

## Registration and Background Form

Use this form to view or edit the general background data.

Patient ID:	Today's date:
Treating Clinic:	Patient Age when diet started:
Treatment Group: <input type="checkbox"/> Resource <input type="checkbox"/> Control	
Patient's Date of Birth:	
Patient Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Other	
Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Other	
Travel time to clinic: _____ hours	
Timing of diet initiation: <input type="checkbox"/> Post <input type="checkbox"/> Prior (when was treatment started?)	
Date diet started: _____ (entry should look like: 3/28/2001)	
Date LMP: _____ leave blank if patient is not pregnant (same date format)	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Unknown	
Patient's years of education:	Husband's years of education:
Patient Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Husband Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Patient's type of work:	Husband's type of work:
Pre-Pregnancy natural blood phenylalanine level (highest or most recent off-diet level): _____ mg/dl	
Pre-Pregnancy height: _____ cm	
Pre-Pregnancy weight: _____ kg - - Weight Status: <input type="checkbox"/> Normal <input type="checkbox"/> Over <input type="checkbox"/> Under	
Patient's Full Scale IQ: (from WAIS -Revised)	
Enter the number of each type of outcome of any previous pregnancies.	
Previous live birth:	
Previous spontaneous abort:	
Previous stillbirth:	
Previous terminated birth:	
To be completed by Children's Hospital, Boston: Hollingshead/redlich Score:	