to later in examination if you feel teenager is nervous.

Sphygmomanometer cuff must have bladder long enough to encircle the arm completely and be wide enough to cover two-thirds of the length of the upper arm. The cuff should preferably be at least 5 inches deep. It is realised that you will be experienced in taking blood pressures, but we ask you to follow the instructions closely for uniformity:—

Sit subject on chair in as relaxed a state as possible. Wrap the cuff around the right upper arm, placing the rubber tubes from the bladder posteriorly for ease of access to right antecubital fossa. Palpate the right radial pulse and inflate the cuff to about 30mm.Hg. above the disappearance of the pulse. Slowly deflate till the pulse reappears. Deflate the cuff.

Place the stethoscope in the antecubital fossa over the brachial artery, but not in contact with any part of the cuff. Rapidly inflate the cuff to about 30mm.Hg. above the systolic pressure and then deflate at a rate of 2-3mm.Hg. per second.

The appearance of faint clear tapping sounds for 2 consecutive beats should be recorded as the *Systolic Pressure*.

Continue to deflate the cuff and the sounds will soften or may become swishing, then sharper sounds will reappear. With continuing deflation, there will be a sudden muffling of sounds, which will become soft and blowing. This is Korotkoff's 4th sound and represents the *Diastolic Pressure*. Do not wait until the point of complete disappearance of sounds.



(a) Systolic pressure — taken by auscultation	(RDS.1)	mm.
(b) Diastolic pressure — taken by auscultation	(RDS.2)	mm.

NOW PLEASE MAKE A GENERAL AND SYSTEMIC EXAMINATION OF THE TEENAGER AND ANSWER QUESTIONS BELOW BASED ON YOUR FINDINGS.

D6. Please state whether or not any abnormal condition has been found in any of the following systems in the teenager.

Answer (a) - (o) and tick one box on line	Not present	Yes present	If present, describe signs. What is diagnosis?
(a) Abnormality of face or general disfiguration	<input type="checkbox"/>	<input type="checkbox"/>	(RD6A.1) (RD6A.2)*
(b) Skin abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6B.1) (RD6B.2)*
(c) Upper respiratory abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6C.1) (RD6C.2)*
(d) Abnormal respiratory signs/ conditions	<input type="checkbox"/>	<input type="checkbox"/>	(RD6D.1) (RD6D.2)*
(e) Cardiovascular abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6E.1) (RD6E.2)*
(f) Gastrointestinal abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6F.1) (RD6F.2)*
(g) Urogenital tract abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6G.1) (RD6G.2)*
(h) Neurological abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6H.1) (RD6H.2)*
(j) Musculo-skeletal abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6J.1) (RD6J.2)*
(k) Endocrine abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6K.1) (RD6K.2)*
(l) Blood or lymphatic abnormality	<input type="checkbox"/>	<input type="checkbox"/>	(RD6L.1) (RD6L.2)*
(m) Behavioural or emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	(RD6M.1) (RD6M.2)*
(n) Mental handicap	<input type="checkbox"/>	<input type="checkbox"/>	(RD6N.1) (RD6N.2)*
(o) Other abnormal condition(s) or syndrome(s)	<input type="checkbox"/>	<input type="checkbox"/>	(RD6O.1) (RD6O.2)*

D7. Did your examination reveal any of the following?

Answer (a) - (e) and tick one box on each line	No	Yes	If YES, please describe:
(a) Any scars (surgical, burns, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	(RD7A.1) (RD7A.2)*
(b) Any hernia?	<input type="checkbox"/>	<input type="checkbox"/>	(RD7B.1) (RD7B.2)*
(c) Any heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	(RD7C.1) (RD7C.2)*
(d) Undescended/ectopic testis?	<input type="checkbox"/>	<input type="checkbox"/>	(RD7D.1) (RD7D.2)*
(e) Any other abnormality not already stated in question D6?	<input type="checkbox"/>	<input type="checkbox"/>	(RD7E.1) (RD7E.2)*

D8. Is there any evidence that this teenager has any past or present congenital abnormality? (Include both major and minor abnormalities).

(RD8) Tick one box

YES If YES, please describe below:

NO

(RD8.1)*

(RD8.2)*

D9. On clinical impression, which of the following terms do you consider to be the most accurate description of the teenager?

Grossly obese

Moderately obese (RD9)

Normal build

Thin

Very thin

Not examined

E. MOTOR COORDINATION TESTS

The following four tests will identify a clumsy or inco-ordinate subject as far as this is possible on clinical examination. Such tests are non-specific and difficult to validate, but will be used in conjunction with other findings and the opinions of teachers and parents, recorded elsewhere. The results will inevitably be influenced by the effects of subject's skill and experience. At the end of the tests the examiner is asked to give a considered opinion as to the degree of clumsiness or inco-ordination.

Please test all Youthscan teenagers except those who are grossly handicapped or those who are incapable of understanding the test(s). In these instances, please enter the reason after question E4.

E1. THROWING A BALL IN THE AIR

You will need a tennis ball, or a rubber ball of equivalent size and weight.

The important point about this test is to discover the subject's optimum performance. We would therefore be grateful if you would carry out the test in the following way:

Ask the subject to stand in a space so that he/she has room to move. Say 'I want you to show me if you can throw the ball up in the air and catch it'. Allow two or three initial attempts. If the subject fails to catch the ball, record the fact and do not proceed with the test.

If the subject can catch the ball, say 'Now throw the ball up in the air and clap your hands together once before you catch it.' Then repeat the procedure increasing the number of claps until the subject fails on two successive attempts. Record the greatest number of claps resulting in a successful catch.

If the greatest number of claps was 2 or more, ask him/her to repeat the test, catching with one hand only. Let him/her use preferred hand.

RESULT	INITIAL THROW	Could not catch ball (RE1) <input type="checkbox"/>	
		Caught ball <input type="checkbox"/>	If caught ball answer 1(a) and 1(b).

1(a). If caught ball successfully, please continue with test and record the maximum number of claps achieved before catching with two hands (RE1.1)
 _____ claps

1(b). If caught ball after at least 2 claps, please continue test catching the ball with the preferred hand, and record the maximum number of claps achieved before catching with preferred hand (RE1.2)
 _____ claps



E2. FIGURE DRAWING ON PALM OF HAND: (GRAPHESTHESIA)

You will need a blunt point, for example a biro with tip retracted.

<input type="checkbox"/>	X	0	3
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Ask the subject to place both his/her hands on a table, palms uppermost. Using the blunt point, firmly describe a figure 8 on the subject's right palm. Take two seconds to draw it, and allow the subject to watch. Ask him/her what you have drawn.

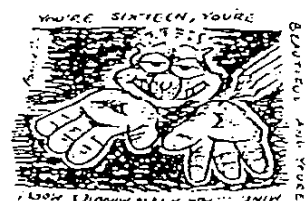
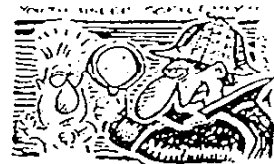
Now please show the subject the 4 figures reproduced above, and ask the subject to name each one.

Ask subject to close his/her eyes. Draw the first figure indicated in the following list on the right palm and ask what it was. Record whether correct, incorrect or uncertain. Continue drawing the figures on the palm indicated and record the results. Please do not repeat any part of the test.

If the subject is non-verbal, ask him/her to point to the correct shape rather than name it.

NOTE: DO NOT LET THE SUBJECT SEE THIS SCORE SHEET

Answer (a)-(h) and tick one box on each line.				
	(Figures)	Response correct	Response incorrect	Response uncertain
(a) Right palm	(RE2.1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Left palm	(RE2.2)	X	<input type="checkbox"/>	<input type="checkbox"/>
(c) Right palm	(RE2.3)	0	<input type="checkbox"/>	<input type="checkbox"/>
(d) Left palm	(RE2.4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Right palm	(RE2.5)	3	<input type="checkbox"/>	<input type="checkbox"/>
(f) Left palm	(RE2.6)	0	<input type="checkbox"/>	<input type="checkbox"/>
(g) Right palm	(RE2.7)	X	<input type="checkbox"/>	<input type="checkbox"/>
(h) Left palm	(RE2.8)	3	<input type="checkbox"/>	<input type="checkbox"/>



E3. STANDING ON ONE LEG: (30 SECONDS)

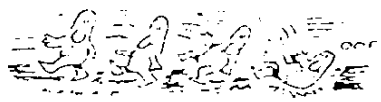
Please make sure the subject has no shoes on.

Ask the subject to stand on his/her right leg with the left foot against the knee of the right leg, hands on hips. Ask him/her to settle for a moment, then to keep the position for 30 seconds.

Watch the position of hands and feet and record how soon the hands move from the hips or the feet move. Repeat the test with subject standing on the left leg, and time in same way.

<p>Right leg: 30 seconds</p> <p>a) Did foot/feet move before 30 seconds? No <input type="checkbox"/> (RE3AA1) Yes <input type="checkbox"/> } If YES, after how many seconds? (RE3AA2)_{secs}</p> <p>b) Did hand(s) move before 30 seconds? No <input type="checkbox"/> (RE3AB1) Yes <input type="checkbox"/> } If YES, after how many seconds? (RE3AB2)_{secs}</p> <p>Comments, if any: (RE3C)*</p>	<p>Left leg: 30 seconds</p> <p>a) Did foot/feet move before 30 seconds? No <input type="checkbox"/> (RE3BA1) Yes <input type="checkbox"/> } If YES, after how many seconds? (RE3BA2)_{secs}</p> <p>b) Did hand(s) move before 30 seconds? No <input type="checkbox"/> (RE3BB1) Yes <input type="checkbox"/> } If YES, after how many seconds? (RE3BB2)_{secs}</p>
---	---

E4. WALKING BACKWARDS (10 STEPS)



Please make sure subject has no shoes on.

Find a straight line on the floor at least 4 metres long, e.g. the groove of a floorboard, or mark one out with chalk. Use a corridor if the examination room is not long enough

Ask the subject to put his/her hands on hips and then to walk backwards along the line, placing one foot behind the other, toe-to-heel.

First demonstrate the test, saying 'I want you to walk like this. Remember your toes must touch your heel with each step you take. Keep your hands on your hips. Walk backwards in a straight line. You may glance behind you if it helps'.

Let the subject have two practices by asking him/her to walk backwards for 5 steps on each occasion.

Then ask the subject to walk backwards for 20 steps. Count the number of steps made before any error occurs.

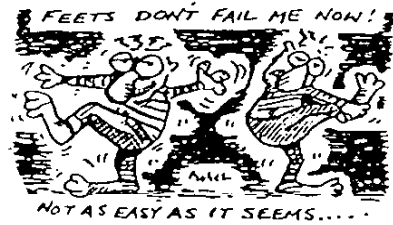
An error occurs if the subject ceases to maintain toe-to heel or deviates from the line or moves either hand from hips. If an error is made in the first 5 steps, continue to count the number of steps until the next error.

<p>RESULT Number of consecutive steps taken before error (or between an error in the first 5 steps and the next error) (RE4A)_{steps}</p> <p>Comments, if any: (RE4B)*</p>

If these tests are not done, give reason (RE4C.1)* (RE4C.2)*

E5. From your observations, which of the following phrases do you consider best describes the teenager?

(RES)	Tick one box
Normal limb co-ordination	<input type="checkbox"/>
Questionably clumsy	<input type="checkbox"/>
Mildly clumsy	<input type="checkbox"/>
Moderately clumsy	<input type="checkbox"/>
Markedly clumsy	<input type="checkbox"/>
Unable to assess	<input type="checkbox"/>



E6. PULSE RATE AT END OF EXAMINATION

Would you please settle the teenager and after at least 2 minutes take the teenager's pulse rate again for at least 60 seconds, with the teenager sitting.

Pulse rate at end of examination (RE6) beats in 1 minute
--

MEDICAL SUMMARY

SUMMARY OF CONDITIONS FOUND AND CONCLUSIONS

F1. Have you found any evidence by examination or from history that this teenager had/has any impairment, disability or handicap? Please include also educational and social problems/difficulties.

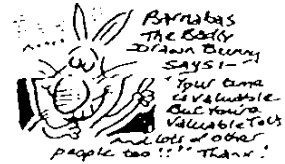
(RF1)

YES

NO

DON'T KNOW

If YES, please answer 1(a) below.



1(a). List each condition below and assess the effect, if any, on the teenagers home or school progress.

Nature of problem/defect/handicap	Condition present but no real disability	Condition resulting in slight disability	Condition resulting in marked disability
1. <u>(RF1A1A) *</u>	<u>(RF1A1B)</u>	<input type="checkbox"/>	<input type="checkbox"/>
2. <u>(RF1A2A) *</u>	<u>(RF1A2B)</u>	<input type="checkbox"/>	<input type="checkbox"/>
3. <u>(RF1A3A) *</u>	<u>(RF1A3B)</u>	<input type="checkbox"/>	<input type="checkbox"/>
4. <u>(RF1A4A) *</u>	<u>(RF1A4B)</u>	<input type="checkbox"/>	<input type="checkbox"/>
5. <u>(RF1A5A) *</u>	<u>(RF1A5B)</u>	<input type="checkbox"/>	<input type="checkbox"/>
6. <u>(RF1A6A) *</u>	<u>(RF1A6B)</u>	<input type="checkbox"/>	<input type="checkbox"/>

F2. Has your medical examination and scrutiny of the teenager's documents revealed the presence of any abnormal condition(s) or symptom(s) which have not previously been diagnosed or are not already under observation?

(RF2)

YES

NO

DON'T KNOW

If YES, please answer 2(a) below.

2(a). Please list each problem/condition not previously diagnosed or not already under observation.

- (RF2A.1) *
- (RF2A.2) *
- (RF2A.3) *

F3. Do you consider that this teenager has any condition(s) requiring ongoing medical observation or treatment for any reason?

(RF3)

NO

YES, condition(s) for which teenager is already receiving observation or treatment

YES, condition(s) present of which teenager is not receiving observation or treatment

CAN'T SAY

If YES, please answer 3(a) below.



3(a) Please state condition(s) and give your recommendation(s) regarding necessary ongoing observation(s) or treatment for each condition.

- (RF3A.1) * (RF3A.2) *
- (RF3A.3) * (RF3A.4) *
- (RF3A.5) * (RF3A.6) *

F4.

ENTER IN THIS SPACE DETAILS OF CLINICAL PROGRESS AND MAJOR FINDINGS ON ANY DEFECT, DISABILITY OR HANDICAPPING CONDITION(S).

See questions B2 & 3. Please also append here or send to us any available copies of relevant child health reports and/or special educational documents relating to such condition(s).

(RF4) *

(RF4.1) *

F5.

PLEASE ADD HERE FURTHER ANSWER(S) TO ANY QUESTIONS WHERE THERE WAS INSUFFICIENT SPACE ON THIS FORM.

(RF5) *

(RF5.1) *

F6.

SPACE FOR ANY COMMENTS BY SCM (CHILD HEALTH) OR PERSON WHO ACTS AS CENTRAL STUDY CO-ORDINATOR Please include here any details from missing or centrally-held child health records.

(RF6) *

(RF6.1) *

Before signing the form would you please check that ALL QUESTIONS have been answered and suitably recorded.

Signature of Medical Officer

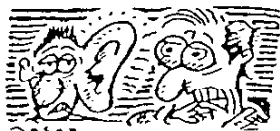
(RSIG)

Date

AS THANK! We want to see you in a hurry...

THANK YOU VERY MUCH FOR YOUR HELP.

And I doubt you will forget it. I will either. YOU...



Survey Number

Please photostat this form rather than detach, if separate completion is indicated.

SECTION 4. AUDIOGRAM

Teenager's Surname Sex: M F

Teenager's Forename(s) Date of birth /14/70

Teenager's Home Address

Please check the teenager's hearing by using either sweep audiometry or pure-tone audiometry, and record the results below.

(a) SWEEP AUDIOMETRY

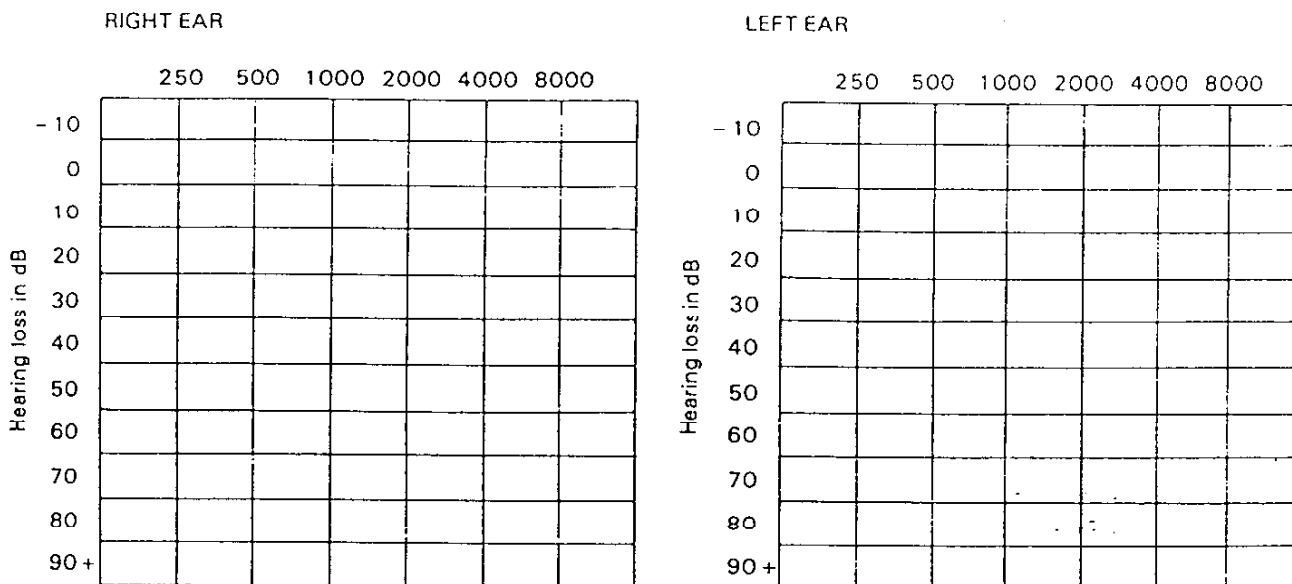
Please tick one box in each row

	Normal	Abnormal	Give reason
Right ear (R-AUDIO1)	<input type="checkbox"/>	<input type="checkbox"/>	(REASON1) *
Left ear (R-AM102)	<input type="checkbox"/>	<input type="checkbox"/>	(REASON2) *

If you are satisfied that the teenager has abnormal or possibly abnormal hearing, please undertake pure-tone audiometry and record the results below.

(b) PURE-TONE AUDIOMETRY

If carried out, please record results below, for air conduction and bone conduction.



Please complete the details below for sweep audiometry, and for pure-tone audiometry if done.

Audiogram recorded at (PTONE) *

Name of recorder

Professional status (PROFST) * Date (RAUD-MT) (RAUD-YR) /86

Make of audiometer (MAUDIO) * Level of sweep (RSWEEP) dB's

Frequencies tested by sweep (RFREQ1) (RFREQ2) (RFREQ3) (RFREQ4) (RFREQ5) (RFREQ6) (RFREQ7) (RFREQ8)

NOTE CAREFULLY

* If it is impossible to arrange for audiometry to be carried out for this survey, please enter date and result of most recent audiogram below, whether sweep or pure-tone. Alternatively, give result of recent clinical assessment, if any.

Type of test (TYPE) *

Result (RESULT) *

Date tested (RHT-MT) (RHT-YR)

CONTINUATION OF R QUESTIONNAIRE

RA2

AGES	5 10	6 11	7 12	8 13	9 14	15
EXAMS.....	(RA2A.1)	(RA2A.2)	(RA2A.3)	(RA2A.4)	(RA2A.5)	
	(RA2A.6)	(RA2A.7)	(RA2A.8)	(RA2A.9)	(RA2A.10)	(RA2A.11)
DEV CHECKS.....	(RA2B.1)	(RA2B.2)	(RA2B.3)	(RA2B.4)	(RA2B.5)	
	(RA2B.6)	(RA2B.7)	(RA2B.8)	(RA2B.9)	(RA2B.10)	(RA2B.11)
VISION SCREEN.....	(RA2C.1)	(RA2C.2)	(RA2C.3)	(RA2C.4)	(RA2C.5)	
	(RA2C.6)	(RA2C.7)	(RA2C.8)	(RA2C.9)	(RA2C.10)	(RA2C.11)
HEARING TESTS.....	(RA2D.1)	(RA2D.2)	(RA2D.3)	(RA2D.4)	(RA2D.5)	
	(RA2D.6)	(RA2D.7)	(RA2D.8)	(RA2D.9)	(RA2D.10)	(RA2D.11)
OTHER	(RA2E.1)	(RA2E.2)	(RA2E.3)	(RA2E.4)	(RA2E.5)	
	(RA2E.6)	(RA2E.7)	(RA2E.8)	(RA2E.9)	(RA2E.10)	(RA2E.11)