



## FAMILY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS [UP THROUGH FAMILY INCOME] AS THEY APPLIED AT THE TIME OF YOUR CHILD'S DEATH.**

Type of home: \_\_\_\_\_  
Age of home: \_\_\_\_\_  
How long did the child reside here? \_\_\_\_\_  
Water source: \_\_\_\_\_  
Number of bedrooms: \_\_\_\_\_  
Main language in home: \_\_\_\_\_  
Number of adults (equal or greater than 18 years of age): \_\_\_\_\_  
and children (<18 years of age, including child): \_\_\_\_\_ living in household. Total = \_\_\_\_\_ people.  
Number of smokers in household: \_\_\_\_\_  
Does usual caregiver smoke? \_\_\_ Yes \_\_\_ No \_\_\_ Unknown If yes, \_\_\_ cigarettes/day  
Caregiver is: \_\_\_ Married \_\_\_ Divorced \_\_\_ Single \_\_\_ Widowed  
Mother and father are living together: \_\_\_ Yes \_\_\_ No  
Highest level of education completed: \_\_\_\_\_ (mother) \_\_\_\_\_ (father)  
Employed? \_\_\_\_\_ (mother) \_\_\_\_\_ (father)  
Pets in household \_\_\_ Yes \_\_\_ No If yes, what type? \_\_\_\_\_  
Were the pets healthy? \_\_\_ Yes \_\_\_ No If not, please explain. \_\_\_\_\_  
The family income is: (circle one)  
0-\$10,000      \$10,001-\$25,000      \$25,001-\$50,000      Over \$50,000

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**PLEASE ANSWER THESE QUESTIONS AS THEY APPLY TO YOU RIGHT NOW:**

How many total pregnancies has the mother had? \_\_\_\_\_  
(include pregnancy for the child who died, and stillbirths, miscarriages, & abortions)

Of these pregnancies, how many were live births? \_\_\_\_\_

How many of the child's brothers and sisters died of SIDS or unexplained death? \_\_\_\_\_

How many living siblings (brothers and sisters) does this child have right now? \_\_\_\_\_

For how many of the child's siblings were apnea/heart monitors used? \_\_\_\_\_

If there were any miscarriages, abortions, or stillbirths, please describe which pregnancy and what happened for each.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the child who died, what number pregnancy was this? \_\_\_\_\_

Did the mother have difficulty conceiving this child?      YES      NO      UNKNOWN

Were fertility drugs used (please specify): \_\_\_\_\_

How long was the mother trying to conceive this child? \_\_\_\_\_

## FAMILY MEDICAL HISTORY

**Is there any family history (up to and including child's grandparents) of:**  
**(check all that apply and indicate relationship to child and date of diagnosis in space provided)**

- |  |       |
|--|-------|
| <input type="checkbox"/> SIDS  | _____ |
| <input type="checkbox"/> Other infant/childhood death                          | _____ |
| <input type="checkbox"/> Sudden, unexplained death in adolescence or adulthood | _____ |
| <input type="checkbox"/> Prematurity (under 37 weeks)                          | _____ |
| <input type="checkbox"/> Miscarriage   | _____ |
| <input type="checkbox"/> Stillborn   | _____ |
| <input type="checkbox"/> Syncope or unexplained fainting                       | _____ |
| <input type="checkbox"/> Apnea (episodes of not breathing)                     | _____ |
| <input type="checkbox"/> Cardiac arrhythmias                                   | _____ |
| <input type="checkbox"/> Congenital heart disease                              | _____ |
| <input type="checkbox"/> Other congenital anomalies                            | _____ |
| <input type="checkbox"/> Metabolic disorders                                   | _____ |
| <input type="checkbox"/> Pneumonia   | _____ |
| <input type="checkbox"/> Other infections                                      | _____ |
| <input type="checkbox"/> Epilepsy  | _____ |
| <input type="checkbox"/> Other seizure disorder                                | _____ |
| <input type="checkbox"/> Febrile seizures<br>(seizures with fever)             | _____ |
| <input type="checkbox"/> Migraine headaches                                    | _____ |
| <input type="checkbox"/> Diabetes  | _____ |
| <input type="checkbox"/> Life-threatening trauma                               | _____ |
| <input type="checkbox"/> Deafness  | _____ |
| <input type="checkbox"/> Tourette syndrome                                     | _____ |
| <input type="checkbox"/> Lupus   | _____ |
| <input type="checkbox"/> Multiple sclerosis                                    | _____ |
| <input type="checkbox"/> Crohn's disease                                       | _____ |
| <input type="checkbox"/> Rheumatoid arthritis                                  | _____ |

List any other genetic or inherited disorders in your family and state their relation to the child.

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**SIBLINGS**

**NOTE: Please include all live births of this mother, including siblings born after the child's death.**

**Child/ Live Birth #1:**

Date of birth \_\_\_\_\_ (month, day, year)

Gender:     MALE       FEMALE

Was this child born prematurely (under 37 weeks)?     YES     NO     UNKNOWN

If deceased, date of death \_\_\_\_\_ (month, day, year)

If deceased, cause of death \_\_\_\_\_

Describe child's development

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Describe child's health

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Did this child ever have:

lung disease?	YES	NO	UNKNOWN
apnea?	YES	NO	UNKNOWN
sleep disorder?	YES	NO	UNKNOWN
heart disease or arrhythmia?	YES	NO	UNKNOWN
seizures or neurologic problem?	YES	NO	UNKNOWN
any muscle weakness?	YES	NO	UNKNOWN

List any other diagnosis of medical disease

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Circle Blood Type	O	A	B	AB
Circle RH Factor	-	+		

**Child/ Live Birth #2:**

Date of birth \_\_\_\_\_ (month, day, year)

Gender:     MALE       FEMALE

Was this child born prematurely (under 37 weeks)?     YES     NO     UNKNOWN

If deceased, date of death \_\_\_\_\_ (month, day, year)

If deceased, cause of death \_\_\_\_\_

Describe child's development

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Describe child's health

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Did this child ever have:

lung disease?	YES	NO	UNKNOWN
apnea?	YES	NO	UNKNOWN
sleep disorder?	YES	NO	UNKNOWN
heart disease or arrhythmia?	YES	NO	UNKNOWN
seizures or neurologic problem?	YES	NO	UNKNOWN
any muscle weakness?	YES	NO	UNKNOWN

List any other diagnosis of medical disease

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Circle Blood Type	O	A	B	AB
Circle RH Factor	-	+		

**Child / Live Birth #3:**

Date of birth \_\_\_\_\_ (month, day, year)

Gender:     MALE     FEMALE

Was this child born prematurely (under 37 weeks)?     YES     NO     UNKNOWN

If deceased, date of death \_\_\_\_\_ (month, day, year)

If deceased, cause of death \_\_\_\_\_

Describe child's development

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Describe child's health

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Did this child ever have:

lung disease?	YES	NO	UNKNOWN
apnea?	YES	NO	UNKNOWN
sleep disorder?	YES	NO	UNKNOWN
heart disease or arrhythmia?	YES	NO	UNKNOWN
seizures or neurologic problem?	YES	NO	UNKNOWN
any muscle weakness?	YES	NO	UNKNOWN

List any other diagnosis of medical disease

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Circle Blood Type	O	A	B	AB
Circle RH Factor	-	+		

**Child / Live Birth #4**

Date of birth \_\_\_\_\_ (month, day, year)

Gender:     MALE     FEMALE

Was this child born prematurely (under 37 weeks)?     YES     NO     UNKNOWN

If deceased, date of death \_\_\_\_\_ (month, day, year)

If deceased, cause of death \_\_\_\_\_

Describe child's development

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Describe child's health

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Did this child ever have:

lung disease?	YES	NO	UNKNOWN
apnea?	YES	NO	UNKNOWN
sleep disorder?	YES	NO	UNKNOWN
heart disease or arrhythmia?	YES	NO	UNKNOWN
seizures or neurologic problem?	YES	NO	UNKNOWN
any muscle weakness?	YES	NO	UNKNOWN

List any other diagnosis of medical disease

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Circle Blood Type	O	A	B	AB
Circle RH Factor	-	+		

**If more sibling forms are needed, copy the previous page and attach to last page of survey.**

## FATHER'S INFORMATION

Describe the father's health: (circle one)

Excellent      Very Good      Good      Fair      Poor

Has the father ever experienced:

Fainting?                      YES      NO      UNKNOWN

Seizure?                      YES      NO      UNKNOWN

Loss of consciousness?    YES      NO      UNKNOWN

State any known disease of the father and year it was diagnosed.

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Does the father smoke?      YES      NO      UNKNOWN

Did the father smoke around the mother:    \_\_\_ Before    \_\_\_ During    \_\_\_ After this pregnancy

How many packs of cigarettes per day? \_\_\_\_\_

***Circle the category that most closely describes the father's drug use: (OPTIONAL)***

Alcohol	none	occasionally	monthly	weekly	daily
Caffeine (tea/ coffee, etc.)	none	occasionally	monthly	weekly	daily
Vitamins	none	occasionally	monthly	weekly	daily
Iron	none	occasionally	monthly	weekly	daily
Aspirin	none	occasionally	monthly	weekly	daily
Acetaminophen (Tylenol)	none	occasionally	monthly	weekly	daily
Ibuprofen	none	occasionally	monthly	weekly	daily
Heart Medicine	none	occasionally	monthly	weekly	daily
Diuretics	none	occasionally	monthly	weekly	daily
Seizure Medicine	none	occasionally	monthly	weekly	daily
Antacid	none	occasionally	monthly	weekly	daily
Blood Pressure Medicine	none	occasionally	monthly	weekly	daily
Tranquilizers	none	occasionally	monthly	weekly	daily
Antidepressants	none	occasionally	monthly	weekly	daily
Antihistamine	none	occasionally	monthly	weekly	daily
Decongestant	none	occasionally	monthly	weekly	daily
Amphetamines	none	occasionally	monthly	weekly	daily
Marijuana	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily

## MOTHER'S INFORMATION

Describe the mother's health: (circle one)

Excellent      Very Good      Good      Fair      Poor

Has the mother ever experienced:

Fainting?	YES	NO	UNKNOWN
Seizure?	YES	NO	UNKNOWN
Loss of consciousness?	YES	NO	UNKNOWN

State any known disease of the mother and year it was diagnosed.

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Does the mother smoke?      YES      NO      UNKNOWN

Did the mother smoke \_\_\_\_\_ Before \_\_\_\_\_ During \_\_\_\_\_ After this pregnancy  
 Cigarettes per day      \_\_\_\_\_ Before \_\_\_\_\_ During \_\_\_\_\_ After this pregnancy

**Circle the category that most closely describes the mother's drug use *PRIOR TO this child's pregnancy*: (OPTIONAL)**

Alcohol	none	occasionally	monthly	weekly	daily
Caffeine (tea/ coffee, etc.)	none	occasionally	monthly	weekly	daily
Vitamins	none	occasionally	monthly	weekly	daily
Iron	none	occasionally	monthly	weekly	daily
Aspirin	none	occasionally	monthly	weekly	daily
Acetaminophen (Tylenol)	none	occasionally	monthly	weekly	daily
Ibuprofen	none	occasionally	monthly	weekly	daily
Heart Medicine	none	occasionally	monthly	weekly	daily
Diuretics	none	occasionally	monthly	weekly	daily
Seizure Medicine	none	occasionally	monthly	weekly	daily
Antacid	none	occasionally	monthly	weekly	daily
Blood Pressure Medicine	none	occasionally	monthly	weekly	daily
Tranquilizers	none	occasionally	monthly	weekly	daily
Antidepressants	none	occasionally	monthly	weekly	daily
Antihistamine	none	occasionally	monthly	weekly	daily
Decongestant	none	occasionally	monthly	weekly	daily
Amphetamines	none	occasionally	monthly	weekly	daily
Marijuana	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily



Vitamins	none	occasionally	monthly	weekly	daily
Iron	none	occasionally	monthly	weekly	daily
Aspirin	none	occasionally	monthly	weekly	daily
Acetaminophen (Tylenol)	none	occasionally	monthly	weekly	daily
Ibuprofen	none	occasionally	monthly	weekly	daily
Heart Medicine	none	occasionally	monthly	weekly	daily
Diuretics	none	occasionally	monthly	weekly	daily
Seizure Medicine	none	occasionally	monthly	weekly	daily
Antacid	none	occasionally	monthly	weekly	daily
Blood Pressure Medicine	none	occasionally	monthly	weekly	daily
Tranquilizers	none	occasionally	monthly	weekly	daily
Antidepressants	none	occasionally	monthly	weekly	daily
Antihistamine	none	occasionally	monthly	weekly	daily
Decongestant	none	occasionally	monthly	weekly	daily
Amphetamines	none	occasionally	monthly	weekly	daily
Marijuana	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily

Were antibiotics taken during this pregnancy? \_\_\_\_\_

If yes, how many times? \_\_\_\_\_

During which trimester(s) were they given? \_\_\_\_\_

For what reason? \_\_\_\_\_

Were hormones taken during this pregnancy? \_\_\_\_\_

If yes, during which trimester(s)? \_\_\_\_\_

Was Nausea medicine taken during the first trimester of this pregnancy? \_\_\_\_\_

If yes, how often? \_\_\_\_\_

Were any other drugs taken during the 2<sup>nd</sup> or 3<sup>rd</sup> trimesters of this pregnancy?

Please specify \_\_\_\_\_

Did the mother experience premature labor during this pregnancy? YES NO UNKNOWN

If so, at what week of pregnancy did it start? \_\_\_\_\_

What was the treatment, when was it given and were any drugs administered directly to the amniotic sack? (steroids for lung development?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did the mother take Rhogam during this pregnancy? YES NO UNKNOWN

Did the mother have a blood transfusion:

Before this pregnancy? YES NO UNKNOWN

During this pregnancy? YES NO UNKNOWN



The length of the pregnancy (gestational age) was \_\_\_\_\_ weeks

The baby's weight at birth was \_\_\_\_\_ pounds \_\_\_\_\_ ounces

The baby's length at birth was \_\_\_\_\_ inches

The baby's head circumference was: \_\_\_\_\_ inches

Was this a multiple pregnancy? (circle one) YES NO UNKNOWN

If yes, specify twins, triplets, etc. \_\_\_\_\_

This baby was born: (circle one) 1st 2nd 3rd 4th 5th

The Apgar score at one minute was: (circle one)

0 1 2 3 4 5 6 7 8 9 10

The Apgar score at 5 minutes was: (circle one)

0 1 2 3 4 5 6 7 8 9 10

The race of the baby is: (circle one) Caucasian Hispanic Black American Indian  
Asian Slavic Mixed (describe) \_\_\_\_\_

The sex of the baby is: (circle one) Male Female Undetermined

The baby's blood type is: (circle one) A+ B+ AB+ O+ Unknown

A- B- AB- O-

The Mom's blood type is: (circle one) A+ B+ AB+ O+ Unknown

A- B- AB- O-

### CHILD'S HEALTH AND MEDICAL HISTORY

#### IN HOSPITAL (AT THE TIME OF DELIVERY)

At BIRTH, was the baby anemic (low blood count)? YES NO UNKNOWN

At BIRTH, was the baby infected (septic)? YES NO UNKNOWN

Did the baby receive oxygen in the hospital? YES NO UNKNOWN

If yes, for how long? \_\_\_\_\_ days

Did the baby require CPR? YES NO UNKNOWN

Did the baby require intubation or did he/she require the use of a ventilator (respirator)? YES NO UNKNOWN

If yes, for how long? \_\_\_\_\_ days

Did the baby receive any blood transfusions? YES NO UNKNOWN

If yes, how many? \_\_\_\_\_

Did the baby receive antibiotics? YES NO UNKNOWN

Was the baby put under a light for jaundice? (yellowing of skin/eyes) YES NO UNKNOWN

Did the baby have surgery? YES NO UNKNOWN

If yes, what type of surgery? \_\_\_\_\_

Did the baby contract an infection?	YES	NO	UNKNOWN
Did the baby become anemic?	YES	NO	UNKNOWN
Did the baby experience tachypnea? (fast breathing)	YES	NO	UNKNOWN
Did the baby experience bradycardia? (abnormally slow heart rate)	YES	NO	UNKNOWN
Did the baby experience any abnormal heartbeats or heart rhythms?	YES	NO	UNKNOWN
Did the baby stop breathing? (apnea)	YES	NO	UNKNOWN
Did the baby turn blue?	YES	NO	UNKNOWN
Did the baby vomit excessively?	YES	NO	UNKNOWN
Did the baby experience respiratory distress?	YES	NO	UNKNOWN
Did the baby have difficulty controlling his temperature?	YES	NO	UNKNOWN
Did the baby have seizures?	YES	NO	UNKNOWN
Did the baby have a birth defect? If so, please specify: _____	YES	NO	UNKNOWN

How was the infant positioned to sleep in the newborn nursery?

Back	_____
Side	_____
Stomach	_____
Unknown	_____

Describe any other pertinent delivery and birth history of the child:

\_\_\_\_\_

\_\_\_\_\_

**CHILD'S HEALTH AND MEDICAL HISTORY**  
**(AFTER GOING HOME, FOLLOWING DELIVERY)**

How was the child positioned to sleep, as a newborn, when you first came home?

Back	_____
Side	_____
Stomach	_____
Unknown	_____

After your child could turn over spontaneously, what was the child's favorite sleep position?

Back	_____
Side	_____
Stomach	_____
Other	_____
Unknown	_____

At what age did your baby first change from one position to another \_\_\_\_\_

Did the child use a pacifier? If so, for how long? \_\_\_\_\_

How many immunizations has the child had? (record with dates; use .5 to indicate half doses)  
DIPHTHERIA, TETANUS, and PERTUSSIS (DPT or DTaP) \_\_\_\_\_

POLIO (OPV, IPV) \_\_\_\_\_

HEPATITIS A \_\_\_\_\_

HEPATITIS B \_\_\_\_\_

HAEMOPHILUS INFLUENZAE TYPE B (HIB) \_\_\_\_\_

MEASLES/MUMPS/RUBELLA \_\_\_\_\_

CHICKEN POX (VARICELLA) \_\_\_\_\_

ROTA VIRUS (Rv) \_\_\_\_\_

PREVNAR (Pneumococcus vaccine) \_\_\_\_\_

MENINGITIS \_\_\_\_\_

Others not listed above- give name and dates: \_\_\_\_\_

Vaccinations administered in the last 72 hours?	YES	NO	UNKNOWN
Vaccinations given in last 2 weeks?	YES	NO	UNKNOWN

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***NOT INCLUDING*** the incident on the day of death,  
***did a caregiver ever find your child not breathing?*** YES NO UNKNOWN

If yes, how many times? \_\_\_\_\_  
Of these, how many times was the child:

Blue?	_____
Pale?	_____
Rigid?	_____
Limp?	_____
Choking/Gasping? (Milk or food in mouth or nose)	_____

Was your child asleep at the time of the event? YES NO UNKNOWN

How long had it been since the last feeding? \_\_\_\_\_

During these events, how many times did the child require:

No assistance?	_____
Vigorous stimulation?	_____
Gentle stimulation?	_____
CPR?	_____

Following these events, how many times did the child:

Stay at home?	_____
Go to the doctor or ER?	_____
Enter the hospital?	_____

Did the child ever experience any seizures? YES NO UNKNOWN  
Please elaborate—type of seizure and age(s) of occurrence \_\_\_\_\_

Did the child ever faint? YES NO UNKNOWN  
Please elaborate \_\_\_\_\_

Did the child experience developmental delay? YES NO UNKNOWN  
Please elaborate \_\_\_\_\_

Did the child ever have a breath holding spell? YES NO UNKNOWN  
Please elaborate \_\_\_\_\_

Prior to the terminal event, had the child ever gone more than 12 hours without eating? YES NO UNKNOWN

Prior to the terminal event, had the child ever experienced vomiting for greater than 12 hours? YES NO UNKNOWN

Was your child ever diagnosed as having any of the following: (check all those that apply)

- Apnea
- Chronic lung disease
- Asthma
- Gastroesophageal reflux (GER)
- Seizure disorder or neurologic problem
- Sleep disorder
- Muscle weakness
- Congenital heart disease of arrhythmia
- Irregular heartbeat
- Choking spells
- Bradycardia (slow heartbeat)

**Please elaborate on any positive history above:**

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Was the child ever on an apnea monitor at home? YES NO UNKNOWN  
If yes, starting at what age? \_\_\_\_\_ months  
And ending at what age? \_\_\_\_\_ months

Did the child use oxygen at home? YES NO UNKNOWN  
If yes, how many months? \_\_\_\_\_ months

Was the child on the monitor when he/she died? YES NO UNKNOWN

Was the child on oxygen at the time of death? YES NO UNKNOWN

**If treated for the above problems:**

Doctor's name: \_\_\_\_\_

Prior to events around their death, how would you describe your child's general health?

Excellent\_\_\_\_ Very Good \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

NUMBER OF OVERNIGHT HOSPITALIZATIONS (not counting their birth or death) \_\_\_\_\_

If ever hospitalized, at what age(s) and for what reason(s)?

\_\_\_\_\_  
\_\_\_\_\_

NUMBER OF EMERGENCY ROOM VISITS (not counting death) \_\_\_\_\_

If ever brought to the emergency room, at what age(s) and for what reason(s)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was your infant/child exposed to secondary smoke

from birth to 6 months?	YES	NO	UNKNOWN	
from 6 to 12 months?	YES	NO	UNKNOWN	
from 1 to 2 years?	YES	NO	UNKNOWN	
from greater than two years of age?	YES	NO	UNKNOWN	N/A

Did the child have any allergies? YES NO UNKNOWN

If so, name them and the symptoms the child encountered. What treatment was given?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was the child's last appointment with their doctor? \_\_\_\_\_

For what reason? What were the comments at that visit?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did the child take medication at home? YES NO UNKNOWN

**If yes, circle the CATEGORY and SPECIFY THE MEDICATION(S) USED:**

ANALGESICS (pain relievers): \_\_\_\_\_

ANTACIDS: \_\_\_\_\_

ANTIBIOTICS: \_\_\_\_\_

ANTIHISTAMINES: \_\_\_\_\_

ANTI-REFLUX MEDICATION: \_\_\_\_\_

INHALED BRONCHODILATORS: \_\_\_\_\_

COLIC MEDICATION: \_\_\_\_\_

DECONGESTANTS: \_\_\_\_\_

HEART MEDICATION/ BLOOD PRESSURE MEDICATION: \_\_\_\_\_

RESPIRATORY STIMULANTS: \_\_\_\_\_

SEIZURE MEDICATION: \_\_\_\_\_

OTHER MEDICATIONS: \_\_\_\_\_

**DIET**

Was the child breastfed?      YES      NO      UNKNOWN

If yes, until what age? \_\_\_\_\_

Did the mother smoke while breastfeeding?      YES      NO      UNKNOWN

Cigarettes per day \_\_\_\_\_

***If child was breastfed, circle the category that most closely describes the mother's drug use WHILE BREASTFEEDING this child: (OPTIONAL)***

Alcohol	none	occasionally	monthly	weekly	daily
Caffeine (tea/ coffee, etc.)	none	occasionally	monthly	weekly	daily
Vitamins	none	occasionally	monthly	weekly	daily
Iron	none	occasionally	monthly	weekly	daily
Aspirin	none	occasionally	monthly	weekly	daily
Acetaminophen (Tylenol)	none	occasionally	monthly	weekly	daily
Ibuprofen	none	occasionally	monthly	weekly	daily
Heart Medicine	none	occasionally	monthly	weekly	daily
Diuretics	none	occasionally	monthly	weekly	daily
Seizure Medicine	none	occasionally	monthly	weekly	daily
Antacid	none	occasionally	monthly	weekly	daily
Blood Pressure Medicine	none	occasionally	monthly	weekly	daily
Tranquilizers	none	occasionally	monthly	weekly	daily
Antidepressants	none	occasionally	monthly	weekly	daily
Antihistamine	none	occasionally	monthly	weekly	daily
Decongestant	none	occasionally	monthly	weekly	daily
Amphetamines	none	occasionally	monthly	weekly	daily
Marijuana	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily
Other: _____	none	occasionally	monthly	weekly	daily

If baby formula was used, at what age was it initiated? \_\_\_\_\_ Months of age

***Circle every item fed to the infant/child:***

- MILK FORMULA      SOY FORMULA      SPECIAL FORMULA  
 COW'S MILK      GOAT'S MILK      INFANT CEREAL      FRUIT      HONEY  
 VEGETABLES      MEATS      FINGER / TODDLER FOOD      NORMAL CHILD DIET

List any known food allergies

***Circle all supplements given to the child:***

VITAMINS      IRON      CALCIUM      POTASSIUM      OTHER \_\_\_\_\_

## DEVELOPMENT

Indicate the month of age that the child started the following:

	Month started	Never started
Smiling	_____	_____
Rolling belly to back	_____	_____
Rolling back to belly	_____	_____
Laughing	_____	_____
Sitting alone	_____	_____
Babbling (“mamamama, babababa”)	_____	_____
Crawling	_____	_____
Clapping	_____	_____
Pulling to stand	_____	_____
Walking holding on	_____	_____
First step	_____	_____
Walking alone	_____	_____
First word	_____	_____
Puts 2 words together	_____	_____
Eats Finger/Toddler Food	_____	_____
Feeds Self with spoon	_____	_____
Up Stairs Independently without support	_____	_____
Runs well	_____	_____
Making 2+ word sentences	_____	_____
Rides tricycle	_____	_____
Rides bicycle	_____	_____
Walks backward	_____	_____
Knows some opposites	_____	_____
Draws three parts of person	_____	_____
Catches small ball with two hands	_____	_____
Knows days of week	_____	_____
Skips	_____	_____

The child’s general personality was: (circle any that apply)

Happy      Easy going      Placid/lethargic      Irritable/short tempered      High strung/restless  
 Shy      Gregarious      None of these      Other \_\_\_\_\_

List anything unusual about the child:

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**TERMINAL EVENT HISTORY**

Number of day(s) since an immunization \_\_\_\_\_

Head Trauma (e.g. from a fall or accident):

0-24 hours prior to death?	YES	NO	UNKNOWN
24-48 hours prior to death?	YES	NO	UNKNOWN
48 hours-2 weeks prior to death?	YES	NO	UNKNOWN

If yes, please describe: \_\_\_\_\_

In the last 48 hours, did the caregiver report:

That the child was breathing strangely	YES	NO	UNKNOWN
That he/she sensed that something was going to happen?	YES	NO	UNKNOWN
That the child seemed to sweat excessively?	YES	NO	UNKNOWN

Emergency room visits in past 2 weeks \_\_\_\_\_

For what reason? \_\_\_\_\_

Did the child fly on an airplane in the past 2 weeks?	YES	NO	UNKNOWN
Exposure to contagious disease in past 2 weeks	YES	NO	UNKNOWN
Illness in past 2 weeks	YES	NO	UNKNOWN
Cold symptoms in 48 hours prior to death?	YES	NO	UNKNOWN

If yes, please describe symptoms \_\_\_\_\_

Lethargy in 48 hours prior to death?	YES	NO	UNKNOWN
Crankiness in 48 hours prior to death?	YES	NO	UNKNOWN
Excessive crying in 48 hours prior to death?	YES	NO	UNKNOWN
Seizure in 48 hours prior to death?	YES	NO	UNKNOWN
Appetite changes in 48 hours prior to death?	YES	NO	UNKNOWN
Vomiting in 48 hours prior to death?	YES	NO	UNKNOWN
Choking in 48 hours prior to death?	YES	NO	UNKNOWN
Fever in 48 hours prior to death?	YES	NO	UNKNOWN
Excessive sweating in 48 hours prior to death?	YES	NO	UNKNOWN
Diarrhea in 48 hours prior to death?	YES	NO	UNKNOWN
Other stool changes in 48 hours prior to death?	YES	NO	UNKNOWN
Injury or other condition not mentioned above?	YES	NO	UNKNOWN

If yes, please describe \_\_\_\_\_



**TERMINAL EVENT: CHILD AND ENVIRONMENT**

The child was discovered in a:  Crib  Toddler bed  Adult bed  Car seat  Stroller  
 Playpen  Other (please describe)\_\_\_\_\_

Please describe the sleeping surface: (please check all that apply)

- Soft surface
- Firm surface
- Fluffy pillows
- Firm pillows
- Blankets
- Quilt
- Stuffed animals
- Sleeping alone
- Sleeping with others

If sleeping with others, how many others?\_\_\_\_\_

If applicable, please describe the individuals who were on the same sleeping surface as the child and their relationship(s) with the child:

Person #1:	Relationship_____	Age_____	Height_____	Weight_____
Person #2:	Relationship_____	Age_____	Height_____	Weight_____
Person #3:	Relationship_____	Age_____	Height_____	Weight_____
Person #4:	Relationship_____	Age_____	Height_____	Weight_____

Body position when placed to sleep:

Back  Stomach  Side  Other  N/A  Unknown

Usual position placed to sleep:

Back  Stomach  Side  Other  N/A  Unknown

Body position when found:

Back  Stomach  Side  Other  Unknown

Face position when found:

To left  To right  Facedown  Face up  Unknown

Nose or mouth was covered or obstructed YES NO UNKNOWN

If yes, please describe: \_\_\_\_\_

Were there any fluids/substances around child's nose or mouth when found unresponsive? YES NO UNKNOWN

If yes, please describe substance in detail:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postmortem changes when found:

None  Rigor (stiff)  Lividity (blotchy purple coloring)  Other  Unknown

Describe what child was wearing when found:

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Number of covers or blanket layers on child: \_\_\_\_\_

Covers on child  Wrapped  No covers

Was there anything between the mattress and sheet?      YES      NO      UNKNOWN  
(sheepskin, pad, pillow etc.)

If yes, please describe:

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Describe other items in contact with child:

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Describe items in crib or immediate environment:

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List devices operating in room:

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Estimated temperature of room area: \_\_\_\_\_ degrees Fahrenheit

Estimated temperature outdoors: \_\_\_\_\_ degrees Fahrenheit

Cooling source in room:  On  Off  Central  Space  None

Heat source in room:  On  Off  Central  Space  None

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Was an autopsy done?      Yes       No

Cause of death \_\_\_\_\_

Date which cause of death was determined \_\_\_\_\_

**PREMONITIONS/INTUITIONS**

Did you ever sense that something would happen to your Child? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, what best describes these senses? (Circle any that apply)

- (1) physical observation of something viewed as abnormal (i.e., blue spells, irregular breathing, lethargy, excessive vomiting, etc.),
- (2) vague, pervasive feelings/ fears, without a definite physical basis, that something was not right...that you would not see your baby grow up,
- (3) Hypnogogic (the state between awake/ asleep) occurrences,
- (4) Dreams of impending death/ funeral,
- (5) Spiritual intervention ("A loving God was forewarning me...it was a time of preparation."), and/or
- (6) Voices or visions.
- (7) Other (Please explain.)

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Describe when and how often these "feelings" occurred?

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**SERVICES**

Were you referred for bereavement services? Yes / No

Who referred you? Circle one.

- ME/Coroner      Hospital Staff      Medical Examiner/Coroner      Funeral Director
- Other \_\_\_\_\_

What organization were you referred to? \_\_\_\_\_

Were you referred to a Center for SIDS? Yes / No

If you were not referred for any services:

Were you aware of bereavement services for SIDS? Yes / No

Were you aware of bereavement services for SUDC? Yes / No

Were metabolic disorders ever discussed as a possible cause of your child's death?

Were cardiac arrhythmias ever discussed as a possible cause of your child's death?

Did you ever receive recommendations to pursue genetic counseling? Yes/ No

By whom? \_\_\_\_\_

Were you ever discouraged from pursuing additional testing after being given a diagnosis of "unexplained death"? Yes / No

If so, by whom and what was the reason given?

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Were you ever encouraged to pursue additional testing after being given a diagnosis of an unexplained death? Yes / No

If Yes, by whom? \_\_\_\_\_

If No, by whom? \_\_\_\_\_