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NINCDS COLLABORATIVE PERINATAL PROJECT
A User's Guide to the Project and Data

Volume II: Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part F: Pediatric and Neurological Exams, Four Months - One Year, Physical Growth Measurements, Interval History, and Summary of Illness or Hospitalization

December 1983

Prepared for
the National Institute of Neurological and Communicative Disorders and Stroke
under Contract 2311105150

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NINCDS COLLABORATIVE PERINATAL PROJECT: A USER'S GUIDE TO THE PROJECT AND DATA

Volume II. Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part F. Pediatric and Neurological Exams, Four Months - One Year, Physical Growth Measurements, Interval History, and Summary of Illness or Hospitalizations

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INTRODUCTION

DOCUMENT OBJECTIVES AND READER ASSUMPTIONS

Volume II, Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File, provides researchers with detailed documentation for how data were collected, coded and stored on the data base. Volume II will help investigators decide: if data were collected in a suitable way for addressing particular research questions; if revision of forms affected the collection of specific data items; if data were coded on master, variable or work files, or are available only on microfilm. The reader is assumed to be the principal investigator for a project in which data from the data base will be used.

DOCUMENT STRUCTURE

Because of its size, this volume is divided into ten separate parts, each containing material on a group of forms related by subject. Each part groups together similar study forms. Generally, a part covers a single time period. The parts do not correspond exactly to the hierarchical classification structure described in Volume I. The parts of Volume II include:

A. Prenatal Record and Medical History
B. Labor and Delivery
C. Pathological Exams and Autopsies
D. Family and Socioeconomic History
E. Neonatal Exams and Observations
F. Pediatric and Neurological Exams, Four Months - One Year
G. Pediatric Neurological Exams, Seven Years
H. Psychological Exams, Eight Months
I. Psychological Exams, Four Years and Seven Years
J. Speech, Language and Hearing Exams, Three Years and Eight Years (Final)

This part of Volume II contains Part F: Pediatric and Neurological Exams, Four Months - One Year and includes Forms PED-10, PED-11, PED-12, PED-14, PED-20 and PED-29.

To allow easy access to the data as they appear on the master file, all documentation for each form or form grouping representing a card series on the master file is identified by form number appearing at the bottom of each page. Forms are arranged in what may appear to be illogical numerical order in some cases, but the arrangement presented here ties forms and their revisions together and allows an investigator to trace an item through all revision cycles. Thus, in Part A of Volume II, OB-42 follows OB-9 and OB-10 appears next to OB-44 and OB-45. (For an explanation of how the master file was organized to result in this ordering, see the next section of the Introduction.)

All material related to a form is organized as a single unit within each part of Volume II. The material included for each form is given below in the order it appears:

- Descriptive Summary of Form. Includes purpose of form, history of use, revisions and location of records stored on Master File. A table is provided for each form (except those on microfilm only) showing the number of records available for each revision.

- Data Items Referencing Form. A list of all data items in computer files originating from form. List ordered by data item identification with reference to item number on form.

- Form. Copy of last revision of form.

- Form item numbers linked to data items. A list organized by form item numbers of all computerized data items originating from the form.

- Definition of codes. Coding instructions detailing the codes assigned to each computerized data item from the form.

- Master File card Image. Illustrates transfer of data on form to Master File card.

- Instructions for Completing Form. The instructions used by study personnel to complete the form for each case.

- Earlier Forms or Manuals. Copies of earlier versions of forms or manuals that were used during the study.

MASTER FILE ORGANIZATION AND REVISION OF FORMS

Some understanding of how the master file was organized should aid investigators who want to trace the entry of data into computerized study files. The numbering system used both on forms and cards provides information on how data may be retrieved from the master file.

Forms

The first forms used in the study were the OB forms; as a consequence, this group of forms underwent the most revision. At first glance, it appears that forms disappear from the file and reappear in strange or bewildering places. In actuality, revisions were made according to a specific method.

Two types of revision and subsequent recodes appear in the master file, both of which appear in the OB series. In the first type of revision, radical changes in the concept of a form created a need for new coding in the computer file. Form OB-9, for example, was replaced by forms OB-40 (an optional form retained by the institution), OB-42, and OB-43 in April 1962. Data for earlier patients were recorded on OB-9 and entered on cards 1309, 2309, 3309 and 4309 of the master file; after April 1962, data was recorded on OB-42 and OB-43 and were entered on cards 0342, 1343 and 2343 of the master file.

In the second type of revision, the Collaborative Perinatal Task Force considered revisions important enough to warrant the distinction of a new form number, but considered the data for both forms to be similar enough to allow combining of data from both the old and new forms on the same card series. An example of this type of revision is form OB-35, replaced by OB-57 in April 1962. Records for both OB-35 and OB-57 are entered on cards 0357, 1357, 2357, 3357, 4357, and 5357 in the master file.

In assigning numbers to forms and their revisions, designers of the study followed a plan: prenatal records, history, and summaries of the prenatal period received numbers 1 through 15; when revised, these forms were assigned numbers in the forties. Labor and hospital records appeared on the 30 series of forms. When these forms were revised, they were assigned numbers in the fifties. Some OB data in the master file were abstracted by NINCDS staff members from forms filled out at the hospital. Cards derived from this procedure were designated as coming from forms ADM-49, 50 and 51 (which were actually ABSTRACT SHEETS). Autopsy protocol and laboratory exams of the placenta were recorded on forms PATH-1, PATH-2 and PATH-3.

Forms for recording family health history and genetic information during pregnancy also received a fair amount of revision. Early records appear on forms FHH-1,2,3 and 4. With revisions in April 1963, form SE-1 replaces part of FHH-1 and FHH-3; FHH-2, FHH-4 and parts of FHH-1 and FHH-3 were replaced by

forms GEN-5 through GEN-8 in May 1961. Form FHH-9, initiated in November 1965 for collection of socioeconomic data at time the child was seven years of age, was not replaced or revised.

The PED series of forms underwent little revision. Records for newborn babies appeared in PED-1 through PED-8; records for children up to age one and interval records were placed on PED-10 through PED-29. Seven year records were included in the series numbered PED-74 and up. Only one pediatrics form was radically revised: PED-7 was replaced by PED-8 in March 1963.

No replacements occur in the PS series, where results of psychological and speech, language and hearing tests were recorded. The PS forms are divided into distinct groups based on time of testing and subject of testing. Psychological testing occurred at 8 months, 4 years and 7 years; speech, language and hearing exams were administered at ages 3 and 8. Only the 8 month psychological examination underwent substantial revisions.

Master File Card Number and NINDB Case Number Rationale

Computer cards for each NCPP study form are numbered to reflect their origin and possible revisions. Card numbers are assigned to identify the type of data (subject), the presence of multiple cards in a series, NCPP study form and form revisions. The first five digits of each card on the master file are the card number. The study forms and card numbers are given in Figure 1.

The first fourteen columns of each master file computer card contain the master file card number and the NINDB case number. Table 1 identifies the function of each of these columns.

Column 1 identifies multiple cards in a series. It contains a zero for cards unique to a particular form (that is, no other cards are present), for example OB-3, or for cards where repetitive data are contained. Cards for OB-2 are an example of this second type; no new categories of information are included on successive cards, but previous births in excess of four must be recorded on an add-on card. For card series where data entered are unique to a card and more than one card is required to complete the series, a "1" is used to designate the first card, for example OB-5. OB-57, PATH-2 and PED-14 are exceptions to these rules.

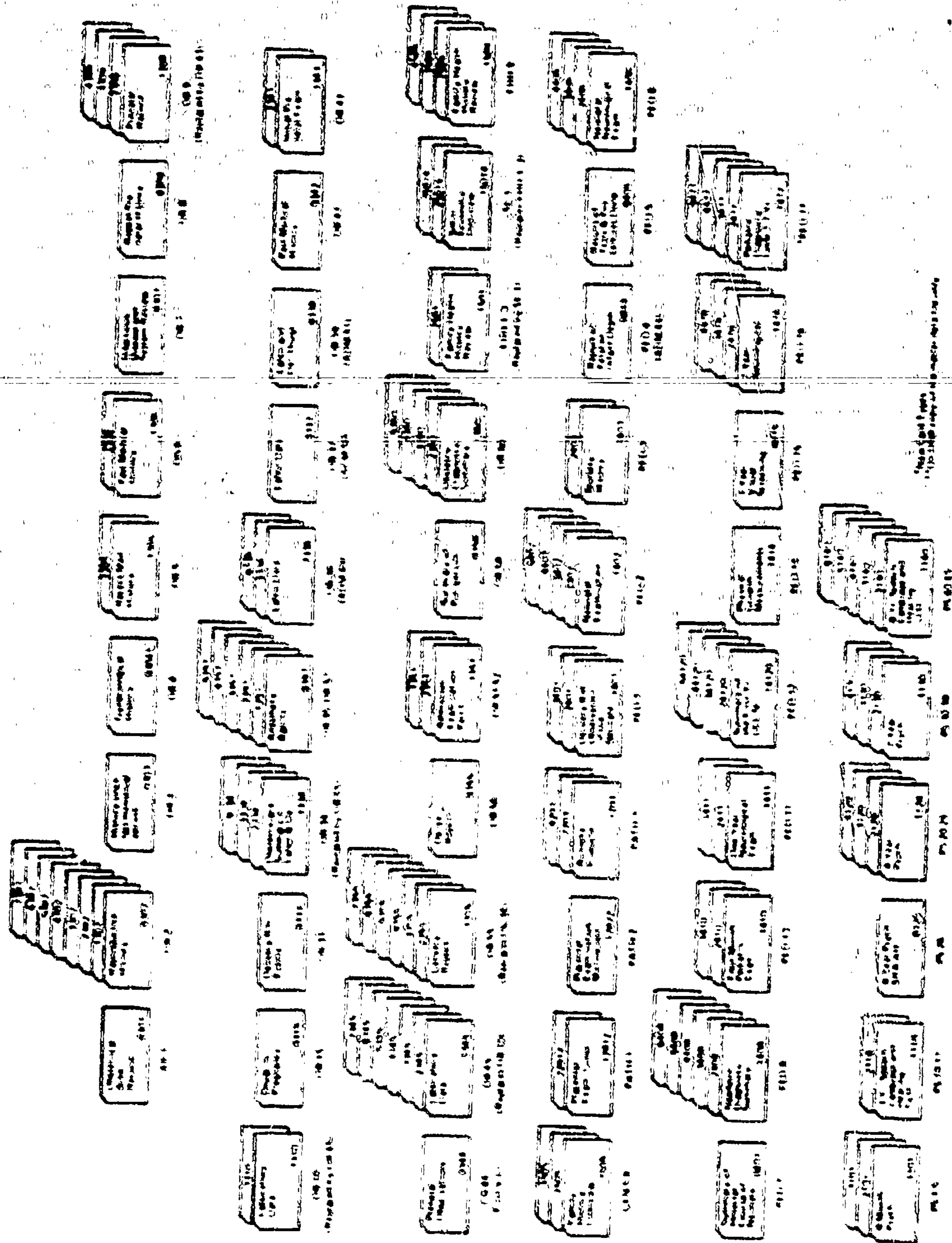

FIGURE 1. Cards on the Master Data File

TABLE 1. Derivation of Master File Card Number and NINDB Case Number.

Contents	Columns
Master File Card Number	
card identifier	1
general subject matter	2
form number	3-4
revision code	5
NINDB Case Number	
collaborating institution	6-7
type of patient selection	8
gravida identification number	9-12
order of the pregnancy	13
identifies child or gravida	14

The second digit on the card reveals the general subject matter covered by data on the card. All cards containing information pertaining to obstetrics, for example, are designated by a "3" in column 2; family histories are designated by a "5"; pathology with a "2"; pediatrics, with a "4"; and psychological testing with a "1".

Columns three and four reveal the form number. In the case of forms where old and new forms having different numbers are included together, the number of the latest form appears on the master file. This rule does not apply to data abstracted from several forms by NINCDS staff (ADM forms).

Column 5 of the card contains a revision code indicating which form or combination of forms was used in arriving at data on a particular card. A typical card will have one to three revision codes, with a zero indicating the first version of a form and "1", "2", and "3" indicating later revisions. As a rule, revision codes used on cards differ from card to card; investigators should check the definition of codes provided in Volume II to determine the meaning of revision codes used.

Each woman and child studied in the project received a unique case number (NINDB case number) composed of nine digits, recorded in columns 6 through 14 of all master file cards. The case number identified the institution, the mother and the child. The first two digits represented the collaborating institution (see Table 2). The third digit indicated the type of patient

selection. A "1" was used for patients selected for the central core study; a "6" indicated that a patient had been transferred from one institution to another, and a "7" indicated that the patient was part of a special study undertaken by the collaborating institution. The fourth through seventh digits were used to identify the gravida, while the eighth digit identified the order of the pregnancy of a given gravida in the project. The ninth digit was used to identify the gravida or child of the pregnancy; "9" indicated the gravida, "0" indicated the child of a single birth, "1" indicated the first child of a multiple birth, "2" indicated the second child of a multiple birth, etc.

TABLE 2. Collaborating Institutions and Their Code Number
(Columns six and seven of all master file cards.)

[illegible] - [illegible]
Harvard Medical School
Boston Lying-in Hospital
Children's Hospital Medical
  Center

10 - Buffalo, New York
University of Buffalo
Children's Hospital

15 - New Orleans, Louisiana
Charity Hospital
Tulane University School of
  Medicine Medical Center
Louisiana State University

[illegible] - New York, New York
Columbia University, College
  of Physicians & Surgeons
Columbia-Presbyterian
  Medical Center

37 - Baltimore, Maryland
The Johns Hopkins University
  School of Medicine
The Johns Hopkins Hospital

[illegible] - Richmond, Virginia
Virginia Commonwealth
  University
Medical College of Virginia

[illegible] - Minneapolis, Minnesota
University of Minnesota Hospital
Health Sciences Center

55 - New York, New York
New York Medical College
Metropolitan Hospital

60 - Portland, Oregon
University of Oregon
Medical School

66 - Philadelphia, Pennsylvania
University of Pennsylvania
Pennsylvania Hospital
The Children's Hospital of
  Philadelphia

[illegible] - Providence, Rhode Island
Brown University
Child Study Center

[illegible] - Memphis, Tennessee
University of Tennessee
  College of Medicine
Gailor Hospital

Data Item Identification and Naming

The NCPP data base contains over [illegible] different data items and blank filler locations on computer files. We have assigned each of these a unique identification and a terse, stylized name. Because names were chosen to facilitate use of this guide, they do not duplicate names used by NINCDS during the active phase of the project. Users should consult appropriate documentation before using data items from the master, variable or work files (Volumes II, III and IV).

The data item identifiers consist of 11 characters. At the far left are four unique numbers that were assigned sequentially. The next character is always a period and is followed by up to six characters. For data items on the master file, these characters describe the data collection form from which a data item was derived; for data items on the variable (VAR) or work (WKx) files, these characters indicate the appropriate file. If the right side is less than six characters, periods are inserted as shown in these examples:

[illegible]..OB-22	an item from OB-22, on the master file
[illegible].PATH-[illegible]	an item from PATH-5, on the master file
6123....VAR	an item on the variable file
[illegible]...WK-[illegible]	an item on work file [illegible] Rupture of Membranes

We assigned the numbers sequentially as they appear in Volume V. For the master file, we followed the order in which the cards would be found within an NCPP case. All card columns are accounted for by one of our data item identifications. For the variable and work files, the numbers were assigned in the order that data items appear within a case.

We categorized each data item according to the person to whom the data refer, by the time of measurement and/or the time to which the item applies and by general type or subject area (Table 1). Then we assigned names to the data items using the following guidelines:

- [illegible] categories may [illegible] stand alone - they must describe the data item out of context.
- The first word in the data item name had to be an important or key word since all names were listed alphabetically as in Volumes VI and VII. Thus "cry, abnormal" was used rather than "abnormal cry" because a

researcher is more likely to look for this item under "C" than under "A" in an alphabetic list.

- Secondary key words were preceded with a semicolon to facilitate preparation of the computed index. For example, "abruptio; placenta" will be found under both the "A" and "P" portion of Volume VI.

- Qualifying words are delimited by commas and will not appear as keywords in Volume VI. Thus "abruptio; placenta, degree" will not be found in the "D" section.

- If medical terminology or usage has changed since the study was conducted, modern terms may be included and will be enclosed in brackets. Thus "mongolism; [Down's syndrome]" will appear under both the "M" and "D" portions of Volume VI.

- If measurement units are associated with a data item name, they are enclosed in parentheses and placed at the end of the name as in "Birthdate (yr)."

- The categories (person, time and subject) are appended to the right of the data item name.

Definitions for each category used in naming data items are given in Table 4 at the end of this introduction. Additional information is found in Chapter 4 of Volume I.

Data item names thus assigned are terse and highly stylized; as we have already indicated, they are not the names used by NINCDS during the active phase of the project. Our aim was to develop standardized names that would stand alone. These names are intended to facilitate a user's search for data items potentially useful in a research project. Before an item is used, a researcher should consult its complete description. For a data item from the master files, e.g., 650..03-34, the data item should be traced to the appropriate study form, e.g., 03-34, located in Volume II. A variable file data item, e.g., 0223....VAR, is traced to Volume III, where it is defined and its original source given. A data item from a work file is traced to Volume IV for its description.

Some data items contained in the indexes may include the notation "DO NOT USE." These items are either inaccurate or an alternative data item is available that gives better information. Users will find more appropriate data items by consulting one of the indexes to the data items (Volumes V, VI and VIII).

Tables of Data Items: Column Headings

For each form, two sets of computer generated pages list all data items in either the master, variable or work files derived from this form. These lists enable a user to trace form items to computerized data items listed in other volumes of the User's Guide and vice versa. The computer listings have the following information.

Column Heading	Description
DATA ITEM ID	A unique identifier for this data item. See Data Item Identification and Naming above for details.
[illegible]	An identifier used on the [illegible] study form to identify the question or group of questions which was used to generate this data item.
CARD NUM	Identifies the master file card on which this data item is located. See Master File Card Number and [illegible] Case Number Rationale above for a description of card number.
[illegible]	Beginning card column for this data item.
[illegible]	Ending card column for this data item.
DATA ITEM NAME	Terse stylized name for this data item. See Data Item Identification and Naming above for details.

[illegible]

By examining the tables provided for each, investigators will be able to determine which computer files contain data of interest. For data contained in the variable file, see Volume III of this Guide; for data contained in work files, see Volume I[illegible].

TABLE 3. Abbreviations for Person, Time and Subject Categories

Person	Time	Subject
Mother	General	Administrative
Father	Preconception	Anesthesia
Placenta	Registration	Clin. Impression
Fetus	Prenatal	Clinical Lab
Child	Admission	Current Pregnancy
M Surrogate	Intrapartum	Environ. Exposure
Family	Delivery	Events
Sibship	Post Partum	Hearing
	Neonatal	Hospitalizations
	Four month	Language
	Eight month	Linkage
	One year	Malformations
	Three year	Diag. & Cond.
	Four year	Med. History
	Seven year	Medications
	Eight year	Neurological Exam
		Observations
		Pathology
		Physical Exam
		Procedure
		Psych. Exam
		Reproductive Hist.
		Serology
		Socioecon. Info
		Speech
		Vision
		Work History
		X-ray
		Summary
		Gyn. History
		Special Studies
		Fam/Genetic Hist.
		SLH Exam

TABLE 4. Definition of Person, Time and Subject Categories

PERSON	DEFINITION
Mother	Study registrant bearing the "study pregnancy"; biologic mother of the "study child"; gravida.
Father	Biologic father of the study child or study pregnancy; in the case of socioeconomic data, this category may indicate either the "father of baby" (not necessarily husband of the mother) or the "husband" (not necessarily related biologically to the study child).
Placenta	The organ of metabolic and gaseous interchange between the fetus and mother; also included in this category are gross and microscopic pathologic data from examination of the umbilical cord.
Fetus	Conceptus; the product of conception including the embryonic stage, i.e., from conception to the moment of birth.
Child	Product of the study pregnancy from the moment of birth onward; study child.
" Surrogate	Person or persons substituting for the mother of a study child, e.g., adoptive parents, foster parents or guardian.
Family	Person or persons biologically related to the mother or father of the study child.
Sibship	Child or children having one or both of the same biologic parents as the study child; siblings; half siblings; full siblings.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

TIME	DEFINITION
General	Data with no pertinent time period or data pertaining to more than one time period.
Preconception	Data pertaining to the period prior to conception of the study pregnancy.
Registration	Data collected at the time of study mother's registration in the study.
Prenatal	Data pertaining to the period from conception of the study pregnancy to delivery of the study child.
Admission	Data collected at the time of study mother's admission to the hospital for delivery of the study child.
Intrapartum	Data pertaining to the period from admission for delivery or onset of labor to delivery of the study child.
Delivery	Data pertaining to the time period during which delivery of the study child occurred.
Post Partum	Data (pertaining to the study mother) collected during the period immediately following birth of the study child.
Neonatal	Data pertaining to the study child during the period from birth to one month of age; the majority of these data were collected prior to or at the time a study child was discharged from the hospital.
Four Month	Data collected at the time of the four month examination of the study child.
Eight Month	Data collected at the time of the eight month examination of the study child.
One Year	Data collected at the time of the one year examination of the study child.
Three Year	Data collected at the time of the three year examination of the study child.
Four Year	Data collected at the time of the four year examination of the study child.
Seven Year	Data collected at the time of the seven year examination of the study child.
Eight Year	Data collected at the time of the eight year examination of the study child.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

SUBJECT	DEFINITION
Administrative	Data pertaining to the administrative aspects of the study.
Anesthesia	Data on medications and procedures used to obtain anesthesia.
Clin. Impression	Impression of abnormality or dysfunction gained by an examiner following evaluation of clinical signs and symptoms and including a subjective component.
Clinical Lab	Data obtained from laboratory examination of clinical specimens.
Current Pregnancy	Personal data and medically relevant information pertaining to the study pregnancy for which the mother is enrolled.
Environ. Exposure	Data on exposure to occupational or other environmental entities or hazards.
Events	Data related to a specific event, occurrence or incidence.
Hearing	Data obtained from examination and testing of hearing function.
Hospitalizations	Data on specific hospital admissions or the number of hospitalizations.
Language	Data obtained from examination and testing of language function.
Linkage	Data on the genetic relationships of family members to the study mother, father or child.
Malformations	Data on the conditions in which failure of normal development has resulted in abnormal physical traits existing at the time of birth.
Diag. & Cond.	Data on specific diagnoses or conditions obtained from past medical history or examination during the study.
Med. History	Data obtained from the study participant or medical records relevant to past or current medical diagnoses or conditions.
Medications	Data on drugs or medications used.
Neurological Exam	Data obtained from observation and physical examination of the central nervous system.
Observations	Data obtained from observations not categorized elsewhere.
Pathology	Data obtained from clinical and anatomical pathological examination.
Physical Exam	Data obtained from physical examination of the study participant.
Procedure	Data relating to specific procedures performed on the study participant prior to or during the period of enrollment in the study.
Psych. Exam	Data obtained from the psychological examinations and observations.

TABLE 4. Definition of Person, Time and Subject Categories. (Cont.)

SUBJECT	DEFINITION
Reproductive Hist.	Data pertaining to the outcome of pregnancies prior to and or during the period of enrollment in the study.
Serology	Data obtained from the laboratory examination of serum by specific immunologic methods.
Socioecon. Info	Data related to the social and economic characteristics and environment of the study participant.
Speech	Data obtained from examination and observation of speech function.
Vision	Data obtained from examination of the eyes.
Work History	Data pertaining to occupation and employment prior to and during the period of enrollment in the study.
X-Ray	Data on diagnostic x rays and diagnostic or therapeutic radiological procedures.
Summary	Data presented as a summary of data collected and recorded elsewhere.
Gyn. History	Medical history specifically related to the female genital tract, reproductive physiology and endocrinology.
Special Studies	Data pertaining to participation in other special organized studies conducted during the period of enrollment in the study.
Fam/Genetic Hist.	Data on the medical histories of family members genetically related to the study child.
SLH Exam	Data obtained from the speech, language and hearing examinations not specifically or exclusively related to one of these areas.

CONTENTS

PED-10	Four Month Pediatric Exam	II.F.1
PED-11	One Year Neurological Exam	II.F.57
PED-12	Summary of First Year of Life After Duration Summarized on PED-8	II.F.131
PED-14	Physical Growth Measurements	II.F.213
PED-20	Interval Medical History	II.F.225
PED-29	Summary of Medical Records of Illness or Hospitalization	II.F.245

PED-10 Four-Month Pediatric Examination

Purpose of the four-month pediatric exam was to detect evidence of injury or disease in the infant. Particular emphasis was placed on differentiating conditions related to the prenatal or perinatal period from conditions acquired in the postnatal period. Date of implementation of PED-10 into the study is uncertain, as the first version of the form was undated. Revision in October 1960 affected the form by changing the order of items, changing wording and by adding some items. Data from PED-10 were recorded on three cards in the master file (Table PED-10.1).

TABLE PED-10.1 Cards and Data Records by Revision for Form PED-10

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-10: Weight, Length, Conditions, Fontanelles	1410		
		0	5,956
		1	40,830
			46,786
PED-10: Musculo-Skeletal System, Tone, Motor Skills	2410		
		0	5,956
		1	40,867
			46,823
PED-10: Eyes, Movements, Moro Response	3410		
		0	5,954
			5,954
total for form			99,563

Data Items Referencing Form PED-10, 4-Month Pediatric Exam

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4297.......		1410	1	5	Card number (sequence, form type, form number, revision number)
4298.......		1410	6	14	NINDB case number
4299.PED-10	5	1410	15	16	Age (wks)
4300.PED-10	4	1410	17	18	Form PED-10 date (mo)
4301.PED-10	4	1410	19	20	Form PED-10 date (day)
4302.PED-10	4	1410	21	22	Form PED-10 date (yr)
4303.PED-10	1	1410	23	24	Birth date (mo)
4304.PED-10	1	1410	25	26	Birth date (day)
4305.PED-10	1	1410	27	28	Birth date (yr)
4306.PED-10	6	1410	29	30	Weight (lbs)
4307.PED-10	6	1410	31	32	Weight (oz)
4308.PED-10	7	1410	33	34	Length; body (cm)
4309.PED-10	7	1410	35	36	Length, lower segment (cm)
4310.PED-10	8	1410	37	38	Head circumference (cm)
4311.PED-10	9	1410	39	40	Chest circumference (cm)
4312.PED-10	10	1410	41	42	Respiratory rate
4313.PED-10	11	1410	43	45	Heart rate
4314.PED-10	12	1410	46	48	Blood pressure, systolic
4315.PED-10	13	1410	49	49	Skin apparence
4316.PED-10	14	1410	50	50	Subcutaneous tissue
4317.PED-10	15	1410	51	51	Hair; nails
4318.PED-10	16	1410	52	52	Head apparence
4319.PED-10	18	1410	53	53	Fontanelles, anterior, condition
4320.PED-10	18	1410	54	55	Fontanelles, anterior, A-P size (cm)
4321.PED-10	18	1410	56	57	Fontanelles, anterior, lateral (cm)
4322.PED-10	18	1410	58	58	Fontanelles, anterior, tension (cm)
4323.PED-10	19	1410	59	59	Fontanelles, posterior, condition
4324.PED-10	19	1410	60	61	Fontanelles, posterior, A-P size (cm)
4325.PED-10	19	1410	62	63	Fontanelles, posterior, lateral (cm)
4326.PED-10	19	1410	64	64	Fontanelles, posterior, tension (cm)
4327.PED-10	22	1410	65	65	Facies
4328.PED-10	23	1410	66	66	Movements; face
4329.PED-10	27	1410	67	67	Eye, right
4330.PED-10	28	1410	68	68	Eye, left
4331.PED-10	30	1410	69	69	Ear, right
4332.PED-10	31	1410	70	70	Ear, left
4333.PED-10	32	1410	71	71	Nose; mouth; pharynx
4334.PED-10	33	1410	72	72	Neck
4335.PED-10	34	1410	73	73	Thorax
4336.PED-10	35	1410	74	74	Respirations
4337.PED-10	36	1410	75	75	Lungs
4338.PED-10	37	1410	76	76	Heart

Data Items Referencing Form Ped-10, 4-Month Pediatric Exam

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4339.PED-10	18	1410	77	77	Pulses; femoral
4340.......		1410	78	78	Blank
4341.PED-10		1410	79	80	Length, upper segment (cm)
4342.......		2410	1	5	Card number (sequence, form type, form number, revision number)
4343.......		2410	6	14	NINDB case number
4344.PED-10	5	2410	15	16	Age (wks)
4345.PED-10	41	2410	17	17	Lymph nodes
4346.PED-10	42	2410	18	18	Abdomen and contents
4347.PED-10	43	2410	19	19	Liver
4348.PED-10	44	2410	20	20	Spleen
4349.PED-10	45	2410	21	21	Kidneys
4350.PED-10	46	2410	22	22	Genitalia
4351.PED-10	47	2410	23	23	Reflex; anal sphincter
4352.PED-10	48	2410	24	24	Spine
4353.PED-10	50	2410	25	25	Musculoskeletal; shoulder girdle
4354.PED-10	51	2410	26	26	Musculoskeletal; arms; wrists
4355.PED-10	52	2410	27	27	Musculoskeletal; hands
4356.PED-10	53	2410	28	28	Musculoskeletal; pelvic girdle
4357.PED-10	54	2410	29	29	Musculoskeletal; legs; ankles
4358.PED-10	55	2410	30	30	Musculoskeletal; feet
4359.PED-10	56	2410	31	31	Motor activity
4360.PED-10	61	2410	32	32	Tone; extremity, upper, bilateral
4361.PED-10	61	2410	33	33	Tone; extremity, upper, right
4362.PED-10	61	2410	34	34	Tone; extremity, upper, left
4363.PED-10	62	2410	35	35	Tone; extremity, lower, bilateral
4364.PED-10	62	2410	36	36	Tone; extremity, lower, right
4365.PED-10	62	2410	37	37	Tone; extremity, lower, left
4366.PED-10	63	2410	38	38	Tone; neck flexor, bilateral
4367.PED-10	63	2410	39	39	Tone; neck flexor, right
4368.PED-10	63	2410	40	40	Tone; neck flexor, left
4369.PED-10	64	2410	41	41	Tone; neck extensor, bilateral
4370.PED-10	64	2410	42	42	Tone; neck extensor, right
4371.PED-10	64	2410	43	43	Tone; neck extensor, left
4372.PED-10	65	2410	44	44	Tone; trunk, bilateral
4373.PED-10	65	2410	45	45	Tone; trunk, right
4374.PED-10	65	2410	46	46	Tone; trunk, left
4375.PED-10	66	2410	47	47	Grasp; palmar
4376.PED-10	67	2410	48	48	Grasp; plantar
4377.PED-10	68	2410	49	49	Reflex; patellar jerk
4378.PED-10	69	2410	50	50	Reflex; ankle jerk
4379.PED-10	70	2410	51	51	Clonus; ankle
4380.PED-10	71	2410	52	52	Hearing response
4381.PED-10	72	2410	53	53	Stepping response

Data Items Referencing Form PED-10, 4-Month Pediatric Exam

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4382.PED-10	73	2410	54	54	Placing response
4383.PED-10	74	2410	55	55	Response to mirror image
4384.PED-10	77	2410	56	56	Response to red ring
4385.PED-10	78	2410	57	57	Motor skills, supports weight
4386.PED-10	78	2410	58	58	Motor skills, prone
4387.PED-10	79	2410	59	59	Motor skills, sitting head erect
4388.PED-10	79	2410	60	60	Motor skills, sitting spine erect
4389.PED-10	80	2410	61	61	Hands, predominant position
4390.PED-10	81	2410	62	62	Cry
4391.PED-10	82	2410	63	63	Vocalization
4392.PED-10	84	2410	64	64	Maternal/child relationship: mother's responsiveness
4393.PED-10	85	2410	65	65	Maternal/child relationship: mother's focus
4394.PED-10	86	2410	66	66	Maternal/child relationship: mother's attitude towards child
4395.PED-10	87	2410	67	67	Maternal/child relationship: child's appearance
4396.PED-10	90	2410	68	68	Neurological abnormalities
4397.PED-10	91	2410	69	69	Non-neurological abnormalities
4398.PED-10	92	2410	70	70	Examination conditions unsatisfactory
4399.PED-10	93	2410	71	71	Disposition for further evaluation
4400.PED-10	94	2410	72	72	Form CP-5 attached
4401.......		2410	73	80	Blank
4402.......		3410	1	5	Card number (sequence, form type, form number, revision number)
4403.......		3410	6	14	NINDB case number
4404.PED-10		3410	15	16	Age (rev 0)
4405.PED-10	6	3410	17	19	Temperature (rev 0)
4406.......		3410	20	20	Blank
4407.PED-10	34	3410	21	22	Eyes: pupil size, right (mm) (rev 0)
4408.PED-10	35	3410	23	24	Eyes: pupil size, left (mm) (rev 0)
4409.PED-10	36	3410	25	25	Eye reaction, right (rev 0)
4410.PED-10	37	3410	26	26	Eye reaction, left (rev 0)
4411.PED-10	40	3410	27	27	Arms: hands (rev 0)
4412.PED-10	41	3410	28	28	Legs: feet (rev 0)
4413.PED-10	47	3410	29	29	Movement: extremities, upper (rev 0)
4414.PED-10	47	3410	30	30	Movement: extremities, lower (rev 0)
4415.PED-10	49	3410	31	31	Neck (rev 0)
4416.PED-10	50	3410	32	32	Trunk (rev 0)
4417.PED-10	51	3410	33	33	Extremity, upper (rev 0)
4418.PED-10	52	3410	34	34	Extremity, lower (rev 0)
4419.PED-10	53	3410	35	35	Suck (rev 0)
4420.PED-10	67	3410	36	36	Movement: head, right, jaw arm (rev 0)
4421.PED-10	67	3410	37	37	Movement: head, right, jaw leg (rev 0)
4422.PED-10	67	3410	38	38	Movement: head, right, occiput arm (rev 0)
4423.PED-10	67	3410	39	39	Movement: head, right, occiput leg (rev 0)
4424.PED-10	67	3410	40	40	Movement: head, right, pelvic rotation (rev 0)

Data Items Referencing Form PED-10, 4-Month Pediatric Exam

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4425.PED-10	68	3410	41	41	Movement: head, left fw arm (rev 0)
4426.PED-10	68	3410	42	42	Movement: head, left fw leg (rev 0)
4427.PED-10	68	3410	43	43	Movement: head, left occiput arm (rev 0)
4428.PED-10	68	3410	44	44	Movement: head, left occiput leg (rev 0)
4429.PED-10	68	3410	45	45	Movement: head, left pelvic rotation (rev 0)
4430.PED-10	75	3410	46	46	Response (rev 0)
4431.PED-10	77	3410	47	47	Moro response, arms (rev 0)
4432.PED-10	78	3410	48	48	Moro response, legs (rev 0)
4433.PED-10	79	3410	49	49	Moro response, how obtained (rev 0)
4434.PED-10	81	3410	50	50	Visual response (rev 0)
4435.PED-10	82	3410	51	51	Diagnosis: abnormal (rev 0)
4436.PED-10	82	3410	52	52	Diagnosis: malformation; congenital (rev 0)
4437.PED-10	82	3410	53	53	Diagnosis: development, abnormal (rev 0)
4438.PED-10	82	3410	54	54	Diagnosis: injury (rev 0)
4439.PED-10	82	3410	55	55	Diagnosis: abnormality, other (rev 0)
4440.......		3410	56	80	Blank
5633....VAR			807	807	Pediatric exam present (4 mo)
5937....VAR	40		1124	1124	Neurological abnormalities, 4 months
5940....VAR	5		1127	1128	Age (wks)
5963....VAR	8		1162	1163	Head circumference, 4 mo (cms)
5964....VAR			1164	1164	Head circumference (coded)
5970....VAR	6		1177	1180	Weight, 4 mo (lbs/oz)
5978....VAR	7		1200	1201	Length: body, 4 mo (cms)
6178....VAR	6		1482	1486	Weight 4 mo (gms)

FOUR-MONTH PEDIATRIC EXAMINATION

2. NAME OF EXAMINER

3. STATUS

4. DATE OF EXAMINATION Mo. Day Year | 5. AGE (In wks.)

6. WEIGHT ______

7. BODY LENGTH

Total (Crown-heel) ______ cm.

Lower Segment (Heel-symphysis) ______ cm.

8. HEAD CIRCUMFERENCE ______ cm.

9. CHEST CIRCUMFERENCE ______ cm.

10. RESPIRATORY RATE (Baby at resting state) ______ per min.

11. HEART RATE (Baby at resting state) ______ per min.

12. SYSTOLIC BLOOD PRESSURE (Palpation) ______

13. SKIN

- Normal (Including Mongolian Spots, ...)
- Pigmented Nevi
- Vascular Nevi
- Other Rashes
- Lesions and Wrinkles
- Café Au Lait Spots – approximate number ______
- Other (Specify)

[All items other than normal must be described.]

14. SUBCUTANEOUS TISSUE

- Normal
- Other (Specify)

15. HAIR AND NAILS

- Normal
- Other (Specify)

16. HEAD

- Normal
- Other (Specify)

17. FONTANELLES

	20. CLOSED	21. OPEN SIZE	TENSION
18. ANT.		AP ______ Lat ______	Normal; Other (Specify)
19. POST.		AP ______ Lat ______	Normal; Other (Specify)

22. FACIES

- Normal
- Asymmetrical
- Other (Specify)

23. MOVEMENTS OF FACE

- Present and Symmetrical
- Asymmetrical
- Absent
- Other (Specify)

24. COMMENTS

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FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

26. EYES

27. Right
- Normal
- Abnormal
  - Lid
  - Conjunctiva
  - Cornea
  - Pupil
  - Lens
  - Extraocular Muscles
  - Other (Specify)

28. Left
- Normal
- Abnormal
  - Lid
  - Conjunctiva
  - Cornea
  - Pupil
  - Lens
  - Extraocular Muscles
  - Other (Specify)

29. EARS

30. Right
- Normal
- Abnormal
  - Shape and Location
  - Canal
  - Drum
  - Other (Specify)

31. Left
- Normal
- Abnormal
  - Shape and Location
  - Canal
  - Drum
  - Other (Specify)

32. NOSE, MOUTH AND PHARYNX
- Normal
- Other (Specify)

33. NECK
- Normal
  - Restricted Range of Motion
  - Masses (Other than Lymph Nodes)
  - Other (Specify)

34. THORAX
- Normal
- Other (Specify)

35. RESPIRATIONS
- Normal
- Other (Specify)

36. LUNGS
- Normal
- Other (Specify)

37. HEART
- Normal
  - Irregular Rhythm
  - Murmur (Describe)
  - Thrill
  - Other (Specify)

38. FEMORAL PULSES
- Strong and Equal Bilaterally
- Other (Specify)

39. COMMENTS

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FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

41. LYMPH NODES
- Normal
- Other (Specify)

42. ABDOMEN AND CONTENTS
- Normal (Including Umbilical Hernia)
- Other (Specify)

43. LIVER
- Normal
- Other (Specify)

44. SPLEEN
- Normal
- Other (Specify)

45. KIDNEYS
- Not Palpable
- Palpable (Describe)

46. GENITALIA
- Normal
- Other (Specify)

47. ANAL SPHINCTER REFLEX
- Normal
- Other (Specify)

48. SPINE
- Normal
- Other (Specify)

49. MUSCULOSKELETAL SYSTEM

	Normal	Other (Specify)
50. Shoulder Girdle	☐	☐
51. Arms and Wrists	☐	☐
52. Hands	☐	☐
53. Pelvic Girdle	☐	☐
54. Legs and Ankles	☐	☐
55. Feet	☐	☐

56. MOTOR ACTIVITY
- Normal
- Tremulous or Jittery Movements
- Rapid Jerky Movements
- Myoclonic Movements
- Writhing Movements
- Asymmetrical Movements
- Paralysis
- Local Convulsions
- Generalized Convulsions
- Other (Specify)

57. DO NOT WRITE IN THIS SPACE

58. COMMENTS

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

60. TONE — Use the following code which will indicate a gradation from flaccid to rigid. Describe any asymmetry in right hand column.

1. Hypotonic
2. Questionable Hypotonicity
3. Normal
4. Questionable Hypertonicity
5. Hypertonic

	Bilateral	Right	Left
61. Upper Extremity	____	____	____
62. Lower Extremity	____	____	____
63. Neck Flexor	____	____	____
64. Neck Extensor	____	____	____
65. Trunk	____	____	____

66. PALMAR GRASP

☐ Present ☐ Asymmetrical ☐ Absent

67. PLANTAR GRASP

☐ Present ☐ Asymmetrical ☐ Absent

68. PATELLAR JERK

☐ Present Bilaterally ☐ Other (Specify)

69. ANKLE JERK

☐ Present Bilaterally ☐ Other (Specify)

70. ANKLE CLONUS

☐ Absent Bilaterally ☐ Other (Specify)

71. HEARING RESPONSE

☐ Normal ☐ Other (Specify)

72. STEPPING (Child erect, sole of foot on surface, one trunk and head inclined forward)

☐ Present Bilaterally and Symmetrically

☐ Questionable Response (Describe)

☐ Absent Bilaterally

☐ Asymmetrical (Describe)

☐ Scissoring

☐ Other (Describe)

73. PLACING (Child held erect and dorsum of foot drawn under lower edge of surface)

☐ Present Bilaterally and Symmetrically

☐ Questionable Response (Describe)

☐ Absent Bilaterally

☐ Asymmetrical (Describe)

☐ Other (Describe)

74. RESPONSE TO IMAGE IN MIRROR (Check highest level of response)

☐ Smiles, Vocalizes or Pats Mirror

☐ Shows Interest in Image (Other than above)

☐ No Response to Image

75. COMMENTS

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

77. RESPONSE TO RED RING (Check highest level of development)

- Plays With Ring
- Grasps Ring
- Follows Ring With Eyes
- Regards Red Ring
- None of Above

78. MOTOR SKILLS

	Yes	No	Unknown
Supports Some Weight On Feet			
Prone – Supports On Forearms			

79. SITTING WITH SUPPORT (Erect position of maximum response)

	Yes	No
Head Erect and Steady		
Spine Erect or Slight Curvature		

80. PREDOMINANT POSITION OF HANDS

- Open
- Closed With Thumb In Fist
- Closed With Thumb Out of Fist
- Asymmetrical [illegible]

81. CRY

- Normal
- Absent
- Other (Specify)

82. VOCALIZATION (Check highest level of development)

- Coos or Laughs
- Other Sounds Only
- No Sounds

83. M.C. EVALUATION (See Manual)

84. Responsiveness to Child's Physical Needs

Unresp.		Rec.	Abs.		NE

85. Mother's Focus of Attention During Examination

Child		Sit.	St.		NE

86. Attitude Toward Child's Test Performance

[illegible]		Int.	Def.		NE

87. Child's Appearance

P.C.F.		Approp.	Ove.		NE

88. COMMENTS

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

IMPRESSION

90. NEUROLOGICAL ABNORMALITIES
- None
- Neurologically Suspicious But No Definite Abnormalities (Describe reasons for this statement in detail)
- Neurologically Abnormal Child (Describe fully and give reasons)

91. NON-NEUROLOGICAL ABNORMALITIES (Check all that apply)
- None
- Minor Abnormalities or Deviations (Describe)
- Questionable Abnormalities (Describe)
- Definite Major Abnormalities (Describe)

92. UNSATISFACTORY CONDITIONS FOR EXAMINATION
- Absent
- Present (Specify)

93. DISPOSITION
- No Indication For F[illegible] [illegible]valuation At This Time
- Further Evaluatio[illegible] [illegible]ted Or Scheduled (Specify)

94. CP-5 ATTACHED
- No
- Yes

95. MEDICAL EDITOR'S COMMENTS

96. COMMENTS

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Form Item Numbers Linked to Data Items on PED-10, 4-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	4404.PED-10	1410	15	16	Age (rev 0)
	5064....VAR		1164	1164	Head circumference (coded)
	4341.PED-10	1410	79	80	Length, upper segment (cm)
	5631....VAR		807	807	Pediatric exam present (4 mo)
1	4304.PED-10	1410	25	26	Birth date (day)
1	4303.PED-10	1410	23	24	Birth date (mo)
1	4305.PED-10	1410	27	28	Birth date (yr)
4	4301.PED-10	1410	19	20	Form PED-10 date (day)
4	4300.PED-10	1410	17	18	Form PED-10 date (mo)
4	4302.PED-10	1410	21	22	Form PED-10 date (yr)
5	4299.PED-10	1410	15	16	Age (wks)
5	4344.PED-10	2410	15	16	Age (wks)
5	5940....VAR		1127	1128	Age (wks)
6	4405.PED-10	1410	17	19	Temperature (rev 0)
6	4306.PED-10	1410	29	30	Weight (lbs)
6	4307.PED-10	1410	31	32	Weight (oz)
6	6178....VAR		1482	1486	Weight 4 mo (gms)
6	5970....VAR		1177	1180	Weight, 4 mo (lbs/oz)
7	4309.PED-10	1410	35	36	Length, lower segment (cm)
7	4308.PED-10	1410	33	34	Length; body (cm)
7	5978....VAR		1200	1201	Length; body, 4 mo (cms)
8	4310.PED-10	1410	37	38	Head circumference (cm)
8	5963....VAR		1162	1163	Head circumference, 4 mo (cms)
9	4311.PED-10	1410	39	40	Chest circumference (cm)
10	4312.PED-10	1410	41	42	Respiratory rate
11	4313.PED-10	1410	43	45	Heart rate
12	4314.PED-10	1410	46	48	Blood pressure, systolic
13	4315.PED-10	1410	49	49	Skin apperence
14	4316.PED-10	1410	50	50	Subcutaneous tissue
15	4317.PED-10	1410	51	51	Hair; nails
16	4318.PED-10	1410	52	52	Head apparence
18	4320.PED-10	1410	54	55	Fontanelles, anterior, A-P size (cm)
18	4319.PED-10	1410	53	53	Fontanelles, anterior, condition
18	4321.PED-10	1410	56	57	Fontanelles, anterior, lateral (cm)
18	4322.PED-10	1410	58	58	Fontanelles, anterior, tension (cm)
19	4324.PED-10	1410	60	61	Fontanelles, posterior, A-P size (cm)
19	4323.PED-10	1410	59	59	Fontanelles, posterior, condition
19	4325.PED-10	1410	62	63	Fontanelles, posterior, lateral (cm)
19	4326.PED-10	1410	64	64	Fontanelles, posterior, tension (cm)
22	4327.PED-10	1410	65	65	Facies
23	4328.PED-10	1410	66	66	Movements; face
27	4329.PED-10	1410	67	67	Eye, right

Form Item Numbers Linked to Data Items on PED-10, 4-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
28	4330.PED-10	1410	68	68	Eye, left
30	4331.PED-10	1410	69	69	Ear, right
31	4332.PED-10	1410	70	70	Ear, left
32	4333.PED-10	1410	71	71	Nose; mouth; pharynx
33	4334.PED-10	1410	72	72	Neck
34	4407.PED-10	3410	21	22	Eyes; pupil size, right (mm) (rev 0)
34	4335.PED-10	1410	73	73	Thorax
35	4408.PED-10	3410	23	24	Eyes; pupil size, left (mm) (rev 0)
35	4336.PED-10	1410	74	74	Respirations
36	4409.PED-10	3410	25	25	Eye reaction, right (rev 0)
36	4337.PED-10	1410	75	75	Lungs
37	4410.PED-10	3410	26	26	Eye reaction, left (rev 0)
37	4338.PED-10	1410	76	76	Heart
38	4339.PED-10	1410	77	77	Pulses; femoral
40	4411.PED-10	3410	27	27	Arms; hands (rev 0)
41	4412.PED-10	3410	28	28	Legs; feet (rev 0)
41	4345.PED-10	2410	17	17	Lymph; nodes
42	4346.PED-10	2410	18	18	Abdomen and contents
43	4347.PED-10	2410	19	19	Liver
44	4348.PED-10	2410	20	20	Spleen
45	4349.PED-10	2410	21	21	Kidneys
46	4350.PED-10	2410	22	22	Genitalia
47	4414.PED-10	3410	30	30	Movement; extremities, lower (rev 0)
47	4413.PED-10	3410	29	29	Movement; extremities, upper (rev 0)
47	4351.PED-10	2410	23	23	Reflex; anal sphincter
48	4352.PED-10	2410	24	24	Spine
49	4415.PED-10	3410	31	31	Neck (rev 0)
50	4353.PED-10	2410	25	25	Musculoskeletal; shoulder girdle
50	4416.PED-10	3410	32	32	Trunk (rev 0)
51	4417.PED-10	3410	33	33	Extremity, upper (rev 0)
51	4354.PED-10	2410	26	26	Musculoskeletal; arms; wrists
52	4418.PED-10	3410	34	34	Extremity, lower (rev 0)
52	4355.PED-10	2410	27	27	Musculoskeletal; hands
53	4356.PED-10	2410	28	28	Musculoskeletal; pelvic girdle
53	4419.PED-10	3410	35	35	Suck (rev 0)
54	4357.PED-10	2410	29	29	Musculoskeletal; legs; ankles
55	4358.PED-10	2410	30	30	Musculoskeletal; feet
56	4359.PED-10	2410	31	31	Motor activity
61	4360.PED-10	2410	32	32	Tone; extremity, upper, bilateral
61	4362.PED-10	2410	34	34	Tone; extremity, upper, left
61	4361.PED-10	2410	33	33	Tone; extremity, upper, right
62	4363.PED-10	2410	35	35	Tone; extremity, lower, bilateral
62	4365.PED-10	2410	37	37	Tone; extremity, lower, left

Form Item Numbers linked to Data Items on PED-10, 4-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
62	4364.PED-10	2410	36	36	Tone: extremity, lower, right
63	4366.PED-10	2410	38	38	Tone: neck flexor, bilateral
63	4368.PED-10	2410	40	40	Tone: neck flexor, left
63	4367.PED-10	2410	39	39	Tone: neck flexor, right
64	4369.PED-10	2410	41	41	Tone: neck extensor, bilateral
64	4371.PED-10	2410	43	43	Tone: neck extensor, left
64	4370.PED-10	2410	42	42	Tone: neck extensor, right
65	4372.PED-10	2410	44	44	Tone: trunk, bilateral
65	4374.PED-10	2410	46	46	Tone: trunk, left
65	4373.PED-10	2410	45	45	Tone: trunk, right
66	4375.PED-10	2410	47	47	Grasp: palmar
67	4376.PED-10	2410	48	48	Grasp: plantar
67	4420.PED-10	3410	36	36	Movement: head, right, jaw arm (rev 0)
67	4421.PED-10	3410	37	37	Movement: head, right, jaw leg (rev 0)
67	4422.PED-10	3410	38	38	Movement: head, right, occiput arm (rev 0)
67	4423.PED-10	3410	39	39	Movement: head, right, occiput leg (rev 0)
67	4424.PED-10	3410	40	40	Movement: head, right, pelvic rotation (rev 0)
68	4425.PED-10	3410	41	41	Movement: head, left jaw arm (rev 0)
68	4426.PED-10	3410	42	42	Movement: head, left jaw leg (rev 0)
68	4427.PED-10	3410	43	43	Movement: head, left occiput arm (rev 0)
68	4428.PED-10	3410	44	44	Movement: head, left occiput leg (rev 0)
68	4429.PED-10	3410	45	45	Movement: head, left pelvic rotation (rev 0)
68	4377.PED-10	2410	49	49	Reflex: patellar jerk
69	4378.PED-10	2410	50	50	Reflex: ankle jerk
70	4379.PED-10	2410	51	51	Clonus: ankle
71	4380.PED-10	2410	52	52	Hearing response
72	4381.PED-10	2410	53	53	Stepping response
73	4382.PED-10	2410	54	54	Placing response
74	4383.PED-10	2410	55	55	Response to mirror image
75	4430.PED-10	3410	46	46	Response (rev 0)
77	4431.PED-10	3410	47	47	Moro response, arms (rev 0)
77	4384.PED-10	2410	56	56	Response to red ring
78	4632.PED-10	3410	48	48	Moro response, legs (rev 0)
78	4386.PED-10	2410	58	58	Motor skills, prone
78	4385.PED-10	2410	57	57	Motor skills, supports weight
79	4433.PED-10	3410	49	49	Moro response, how obtained (rev 0)
79	4387.PED-10	2410	59	59	Motor skills, sitting head erect
79	4388.PED-10	2410	60	60	Motor skills, sitting spine erect
80	4389.PED-10	2410	61	61	Hands, predominant position
81	4390.PED-10	2410	62	62	Cry
81	4434.PED-10	3410	50	50	Visual response (rev 0)
82	4435.PED-10	3410	51	51	Diagnosis: abnormal (rev 0)
82	4439.PED-10	3410	55	55	Diagnosis: abnormality, other (rev 0)

Form Item Numbers linked to Data Items on PED-10, 4-Month Pediatric Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
82	4437.PED-10	3410	53	53	Diagnosis: development, abnormal (rev 0)
82	4438.PED-10	3410	54	54	Diagnosis: injury (rev 0)
82	4436.PED-10	3410	52	52	Diagnosis: malformation; congenital (rev 0)
82	4391.PED-10	2410	63	63	Vocalization
84	4392.PED-10	2410	64	64	Maternal/child relationship: mother's responsiveness
85	4393.PED-10	2410	65	65	Maternal/child relationship: mother's focus
86	4394.PED-10	2410	66	66	Maternal/child relationship: mother's attitude towards child
87	4395.PED-10	2410	67	67	Maternal/child relationship: child's appearance
90	4396.PED-10	2410	68	68	Neurological abnormalities
90	5937....VAR		1124	1124	Neurological abnormalities, 4 months
91	4397.PED-10	2410	69	69	Non-neurological abnormalities
92	4398.PED-10	2410	70	70	Examination conditions unsatisfactory
93	4399.PED-10	2410	71	71	Disposition for further evaluation
94	4400.PED-10	2410	72	72	Form CP-5 attached

DEFINITION OF CODES
FOUR MONTH PEDIATRIC EXAMINATION
FORM PED-10 CARD 1410

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 410	2-4
3.	Revision Number * Code: 0 - Form Dated: Undated 1 - Form Dated: Rev. 10/60	5
4.	NINDB # Item 3 Nine-digit number for Patient Identification	6-14
5.	Age Item 5 Code: As given 98 - 98 weeks or more	15-16
6.	Date of Examination Item 4 Six-digit code for month (cols. 17-18), day (cols. 19-20) and year (cols. 21-22) Code: As given	17-22
7.	Date of Birth Item 1 Code: Same as in Field 6	23-28
8.	Weight Item 6 Code: 0500-2515 - As given in pounds and ounces 9999 - Not reported	29-32

* Unless specified Fields, Codes and Card Columns refer to Revisions "0" and "1". Item numbers refer to Form Dated: Rev. 10/60.

FIELD		CARD COLUMN
9.	**Body Length - Total** Item 7 Code: 25-75 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 76-78, 80	33-34
10.	**Body Length - Lower Segment** Item 7 Code: 12-45 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 65	35-36
11.	**Head Circumference** Item 8 Code: 30-48 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 27,49, 50, 53, 60	37-38
12.	**Chest Circumference** Item 9 Code: 30-50 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 26-28, 29, 51	39-40
13.	**Respiratory Rate** Item 10 Code: 10-97 - As given in cms. 98 - 98 or more 99 - Not reported	41-42
14.	**Heart Rate** Item 11 Code: 050-200 - As given 999 - Not reported Additional codes reviewed and approved : 040, 204, 205, 210, 216, 220, 224	43-45
15.	**Systolic Blood Pressure** Item 12 Code: 040-200 - As given 999 - Not reported Additional codes reviewed and approved: 030, 032, 035, 036, 038, 039, 230	46-48

FIELD		CARD COLUMN
16.	**Skin** Item 13. Code: 0 - Normal 1 - Pigmented nevi (Revision "1" only) 2 - Vascular nevi (Revision "1" only) 3 - Other rashes (Revision "1" only) 4 - Loose and wrinkled (Revision "1" only) 5 - Cafe au lait spots (Revision "1" only) 7 - Combination of codes (Revision "1" only) 8 - Other 9 - Not reported	49
17.	**Subcutaneous Tissue** (Revision "1" only) Item 14. Code: Blank - Not on Revision "0" 0 - Normal 8 - Other 9 - Not reported	50
18.	**Hair and Nails** (Revision "1" only) Item 15 Code: Blank - Not on Revision "0" 0 - Normal 8 - Other 9 - Not reported	51
19.	**Head** Item 16. Code: 0 - Normal 8 - Other 9 - Not reported	52

DEFINITION OF CODES (Continued)

FORM PED-10
Card 1410

FIELD		CARD COLUMN
20.	Anterior Fontanelles Item 18 Code: 0 - Closed 1 - Open 9 - Not reported	53
21.	Anterior Fontanelles - AP Size Item 18 Code: X and blank - Closed or not reported in Field 20 (Rev. "1" only) 00 - Less than one cm. 01-08 - As given in cms. 99 - Not reported Additional codes reviewed and approved: 09-12, 15	54-55
22.	Anterior Fontanelles - Lat. Size Item 18 Code: Same as in Field 21 except that Blank = Closed or not reported in Field 20 (Rev. "1" only) Additional codes reviewed and approved: 09, 10, 12	56-57
23.	Anterior Fontanelles - Tension (Rev. "1" only) Item 18 Code: Blank - Closed or not reported in Field 20 for Rev. "1" only, not on Rev. "0" 0 - Tension 8 - Other 9 - Not reported	58
24.	Posterior Fontanelles Item 19 Code: Same as in Field 20	59
25.	Posterior Fontanelles - AP Size Item 19 Code: Same as in Field 21 except that numeric (-) and blank = Closed or not reported in Field 24 (Rev. "1" only) Additional codes reviewed and approved: 09	60-61
26.	Posterior Fontanelles - Lat. Size Item 19 Code: Same as in Field 21 except that Blank = Closed or not reported in Field 24 (Rev. "1" only)	62-63

FIELD		CARD COLUMN
27.	Posterior Fontanelles - Tension (Revision "1" only) Item 19 Code: Blank - Closed or not reported in Field 24, not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	64
28.	Facies (Revision "1" only) Item 22 Code: Blank - Not on Rev. "0" 0 - Normal 1 - Asymmetrical 8 - Other 9 - Not reported	65
29.	Movements of Face Item 23 Code: 0 - Present and symmetrical 1 - Asymmetrical 2 - Absent 8 - Other 9 - Not reported	66
30.	Right Eye Item 27 Code: 0 - Normal 1 - Lid abnormal (Rev. "1' only) 2 - Conjunctiva (Rev. "1" only) 3 - Cornea 4 - Pupil 5 - Lens 6 - Extraocular muscles(Rev. "1" only) 7 - Combination of codes 8 - Other 9 - Not reported	67
31.	Left Eye Item 28 Code: Same as in Field 30	68

DEFINITION OF CODES (Continued)

FORM PED-10
Card 1410

FIELD

CARD COLUMN

32. **Right Ear** — 69
Item 30
Code: 0 - Normal
1 - Shape and Location
2 - Canal
3 - Drum
7 - Combination of codes
8 - Other
9 - Not reported

33. **Left Ear** — 70
Item 31
Code: Same as in Field 32

34. **Nose, Mouth and Pharynx** — 71
Item 32
Code: 0 - Normal
8 - Other
9 - Not reported

35. **Neck** — 72
Item 33
Code: 0 - Normal
1 - Restricted range of motion
2 - Masses
7 - Combination of codes (Rev. "1" only)
8 - Other
9 - Not reported

36. **Thorax** (Revision "1" only) — 73
Item 34
Code: Blank - Not on Rev. "0"
0 - Normal
8 - Other
9 - Not reported

37. **Respirations** — 74
Item 35
Code: 0 - Normal
8 - Other
9 - Not reported

FIELD		CARD COLUMN
38.	**Lungs** Item 36 Code: Same as in Field 37	75
39.	**Heart** Item 37 Code: 0 - Normal 1 - Irregular rhythm 2 - Murmur 3 - Thrill 7 - Combination of codes 8 - Other 9 - No report	76
40.	**Femoral Pulses** (Revision "1" only) Item 38 Code: Blank - Not on Rev. "0" 0 - Strong and equal bilaterally 8 - Other 9 - Not reported	77
41.	Blank	78
42.	**Length - Upper Segment** (Rev. "0" only) Two-digit code for centimeters Code: 00 - Less than one cm. 01-97 - As given in cms. 98 - 98 and over 99 - Not reported Blank - not on Rev. 1	79-80

FIELD		CARD COLUMN
1.	Card Number Code: 2	1
2.	Basic Data * Code: Same as in columns 2-16 of Card 1	2-16
3.	Lymph Nodes (Revision "1" only) Item 41 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	17
4.	Abdomen and Contents Item 42 Code: 0 - Normal 8 - Other 9 - Not reported	18
5.	Liver Item 43 Code: 0 - Normal 8 - Other 9 - Not reported	19
6.	Spleen Item 44 Code: 0 - Normal 8 - Other 9 - Not reported	20

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0" and "1". Item numbers refer to Form Dated: Rev. 10/60.

FIELD		CARD COLUMN
7.	Kidneys Item 45 Code: 0 - Not palpable 1 - Palpable 9 - Not reported	21
8.	Genitalia Item 46 Code: 0 - Normal 8 - Other 9 - Not reported	22
9.	Anal Sphincter Reflex (Revision "1" only) Item 47 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	23
10.	Spine Item 48 Code: 0 - Normal 8 - Other 9 - Not reported	24
11.	Shoulder Girdle (Revision "1" only) Item 50 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	25
12.	Arms and Wrists (Revision "1" only Item 51 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	26

FIELD		CARD COLUMN
13.	<u>Hands</u> (Revision "1" only) Item 52 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	27
14.	<u>Pelvic Girdle</u> (Revision "1" only) Item 53 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	28
15.	<u>Legs and Ankles</u> (Revision "1" only) Item 54 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	29
16.	<u>Feet</u> (Revision "1" only) Item 55 Code: Blank - Not on Rev. "0" 0 - Normal 8 - Other 9 - Not reported	30
17.	<u>Motor Activity</u> Item 56 Code: 0 - Normal 1 - Tremulous or jittery movements 2 - Jerky or myoclonic movements 3 - Writhing movements 4 - Asymmetrical movements (Revision "1" only) 5 - Local convulsions 6 - Generalized convulsions 7 - Combination of codes (Revision "1" only) 8 - Other (Paralysis) 9 - Not reported	31

FIELD		CARD COLUMN
18.	Tone: Upper Extremity (Rev. "1" only) Item 61 Three-digit code for: Bilateral (col. 32) Right (col. 33) Left (col. 34) Code for each column: Blank - Not on Rev. "0" 0 - Not applicable 1 - Hypotonic 2 - Questionable hypotonicity 3 - Normal 4 - Questionable hypertonicity 5 - Hypertonic 9 - Not reported	32-34
19.	Tone: Lower Extremity (Rev. "1" only) Item 62 Code: Same as in Field 18	35-37
20.	Tone: Neck Flexor (Rev. "1" only) Item 63 Code: Same as in Field 18	38-40
21.	Tone: Neck Extensor (Rev. "1" only) Item 64 Code: Same as in Field 18	41-43
22.	Tone: Trunk (Rev. "1" only) Item 65 Code: Same as in Field 18	44-46
23.	Palmar Grasp Item 66 Code: 0 - Present 1 - Asymmetrical 2 - Absent 9 - Not reported	47

FIELD		CARD COLUMN
24.	Plantar Grasp (Revision "1" only) Item 67 Code: Blank - Not on Rev. "0" 0 - Present 1 - Asymmetrical 2 - Absent 9 - Not reported	48
25.	Patellar Jerk Item 68 Code: 0 - Present bilaterally 8 - Other 9 - Not reported	49
26.	Ankle Jerk Item 69 Code: 0 - Present bilaterally 8 - Other 9 - Not reported	50
27.	Ankle Clonus Item 70 Code: 0 - Absent bilaterally 8 - Other 9 - Not reported	51
28.	Hearing Response Item 71 Code: 0 - Normal 8 - Other 9 - Not reported	52

FIELD		CARD COLUMN
29.	**Stepping** (Revision "1" only) Item 72 Code: Blank - Not on Rev. "0" 0 - Present bilaterally and symmetrically 1 - Questionable response 2 - Absent bilaterally 3 - Asymmetrical 4 - Scissoring 8 - Other 9 - Not reported	53
30.	**Placing** (Revision "1" only) Item 73 Code: Blank - Not on Rev. "0" 0 - Present bilaterally and symmetrically 1 - Questionable response 2 - Absent bilaterally 3 - Asymmetrical 8 - Other 9 - Not reported	54
31.	**Response to Image in Mirror (Revision "1" only)** Item 74 Code: Blank - Not on Rev. "0" 1 - Smiles, vocalizes or pats mirror 2 - Shows interest in mirror 8 - No response to image 9 - Not reported	55
32.	**Response to Red Ring** (Revision "1" only) Item 77 Code: Blank - Not on Rev. "0" 1 - Plays with ring 2 - Grasps ring 3 - Follows ring with eyes 4 - Regards red ring 8 - None of above 9 - No report	56

FIELD		CARD COLUMN
33.	Motor Skills: Supports Weight (Revision "1" only)	57
	Item 78 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Unknown	
34.	Motor Skills: Prone (Rev. "1" only)	58
	Item 78 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Unknown	
35.	Sitting With Support: Head Erect (Revision "1" only)	59
	Item 79 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Not reported	
36.	Sitting With Support: Spine Erect (Revision "1" only)	60
	Item 79 Code: Blank - Not on Rev. "0" 0 - Yes 1 - No 9 - Not reported	
37.	Predominant Position of Hands (Revision "1" only)	61
	Item 80 Code: Blank - Not on Rev. "0" 1 - Open 2 - Closed with thumb in fist 3 - Closed with thumb out of fist 4 - Asymmetrical 9 - Not reported	

FIELD		CARD COLUMN
38.	Cry (Revision "1" only)	62
	Item 81 Code: Blank - Not on Rev. "0" 0 - Normal 1 - Absent 8 - Other 9 - Not reported	
39.	Vocalization (Revision "1" only)	63
	Item 82 Code: Blank - Not on Rev. "0" 1 - Coos or laughs 2 - Other sounds only 3 - No sounds 9 - Not reported	
40.	Evaluation: Mother's Responsiveness (Revision "1" only)	64
	Item 84 Code: Blank - Not on Rev. "0" 1 - Unaware and unresponsive 2 - Slow in responding 3 - Appropriate recognition 4 - Overprotective in moderation 5 - Extremely absorbed 9 - Unknown	
41.	Evaluation: Mother's Focus (Rev. "1" only)	65
	Item 85 Code: Blank - Not on Rev. "0" 1 - All attention on child 2 - Tried to involve herself 3 - Appropriate attention 4 - Occasionally interrupted 5 - Demanded all attention 9 - Unknown	
42.	Evaluation: Attitude Towards Child (Revision "1" only)	66
	Item 86 Code: Blank - Not on Rev. "0" 1 - Completely indifferent 2 - Brief and fleeting interest 3 - Intermediate	

FIELD		CARD COLUMN
42.	Evaluation: Attitude Towards Child (Continued) Code: 4 - Excessive pride in successes, and minimized failures 5 - Overly absorbed in performance 9 - Unknown	66
43.	Evaluation: Child's Appearance (Revision "1" only) Item 87 Code: Blank - Not on Rev. "0" 1 - Poorly cared for 2 - Moderately poorly cared for 3 - Appropriate care and attention 4 - Moderately overdone 5 - Overdone to extreme 9 - Unknown	67
44.	Neurological Abnormalities (Rev. "1" only) Item 90 Code: Blank - Not on Rev. "0" 0 - None 1 - Suspicious 2 - Definite 9 - Not reported	68
45.	Non-Neurological Abnormalities (Rev. "1" only) Item 91 Code: Blank - Not on Rev. "0" 0 - None 1 - Minor 2 - Questionable 3 - Definite 7 - Combination of codes 9 - Not reported	69
46.	Unsatisfactory Conditions for Examination (Rev. "1" only) Item 92 Code: Blank - Not on Rev. "0" 0 - Absent 1 - Present 9 - Not reported	70

FIELD		CARD COLUMN
47.	Disposition (Revision "1" only) Item 93 Code: Blank - Not on Rev. "0" 0 - No indication for further evaluation 8 - Further evaluation 9 - Not reported	71
48.	CP-5 Attached (Revision "1" only) Item 94 Code: Blank - Not on Rev. "0" 0 - Not attached 1 - Attached 9 - Not reported	72

NOTE: This card should not be used in Tabulations.

FIELD		CARD COLUMN
1.	Card Number Code: 3	1
2.	Basic Data * Code: Same as in columns 2-16 of Card 1, except column 5 is Rev. "0" only	2-16
3.	Body Temperature Item 6 Code: 093-107 - As given 999 - Not reported	17-19
4.	Chest Item 12 Code: 0 - Symmetrical 1 - Asymmetrical 9 - Not reported	20
5.	Right Pupil - Size Item 34 Code: As given in mm. 99 - Not reported	21-22
6.	Left Eye - Size Item 35 Code: Same as in Field 5	23-24
7.	Right Eye - Reaction Item 36 Code: 0 - Present 1 - Absent 9 - Not reported	25

* Fields, Codes, Item Numbers and Card Columns refer to Revision "0" only.

FIELD		CARD COLUMN
8.	Left Eye - Reaction Item 37 Code: 0 - Present 1 - Absent 9 - Not reported	26
9.	Arms and Hands Item 40 Code: 0 - Normal 1 - Abnormal 9 - Not reported	27
10.	Legs and Feet Item 41 Code: 0 - Normal 1 - Abnormal 9 - Not reported	28
11.	Movement of Upper Extremities Item 46 Code: 0 - Normal 1 - Abnormal 9 - Not reported	29
12.	Movement of Lower Extremities Item 47 Code: 0 - Normal 1 - Abnormal 9 - Not reported	30
13.	Neck Item 49 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	31

FIELD		CARD COLUMN
14.	Trunk Item 50 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	32
15.	Upper Extremity Item 51 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	33
16.	Lower Extremity Item 52 Code: 0 - Normal 1 - Flaccid 2 - Hypertonic 9 - Not reported	34
17.	Suck Item 53 Code: 0 - Strong 1 - Weak 2 - Absent 9 - Not reported	35
18.	Head Movement to Right Item 67 Five-digit code for: Jaw Arm (col. 36) Jaw Leg (col. 37) Occiput Arm (col. 38) Occiput Leg (col. 39)	36-40

18. **Head Movement to Right** (continued) — 36-40

Code for each column:
- 0 - Extension present
- 1 - Flexion present
- 2 - Extension and Flexion absent
- 8 - No pattern
- 9 - No report

Pelvic Rotation (col. 40)
Code:
- 0 - Rotation away from jaw
- 1 - Rotation toward jaw
- 2 - No rotation
- 8 - No constant pattern
- 9 - No report

19. **Head Movement to Left** — 41-45
Item 68
Code: Same as in Field 18

20. **Response** — 46
Item 73
Code:
- 1 - Obtained with ease
- 2 - Obtained with difficulty
- 3 - No constant pattern
- 9 - Not reported

21. **Moro: Response of Arms** — 47
Item 77
Code:
- 0 - Normal
- 1 - Flexor component absent
- 2 - Asymmetrical
- 3 - No constant pattern
- 4 - Absent
- 8 - Other
- 9 - Not reported

22. **Moro: Response of Legs** — 48
Item 78
Code:
- 0 - Flexor
- 3 - No constant pattern
- 4 - Absent
- 8 - Other
- 9 - Not reported

FIELD		CARD COLUMN
23.	**Moro: Response** Item 79 Code: 1 - Obtained with ease 2 - Obtained with difficulty 3 - No constant pattern 9 - Not reported	49
24.	**Visual Response** Item 81 Code: 0 - Present 1 - Absent 9 - Not reported	50
25.	**Diagnosis** Item 82 Five-digit code for: Abnormal (col. 51) Congenital Malformation (col. 52) Abnormal Development (col. 53) Injury (col. 54) Other Abnormality (col. 55) Code for each column: 0 - No 1 - Yes 9 - No report	51-55

FOUR-MONTH PEDIATRIC EXAMINATION
FORM PED-10

ITEM # ON FORM *		1	5	4	1	6	7	8	9	10	11	12	[illegible]	18	19	[illegible]	
	CARD # 1410	NINDB #	AGE	DATE OF EXAM (MO. DAY YR.)	DATE OF BIRTH (MO. DAY YR.)	WEIGHT: POUNDS, OUNCES	BODY LENGTH: TOTAL, LOWER SEGMENT	HEAD CIRCUMFERENCE	CHEST CIRCUMFERENCE	RESPIRATORY RATE	HEART RATE	SYSTOLIC BLOOD PRESSURE	[illegible]	FONTANELLES ANTERIOR: AP SIZE, LAT SIZE, [illegible]	FONTANELLES POSTERIOR: AP SIZE, LAT SIZE, [illegible]	[illegible]	LENGTH: UPPER SEGMENT

* Item numbers refer to form dated: Rev. 10/60

PED-10- 2

FOUR-MONTH PEDIATRIC EXAMINATION
FORM PED-10

ITEM # on FORM *

CARD # 2410

1 — NINDB *

5 — AGE

MUSCULO-SKELETAL SYSTEM

TONE

61	62	63	64	65
UPPER EXTREMITIES	LOWER EXTREMITIES	NECK FLEXION	NECK EXTENSION	TRUNK

EVALUATION

BLANK

* Item numbers refer to form dated: Rev. 10/60

FOUR-MONTH PEDIATRIC EXAMINATION
FORM PED-10

ITEM # ON FORM *

CARD # 3410 **

NIUDB*

AGE

BODY TEMPERATURE

6 39 35 67 68 82

PUPIL SIZE: RIGHT, LEFT

EYE REACTION

HEAD MOVEMENT: RIGHT, LEFT

DIAGNOSIS

BLANK

* Item numbers refer to Rev. "O" only
** This card should not be used in tabulations

PEDIATRICS MANUAL
4-Month Pediatric Examination
(For Form PED-10, Rev. 10-60)

I. INTRODUCTION

The purpose of the 4-Month Pediatric Examination is to detect evidences of injury or disease in the infant with particular emphasis on differentiating conditions related to the prenatal or perinatal period from those acquired in the postnatal period. Measurements and other pertinent observations are to be recorded as baseline information against which subsequent observations and measurements can be compared. The examination also includes a judgment of the child's status – normal or abnormal – and a judgment of the maternal-child relationship.

A form (PED-10) has been developed for the recording of information obtained in the 4-Month Pediatric Examination. This manual has been prepared for use as a guide to performing the examination and also to assist in the proper recording of the information obtained.

II. GENERAL INSTRUCTIONS

A. THE EXAMINER

A pediatrician should conduct the 4-Month Pediatric Examination. He may instruct a nurse to obtain measurements and vital signs.

B. TIMING OF EXAMINATION

The examination should be done between 14 and 20 weeks of age. If this is impossible every effort should be made to perform the examination as close as possible to the specified time.

C. ABNORMALITIES

When abnormalities are found, additional observations and tests as necessary to describe and elucidate the abnormality are expected to be performed. The examiner need not limit his description of abnormalities to conform to the limits of this examination. Additional tests or data about abnormalities should be recorded on an attached CP-5.

D. ELIMINATION OF BIAS

The examiner should not know the child's history or the findings of previous examinations prior to doing the examination.

The examiner should not be the person taking the 4-Month Interval History. However, once having completed the examination he should refer to the 4-Month Interval History and past physical examinations and all abnormal or suspicious findings should be rechecked. Such observations and correlations with histories, if made, should be recorded on an attached CP-5 and Item 94 checked.

E. RECORDING INSTRUCTIONS

All items on this form are to be completed. If unable to evaluate or properly record an item write NE (not evaluated) next to the item and explain in the right-hand column.

If checked other than normal, a description should accompany the item in the right-hand column. To insure identification of descriptions and comments each should bear the number of the item it concerns.

III. SPECIFIC INSTRUCTIONS

Item 1, Patient Identification. Use the patient's name plate. This should contain at least the child's name, NINDB number, birth date, birth weight, race, and sex.

Item 2, Examiner's Name. Record surname and initials, or full name if necessary for positive identification.

Item 3, Examiner's Status. Record the examiner's status such as pediatrician, pediatric resident, etc.

Item 4, Date of Examination. Record the date using the sequence month, day and year.

Item 5, Age. Record the child's age as weeks completed.

Item 6, Weight. It is desirable that weight be recorded in metric units. However, if an English system scale is used, report weight in pounds and ounces rather than converting to grams.

Item 7, Body Length. The total body length (crown to heel) should be measured with the child in supine position using an "Infantometer" or other similar measuring device. The length of the lower segment (heel to symphysis) should be measured with a flexible measuring tape from

the heel to the upper portion of the symphysis. All measurements should be recorded in centimeters.

Item 8, Head Circumference. Head circumference is measured with a flexible tape applied firmly over supra-orbital ridges anteriorly and that part of the occiput posteriorly which gives the maximum circumference. Record in centimeters.

Item 9, Chest Circumference. The girth of the thorax is measured at the level of the nipples in a plane at right angles to the vertebral column. Attempt to measure at expiration. Record in centimeters.

Item 10, Respiratory Rate. Respirations are counted for at least 30 seconds with the child in a resting state. Record the rate as respirations per minute. If impossible to put the child in a resting state record as "NE" (not evaluated).

Item 11, Heart Rate. Count the heart beats for at least 30 seconds with the child in a resting state. Record the rate as beats per minute. If unable to put the child in a resting state record as "NE" (not evaluated).

Item 12, Systolic Blood Pressure. Determine systolic blood pressure in the upper part of the right arm using the palpation method. Approximately 2/3 of the upper arm should be covered with the blood pressure cuff. Determine blood pressure with the child in a resting state. If unable to put the child in a resting state record as "NE" (not evaluated).

Item 13, Skin. This calls for an observation of the color and texture of the skin as well as a search for specific lesions. "Stork bites," Mongolian spots, and diaper rash are to be considered normal findings and are not to be described. "Stork bites" are defined as those capillary clusters or nonelevated hemangiomas found frequently on the nape of the neck, bridge of the nose, or eyelids. Cafe au lait spots should be described as to size, shape and depth of pigment if their number is six or over. Rashes other than uncomplicated ammoniacal dermatitis should be recorded and described. All findings other than normal should be described in the right-hand column. Do not include pilonidal sinuses or dimples here but record instead under Item 48, "Spine."

Item 14, Subcutaneous Tissue. Evaluate by observation and palpation. Quantity, texture and distribution should be noted if other than normal.

Item 15, Hair and Nails. Observe the texture, quantity, distribution, color, etc., of the hair and the size, configuration and texture of the nails. Evaluate and describe unusual findings.

Item 16, Head. Evaluate the child's head noting especially the size and configuration. Include an evaluation of the sutures.

Items 17-21, Fontanelles. Evaluate the size and tension of fontanelles. If open, record the size of the fontanelle in centimeters giving both the antero-posterior and lateral measurements. Do not record size in fingertips or fingerbreadths. If either or both fontanelles are closed indicate by checking the appropriate box. If the box "Closed" is checked, no mark is necessary in the corresponding "Size" and "Tension" spaces.

Item 22, Facies. Evaluate expression, symmetry and structure. Unusual facies should be described. Muscle function should be reported in Item 23, Movements of Face.

Item 23, Movements of Face. This represents the examiner's observation of the spontaneous movements of the infant's face. The observation should not be a brief one. It should take place periodically throughout the examination. No judgment or recording of this item should be made until the examination is complete. No special stimuli should be used to bring out the facial movements; the stimuli of the examination procedures should be sufficient. "Present and symmetrical" is considered the normal response.

Item 24, Comments. Record comments or descriptions concerning the numbered items. Be careful to identify the comment with the number of the item it concerns.

Item 25, Patient Identification. Same as Item 1.

Items 26-28, Eyes. The lid, conjunctiva, cornea, pupil, lens and extraocular muscles should be evaluated. Report ptosis and strabismus under category 6, "Extraocular Muscles," and spontaneous nystagmus under category 8, "Other." Clearly identify abnormalities as "right," "left," or "bilateral."

Items 29-31, Ears. Evaluate the shape and location of the external ears as well as examining the canal and drum. Clearly identify abnormalities as "right," "left," or "bilateral." Interpret the phrase "Abnormal – Shape and Location"

as "Abnormal – Shape and or Location."

Item 32, Nose, Mouth and Pharynx. Look for discharge, specific lesions and malformations. Unusual dental findings should be described here.

Item 33, Neck. Evaluate by inspection, palpation and manipulation. Enlarged cervical nodes should be recorded under Item 41, Lymph Nodes.

Item 34, Thorax. Evaluate the thoracic cage. Do not include cardiorespiratory findings under this item; record under Items 35-37.

Item 35, Respirations. Evaluate the rhythm, symmetry and character of the respirations with the infant in as near a resting state as possible. Since rate is reported above do not use abnormal rate as the sole criterion in determining an abnormality under this item.

Item 36, Lungs. Evaluate by auscultation and percussion.

Item 37, Heart. Evaluate by palpation and auscultation. Murmurs should be described as to character, grade of intensity (use 4 point scale), point of maximal intensity, distribution, transmission and postural variation.

Item 38, Femoral Pulses. Determine by palpation the strength and symmetry of the femoral pulses.

Item 39, Comments. Same as Item 24.

Item 40, Patient Identification. Same as Item 1.

Item 41, Lymph Nodes. Palpate the major superficial lymph node areas and report any unusual findings.

Item 42, Abdomen and Contents. Evaluate the abdominal wall and contents by inspection, palpation and percussion. Report here masses, distension, marked diastasis recti, inguinal and femoral hernias, and complicated umbilical hernias, fluid, etc. Do not record findings of the liver, spleen and kidneys under this item; record instead under Items 43-45. Do not report uncomplicated umbilical hernias or mild diastasis recti.

Item 43, Liver. Normal liver size is defined as two centimeters or less below the costal margin in the right midclavicular line. If liver size is greater or consistency is unusual record as "other" and describe.

Item 44, Spleen. Normal spleen size is defined as being not more than one centimeter below the costal margin in the left anterior axillary line. A spleen greater in size or of unusual consistency should be recorded as "other" and described.

Item 45, Kidneys. The size and location of a palpable kidney should be described.

Item 46, Genitalia. Evaluate by inspection and palpation. Do not report circumcision. Any question of abnormality should be reported.

Item 47, Anal Sphincter Reflex. Elicit by stroking the perianal region with a piece of cotton.

Item 48, Spine. Evaluate the spine by inspection, palpation and manipulation. If a pilonidal sinus or dimple is present it should be recorded under this item.

Items 49-55, Musculo-Skeletal System. Evaluate the structure and functional integrity of this system in each of the six areas listed on the form. Include an evaluation of joint motion. This item is not intended to reflect the function of the Central Nervous System (this is covered elsewhere) but rather is an observation of the anatomy and mobility.

Item 56, Motor Activity. Throughout the examination evaluate the spontaneous body movements of the child. For the purposes of this examination the following definitions are to be used:

(1) Tremulous or Jittery Movements. – This includes tremulous movements occurring spontaneously or in response to a stimulus. They appear principally in the arms and are to be distinguished from the more coarse myoclonic movements.

(2) Rapid Jerky Movements. – These are sudden nonrepetitive purposeless twitches or jerks.

(3) Myoclonic Movements. – These represent slow, gross rhythmic movements usually symmetrical and usually triggered by a stimulus.

(4) Writhing Movements. – These are sinuous, asymmetric stretching movements.

(5) Asymmetrical Movements. – These are movements which differ in degree or quality be-

tween the two sides of the body.

(6) Convulsions. – These are usually clonic or tonic movements which are spontaneous in nature but this term also includes unconscious or atonic spells. If the convulsive movement is localized to a definable area it is to be termed a localized convulsion.

Item 57, Do Not Write in this Space. This is to be used for data processing purposes. Please do not write here.

Item 58, Comments. Same as Item 24.

Item 59, Patient Identification. Same as Item 1.

Items 60-65, Tone. Muscle tone should be evaluated in each of the five areas listed on the form. Express tone as a numerical value using a scale of five as defined on the form. Flaccid paralysis should be coded with hypotonicity (1) and spastic paralysis with hypertonicity (5). If tone is symmetrical record only in "Bilateral" blank.

Item 66, Palmar Grasp. The examiner's finger is applied to the palm of the child's hand from the ulnar side. Sometimes a slight rubbing motion helps elicit the response. If not obtained try applying the finger from the radial side. Be hesitant to call the response absent until a number of attempts have been made.

Item 67, Plantar Grasp. The examiner's finger is applied to the medial side of the child's foot. Sometimes a slight rubbing motion helps produce the desired response. Be hesitant to call the response absent until a number of attempts have been made.

Item 68, Patellar Jerk. Evaluate patellar jerks with the child in supine position, hips and knees moderately flexed and head in midline with face forward. Use a reflex hammer.

Item 69, Ankle Jerk. Evaluate ankle jerks with child in supine position. Use a reflex hammer.

Item 70, Ankle Clonus. Evaluate with child in supine position. The child's foot should be dorsiflexed by sudden firm pressure on the ball of the foot. If clonic movements occur check "other" and describe the intensity and approximate number.

Item 71, Hearing Response. Test with a xylophone using high and low frequencies. The examiner's judgment must be used in determining what response indicates the child hears the sound.

Item 72, Stepping. This is the observation of the infant's response when placed in an erect position with the soles of his feet touching a flat surface. This response is elicited by holding the child erect and placing the soles of both feet on a flat surface. A walking, stepping or jumping response is expected. If such a response is not obtained, it is desirable to incline the child's head, shoulders, and trunk slightly forward and, by rotating the child's trunk alternatingly, simulate a walking motion. The child will be expected to place one foot ahead of the other alternately in a pseudo-walking motion. The normal recording for this item is "present bilaterally and symmetrically." If scissoring is observed check the corresponding box.

Item 73, Placing. This is the observation of the child's response when being held in an erect position, the dorsum of both feet drawn under the lower edge of a moderately sharp surface such as the edge of a desk or examination table. The child is expected to lift both feet and place them on top of this surface. If such a response is obtained the normal item "present bilaterally and symmetrically" should be checked.

Item 74, Response to Image in Mirror. Hold a mirror (Bayley Test Mirror) close enough that the child may reach it easily taking care that it is his own image he sees and not his mother's. Record the child's response to his image in the appropriate box.

Item 75, Comments. Same as Item 24.

Item 76, Patient Identification. Same as Item 1.

Item 77, Response to a Red Ring. As child lies on back suspend a red ring (Bayley Test Red Ring) by the string before the child within easy reaching distance. His response to the ring should be recorded by checking the appropriate box. The categories are arranged in a descending order of development. Check only the highest level of development.

Item 78, Motor Skills. Check the appropriate "yes," or "no," or "unknown" box after each of the categories.

Item 79, Sitting with Support. Evaluate the child's

posture when sitting with support. Sitting with support is defined as the position the child is in after being pulled from a supine to a sitting position by traction on the arms. The test begins with the child lying supine. The examiner grasps the child's hand and forearms and pulls the child gently forward to a sitting position. This position, with the examiner holding the child's hands, should be maintained for approximately 15 seconds. Evaluate both head control and spine position. If spine position is either "erect" or "slight kyphosis only" check the corresponding "yes" box. If there is marked kyphosis or inability to maintain sitting position, check "Spine erect . . . ., No."

Item 80, Predominant Position of Hands. The usual position of the child's hands when he is relaxed and not crying or agitated should be recorded by checking the appropriate box under this item.

Item 81, Cry. If the child does not cry spontaneously, attempt to make it cry. If unable to make the child cry, check the box "absent." If the child cries spontaneously, consider such unusual qualities as "high pitched," "feeble," "whining," "hoarse," or "stridulous" in evaluating whether the cry is normal or other, and check the appropriate box.

Item 82, Vocalization. Evaluate the child's vocalization. If the child coos or laughs check the first box regardless of other sounds made. If sounds other than cooing or laughing are the only ones heard check the second box. If no sounds are heard check the third box. No comments are necessary.

Item 83, M. C. Evaluation (Maternal-Child Relationship Evaluation). The following four items (84-87) provide for a systematic evaluation of certain aspects of the maternal-child interaction as observed by the pediatrician. Each item has a five-point scale representing three grades of reaction: Appropriate, Moderately inappropriate or unusual. Definitely inappropriate or extremely unusual. The center grade (box 3) represents the response which the examiner feels is appropriate to the situation, the intermediate categories (box 2 and 4) represent moderate grades of the inappropriate responses indicated by the captions, and the extreme categories (boxes 1 and 5) represent the extreme grades of the inappropriate responses. The box labeled "NE" refers to not evaluated, e.g., mother not present.

The response designations on the form are given in cryptic abbreviations to minimize chances of the mother accidentally reading and interpreting these items unfavorably.

For further elaboration of this section see manual PS-5 (Maternal Behavior in Testing Situation) dated 11/60.

Item 84, Responsiveness to Child's Physical Needs. This represents the examiner's evaluation of the mother's perception of and care of the child's needs, such as feeding, protection from cold, change of diapers, etc. The categories are:

(1) Mother seemed unaware of and *unresponsive* to child's needs.

(2) Mother was slow in recognizing and responding to child's needs.

(3) Appropriate *recognition* and care of child's needs.

(4) Overly absorbed with child's needs, overprotective in moderation.

(5) Extremely *absorbed* with child's needs, overly solicitous, overprotective in the extreme.

Item 85, Mother's Focus of Attention During Examination. The categories of classification are:

(1) Mother centered all attention on *child* and tried to keep child's attention on her, excluding both the examiner and test material from the situation.

(2) Mother accepted presence of examiner and the fact that test material was interesting to the child, but mother tried to involve herself with these foci of interest.

(3) Appropriate attention to entire *situation*. Mother was comfortable in letting child respond to examiner and materials.

(4) Mother occasionally interrupted examination to talk about her own perceptions of and reactions to the situation.

(5) Mother demanded that all attention be centered on *herself*, distracting the examiner from the child; disregarded test materials and focussed on events and problems extraneous to the situation.

Item 86, Attitude Toward Child's Test Performance. The categories of this dimension are:

(1) Mother seemed completely *indifferent* to child's performance.

(2) Mother showed brief and fleeting interest in child's performance, but this was done "politely" as though she felt this was expected of her; played role of a passive observer throughout.

(3) *Intermediate.* Mother seems pleased with child's successes and indicated this by smiling, etc.; accepted failures realistically when material and requests were obviously beyond child's abilities.

(4) Mother responded with excessive pride to child's successes; minimized any failures by child.

(5) Mother was overly absorbed in child's performance; *defensive* of child's failures as due to unfamiliarity with material; demanded constant praise from examiner; criticized examiner and test procedures for being unfair to child.

Item 87, Child's Appearance. This represents the examiner's evaluation of the general care the child gets as reflected by cleanliness, grooming, clothing, skin lesions, etc. The categories for this dimension are:

(1) *Poorly cared for,* neglected.

(2) Moderate degree of (1).

(3) Appearance reflects *appropriate* care and attention to appearance.

(4) Moderately overdone.

(5) *Overdone* to an extreme. Child seemed excessively dressed up, to the point of discomfort; child seemed to be a vehicle for clothes of which the mother was very proud.

Item 88, Comments. Same as Item 24.

Item 89, Patient Identification. Same as Item 1.

Item 90, Neurological Abnormalities. If the examiner considers the child to be completely normal neurologically the first box "None" should be checked.

If, on the basis of his examination, the examiner has reason to feel that the child is not completely normal neurologically, but cannot be classified as a definite clinical syndrome or "Neurologically Abnormal Child," the second box "Neurologically Suspicious..." should be checked.

If the examiner is able to state a definite or provisional diagnosis of a recognized syndrome, or feels the child is definitely neurologically abnormal but doesn't at this time fit into any diagnostic category, the third box "Neurologically Abnormal Child" should be checked.

Descriptions of suspected or definite neurological abnormalities deserve the most careful attention to completeness and specificity.

Item 91, Non-neurological Abnormalities. (Check all that apply.) This item calls for the examiner to summarize and comment on all abnormalities or deviations from the ideal, with a few exceptions. These *exceptions* are:

(1) Neurological abnormalities noted and described in Item 90.

(2) Mongolian spots and "stork bites."

(3) Small or uncomplicated umbilical hernias.

(4) Uncomplicated diaper rash or other minor acute skin conditions.

(5) Minor acute upper respiratory infections.

If the examiner considers the child to be completely normal, aside from any of the exceptions listed in the preceding paragraph, the first box "None" should be checked.

The second box "Minor Abnormalities or Deviations" should be checked if there is definitely present any deviation from the ideal state (other than the exclusions listed above) which is considered by the examiner to be of questionable or little significance. Examples of conditions in this category are:

(1) Pigmented nevi.

(2) Epicanthic folds or supernumerary digits.

(3) Undescended testes or hydrocele.

(4) Tibial torsion or correctable metatarsus varus.

If there is a suggestion of an abnormality which cannot be definitely ruled in or out by the physical examination and, which the examiner feels may be of significance to the child's health if present, the third category "Questionable Abnormalities" should be checked. Examples of situations which should be classified in this category are:

(1) Suspicion of congenital heart disease.

(2) Suspicion of congenital dislocation of the hip.

(3) Suspicion of cretinism.

If there is definitely present an abnormality which the examiner feels is of major importance to the child's health, the third category "Definite Major Abnormalities" should be checked. This should include conditions which the examiner can state only as provisional diagnoses, provided he is reasonably confident that his impression will be corroborated by further studies or subsequent examinations.

Item 92, Unsatisfactory Conditions for Examination. This provides the examiner with the opportunity to specify any unsatisfactory conditions which may have existed during the examination such as, unusually irritable child, interfering mother, etc.

Item 93, Disposition. Indicate whether findings on this examination indicate further examinations or tests. If further evaluation has been proposed or scheduled indicate what type.

Item 94, CP-5 Attached. Check whether or not supplemental information on CP-5 accompanies the form.

Item 95, Medical Editor's Comment. Reserved for comments of the Medical Editor. This may be completed after supplemental information from additional diagnostic studies, if any, are available.

Item 96, Comments. Same as Item 24.

No NUMBER — NO DATE
on original

Blue

FOUR-MONTH PEDIATRIC EXAMINATION

superseded by
CDC R-3004-10
rev. 10-60

INSTRUCTIONS: Every numbered item should be checked (√). If not normal, findings should be checked (√) and described in margin at right.

1. EXAMINED BY	2. TIME
3. STATUS	4. DATE (Mo-Day-Yr)
5. WEIGHT	6. BODY TEMP. (If taken)

Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reason for not evaluating any item.

NOTE: This form was originally printed without PHS number and date in BLUE. It was also printed in YELLOW. It was superseded by the CDC R-3004-10 (rev. 10-60) on YELLOW paper — and superseded by the use of white paper.

7. LENGTH

8. UPPER SEGMENT (Crown-Symphysis) ______

9. LOWER SEGMENT (Symphysis-Heel) ______

10. SKIN

- NORMAL COLOR 0
- ABNORMAL
  - RASH 1
  - CYANOSIS 2
  - JAUNDICE 3
  - PALLOR 4
  - OTHER ABNORMALITIES (Specify) 9

11. RESPIRATIONS – RATE (Resting) ______

- NORMAL 0
- ABNORMAL (Describe) 9

12. CHEST – CIRCUMFERENCE ______

- SYMMETRICAL 0
- ASYMMETRICAL 1

13. LUNGS

- NORMAL TO PERCUSSION AND AUSCULTATION 0
- OTHER (Specify) 9

14. HEART RATE – (Resting) ______

15. BLOOD PRESSURE – RIGHT ARM (Patient lying down – by palpitation) ______

16. HEART

- NORMAL 0
- ABNORMAL
  - IRREGULAR RHYTHM 1
  - MURMUR 2
  - THRILL 3
  - ABNORMAL SOUNDS 4
  - ABNORMAL SIZE 5
  - OTHER (Specify) 9

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

17. ABDOMEN
☐ NORMAL (0)

ABNORMAL
☐ ABNORMAL DISTENSION (1)
☐ ABNORMAL MUSCULATURE (2)
☐ MASSES (3)

18. LIVER
☐ NOT PALPABLE (0)
☐ PALPABLE (Describe) (1)

19. SPLEEN
☐ NOT PALPABLE (0)
☐ PALPABLE (Describe) (1)

20. KIDNEYS
☐ NOT PALPABLE (0)
☐ PALPABLE (Describe) (1)

21. GENITALIA
☐ NORMAL (0)
☐ ABNORMAL – MALE (1)
☐ ABNORMAL – FEMALE (2)

22. HEAD – CIRCUMFERENCE ____________

23. SHAPE – ☐ NORMAL (0)
☐ ABNORMAL (1)

24. FONTANEL – ANTERIOR
☐ OPEN (Give size) ____________ (0)
☐ CLOSED (1)

– POSTERIOR
☐ OPEN (Give size) ____________ (0)
☐ CLOSED (1)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

Department of Health, Education, and Welfare
Public Health Service

(PED-10)

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

25. EARS

26. RIGHT	27. LEFT
☐ 0 NORMAL	☐ 0 NORMAL
ABNORMAL	ABNORMAL
☐ 1 EXTERNAL FORM	☐ 1 EXTERNAL FORM
☐ 2 CANAL	☐ 2 CANAL
☐ 3 DRUM	☐ 3 DRUM
☐ 9 OTHER (Specify)	☐ 9 OTHER (Specify)

28. NOSE

☐ 0 NORMAL

☐ 1 ABNORMAL

29. MOUTH AND PHARYNX

☐ 0 NORMAL

☐ 1 ABNORMAL

30. EYES

31. RIGHT	32. LEFT
☐ 0 NORMAL	☐ 0 NORMAL
ABNORMAL	ABNORMAL
☐ 1 PUPIL	☐ 1 PUPIL
☐ 2 CORNEA	☐ 2 CORNEA
☐ 3 LENS	☐ 3 LENS
☐ 9 OTHER (Specify)	☐ 9 OTHER (Specify)

33. PUPILS

	RIGHT	LEFT
SIZE (Use dia.)	34. ________	35. ________
DIRECT REACTION TO LIGHT	36. ☐ 0 PRESENT ☐ 1 ABSENT	37. ☐ 0 PRESENT ☐ 1 ABSENT

38. NECK

☐ 0 NORMAL

ABNORMAL

☐ 1 RANGE OF MOTION

☐ 2 MASSES

☐ 9 OTHER (Specify)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

39. SKELETAL SYSTEM

40. ARMS AND HANDS

☐ NORMAL (0)

☐ ABNORMAL (1)

41. LEGS AND FEET

☐ NORMAL (0)

☐ ABNORMAL (1)

42. SPINE

☐ NORMAL (0)

☐ ABNORMAL (1)

43. NEUROMUSCULAR SYSTEM

44. MOVEMENTS OF FACE

☐ PRESENT AND SYMMETRICAL (0)

ABNORMAL

☐ ABSENT (1)

☐ ASYMMETRICAL (2)

☐ OTHER (Specify) (3)

45. BODY MOVEMENTS

☐ NORMAL (0)

ABNORMAL

☐ TREMULOUS (1)

☐ RAPID, JERKY MOVEMENTS (2)

☐ WRITHING MOVEMENTS (3)

CONVULSIONS

☐ LOCAL (4)

☐ GENERALIZED (5)

☐ OTHER (Specify) (6)

46. MOVEMENTS OF UPPER EXTREMITIES

☐ NORMAL (Symmetrical with normal range of motion) (0)

☐ ABNORMAL (1)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

47. MOVEMENTS OF LOWER EXTREMITIES
- ☐ 0 NORMAL (Symmetrical with normal range of motion)
- ☐ 1 ABNORMAL

48. BODY TONE

49. NECK –
- ☐ 0 NORMAL
- ☐ 1 FLACCID (Limp)
- ☐ 2 HYPERTONIC (Rigid)

50. TRUNK –
- ☐ 0 NORMAL
- ☐ 1 FLACCID (Limp)
- ☐ 2 HYPERTONIC (Rigid)

51. UPPER EXTREMITY –
- ☐ 0 NORMAL
- ☐ 1 FLACCID (Limp)
- ☐ 2 [illegible]

52. LOWER EXTREMITY –
- ☐ 0 NORMAL
- ☐ 1 FLACCID (Limp)
- ☐ 2 HYPERTONIC (Rigid)

53. SUCK (Evaluate with finger)
- ☐ 0 STRONG
- ☐ 1 WEAK
- ☐ 2 ABSENT

54. PALMAR GRASP (Stimulus – finger applied to ulnar side of palm)

55. RIGHT
- ☐ 0 PRESENT
- ☐ 1 ABSENT

56. LEFT
- ☐ 0 PRESENT
- ☐ 1 ABSENT

- ☐ [illegible] ASYMMETRICAL

57. PATELLAR JERK

58. RIGHT
- ☐ 0 PRESENT
- ☐ 1 ABSENT

59. LEFT
- ☐ 0 PRESENT
- ☐ 1 ABSENT

- ☐ [illegible] ASYMMETRICAL

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

Department of Health, Education, and Welfare
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(PED-10) PAGE 6 OF 7

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

60. ANKLE JERK –

61. RIGHT
- ☐ PRESENT (0)
- ☐ ABSENT (1)

62. LEFT
- ☐ PRESENT (0)
- ☐ ABSENT (1)

☐ ASYMMETRICAL (4)

63. ANKLE CLONUS –

64. RIGHT
- ☐ ABSENT (0)
- ☐ PRESENT (1)

65. LEFT
- ☐ ABSENT (0)
- ☐ PRESENT (1)

☐ ASYMMETRICAL (4)

66. TONIC NECK (Elicit by turning head slowly to Child's right or Child's left. Note position 30 to 60 seconds after head movement)

67. HEAD MOVEMENT TO RIGHT

69. EXTENSION PRESENT in
- ☐ JAW ARM (1)
- ☐ JAW LEG (2)
- ☐ OCCIPUT ARM (3)
- ☐ OCCIPUT LEG (4)
- ☐ ABSENT (5)

71. FLEXION PRESENT in
- ☐ JAW ARM (1)
- ☐ JAW LEG (2)
- ☐ OCCIPUT ARM (3)
- ☐ OCCIPUT LEG (4)
- ☐ ABSENT (5)

73. PELVIC ROTATION
- ☐ AWAY FROM JAW (1)
- ☐ TOWARD JAW (2)
- ☐ ABSENT (5)

68. HEAD MOVEMENT TO LEFT

70. EXTENSION PRESENT in
- ☐ JAW ARM (1)
- ☐ JAW LEG (2)
- ☐ OCCIPUT ARM (3)
- ☐ OCCIPUT LEG (4)
- ☐ ABSENT (5)

72. FLEXION PRESENT in
- ☐ JAW ARM (1)
- ☐ JAW LEG (2)
- ☐ OCCIPUT ARM (3)
- ☐ OCCIPUT LEG (4)
- ☐ ABSENT (5)

74. PELVIC ROTATION
- ☐ AWAY FROM JAW (1)
- ☐ TOWARD JAW (2)
- ☐ ABSENT (5)

75. RESPONSE
- ☐ OBTAINED WITH EASE (1)
- ☐ OBTAINED WITH DIFFICULTY (2)
- ☐ NO CONSTANT PATTERN (5)

Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reason for not evaluating any item.

FOUR-MONTH PEDIATRIC EXAMINATION
(Continued)

76. MORO (Support child under back and head. Let child's head drop back about 30 degrees.)

77. RESPONSE OF ARMS

- ☐ 0 NORMAL (Flexor and extensor components symmetrically present)
- ☐ 1 FLEXOR COMPONENT ABSENT
- ☐ 2 ASYMMETRICAL
- ☐ 9 OTHER (Specify)

78. RESPONSE OF LEGS

- ☐ 0 FLEXOR
- ☐ 9 OTHER (Specify)

79. RESPONSE

- ☐ 1 OBTAINED WITH EASE
- ☐ 2 OBTAINED WITH DIFFICULTY
- ☐ 3 NO CONSTANT PATTERN

80. HEARING RESPONSE

- ☐ 0 NORMAL
- ☐ 1 QUESTIONABLE
- ☐ 2 ABNORMAL

81. VISUAL RESPONSE – FOLLOWING OF OBJECTS

- ☐ 0 PRESENT
- ☐ 1 ABSENT

82. DIAGNOSIS

- ☐ 0 NORMAL

ABNORMAL

- ☐ 1 CONGENITAL MALFORMATION (Describe)
- ☐ 2 ABNORMAL DEVELOPMENT (Describe)
- ☐ 3 INJURY (Describe)
- ☐ 9 OTHER (Describe)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

MICROCOPY RESOLUTION TEST CHART

CONTINUED ON NEXT FICHE

THE NATIONAL ARCHIVES OF THE UNITED STATES
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PED-11 One-year Neurological Examination

Form PED-11 was used to record information from the one-year neurological exam for the purposes of characterizing the child as neurologically normal or other-than-normal at the time of the examination. Manifestations of suspected or definite neurological abnormality were identified on the form, in addition to manifestations of other body systems as determined by physical examination. Implemented as a study form in November [illegible], the form was revised once in May [illegible]. Changes in the order of items, wording, and the addition of new items resulted from revision. Data from PED-11 were recorded on three cards in the master file (Table PED-11).

TABLE PED-11.1 Cards and Data Records by Revision for Form PED-11

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-11: Weight, Length, Fontanelles, Eyes, Ears, Heart	1411		
		0	4,303
		1	38,095
		2	330
		3	2,865
			45,593
PED-11: Motor Ability, Sensations, Eye Responses	2411		
		0	4,266
		1	38,011
		2	348
		3	2,963
			45,608
PED-11: Motor System, Eyes, Labyrinthine	3411		
		0	4,292
		2	349
			4,641
	total for form		95,842

Data Items Referencing Form PED-11, 1-Year Neurological Exam

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4441........		1411	1	5	Card number (sequence, form type, form number, revision number)
4442........		1411	6	14	NINCDS case number
4443.PED-11	5	1411	15	16	Age
4444.PED-11	4	1411	17	18	Form PED-11 date (mo)
4445.PED-11	4	1411	19	20	Form PED-11 date (day)
4446.PED-11	4	1411	21	22	Form PED-11 date (yr)
4447.PED-11	1	1411	23	24	Birth date (mo)
4448.PED-11	1	1411	25	26	Birth date (day)
4449.PED-11	1	1411	27	28	Birth date (yr)
4450.PED-11	6	1411	29	30	Weight (lbs)
4451.PED-11	6	1411	31	32	Weight (oz)
4452.PED-11	7	1411	33	34	Length: body (cm)
4453.PED-11	8	1411	35	36	Length, lower segment (cm)
4454.PED-11	9	1411	37	38	Head circumference (cm)
4455.PED-11	10	1411	39	40	Chest circumference (cm)
4456.PED-11	11	1411	41	41	Head, shape and contour
4457.PED-11	12	1411	42	42	Fontanelle, anterior, condition
4458.PED-11	13	1411	43	44	Fontanelle, anterior, A-P dimensions (cm)
4459.PED-11	14	1411	45	46	Fontanelle, anterior, lateral dimension (cm)
4460.PED-11	15	1411	47	47	Fontanelle, anterior, tension
4461.PED-11	16	1411	48	48	Fontanelle, anterior, transillumination
4462.PED-11	17	1411	49	49	Facies
4463.PED-11	18	1411	50	50	Eyes, external exam
4464.PED-11	19	1411	51	51	Eyes: ophthalmoscopic
4465.PED-11	20	1411	52	52	Ears: size, shape, location
4466.PED-11	21	1411	53	53	Ears: otoscopic exam
4467.PED-11	22	1411	54	54	Nose, mouth, pharynx
4468.PED-11	25	1411	55	55	Neck
4469.PED-11	26	1411	56	56	Thorax
4470.PED-11	27	1411	57	57	Respirations
4471.PED-11	28	1411	58	58	Lungs
4472.PED-11	29	1411	59	59	Heart, normal
4473.PED-11	29	1411	60	60	Heart, rhythm irregular
4474.PED-11	29	1411	61	61	Heart: murmur
4475.PED-11	29	1411	62	62	Heart: thrill
4476.PED-11	29	1411	63	63	Heart, other
4477.PED-11	30	1411	64	64	Pulses: femoral
4478.PED-11	32	1411	65	65	Abdomen and contents
4479.PED-11	33	1411	66	66	Liver
4480.PED-11	34	1411	67	67	Spleen
4481.PED-11	35	1411	68	68	Kidneys
4482.PED-11	36	1411	69	69	Genitalia

Data Items Referencing Form PED-11, 1-Year Neurological Exam

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4483.PED-11	17	1411	70	70	Skin Appearance
4484.PED-11	18	1411	71	71	Spine
4485.PED-11	42	1411	72	72	Musculoskeletal: shoulder girdle
4486.PED-11	43	1411	73	73	Musculoskeletal: arms; wrists
4487.PED-11	44	1411	74	74	Musculoskeletal: hands
4488.PED-11	45	1411	75	75	Musculoskeletal: pelvic girdle
4489.PED-11	46	1411	76	76	Musculoskeletal: legs; ankles
4490.PED-11	47	1411	77	77	Musculoskeletal: feet
4491.PED-11	48	1411	78	78	Consciousness, state of
4492.PED-11	49	1411	79	79	Affective response
4493.PED-11	51	1411	80	80	Phonation, observed
4494........		2411	1	5	Card number (sequence, form type, form number, revision number)
4495........		2411	6	14	NINDB case number
4496.PED-11	5	2411	15	16	Age
4497.PED-11	52	2411	17	17	Phonation, reported
4498.PED-11	54	2411	18	18	Development, observed: locomotor; postural
4499.PED-11	55	2411	19	19	Development, reported: locomotor; postural
4500.PED-11	56	2411	20	20	Gait abnormality; posture abnormality
4501.PED-11	57	2411	21	21	Grasp; prehension
4502.PED-11	60	2411	22	22	Coordination; reaching
4503.PED-11	61	2411	23	23	Hand preference
4504.PED-11	62	2411	24	24	Sensation, light touch
4505.PED-11	63	2411	25	25	Sensation, pin prick
4506.PED-11	64	2411	26	26	Movement: face, spontaneous
4507.PED-11	65	2411	27	27	Palpebral fissures
4508.PED-11	66	2411	28	28	Lid closure
4509.PED-11	67	2411	29	29	Reflex: corneal
4510.PED-11	68	2411	30	30	Follows light or object
4511.PED-11	69	2411	31	31	Optokinetic nystagmus
4512.PED-11	72	2411	32	32	Visual fields by confrontation
4513.PED-11	73	2411	33	33	Eyes, position at rest
4514.PED-11	75	2411	34	34	Eye weakness or paralysis, right
4515.PED-11	76	2411	35	35	Eye weakness or paralysis, left
4516.PED-11	77	2411	36	36	Nystagmus, spontaneous
4517.PED-11	78	2411	37	37	Eyes: pupils, shape and symmetry
4518.PED-11	79	2411	38	38	Eyes: pupils, reaction to light, direct
4519.PED-11	80	2411	39	39	Eyes: pupils, reaction to light, consensual
4520.PED-11	81	2411	40	40	Response: sound
4521.PED-11	82	2411	41	41	Reflex: jaw
4522.PED-11	83	2411	42	42	Movement: palate
4523.PED-11	84	2411	43	43	Tongue
4524.PED-11	87	2411	44	44	Movements, involuntary, abnormal
4525.PED-11	89	2411	45	46	Tone: extremity, upper

Data Items Referencing Form PED-11, 1-Year Neurological Exam

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4526.PED-11	90	2411	47	48	Tone: extremity, lower
4527.PED-11	91	2411	49	50	Tone: neck flexor
4528.PED-11	92	2411	51	52	Tone: neck extensor
4529.PED-11	93	2411	53	54	Tone: trunk
4530.PED-11	95	2411	55	56	Reflex: biceps jerk
4531.PED-11	96	2411	57	58	Reflex: triceps jerk
4532.PED-11		2411	59	60	Reflex: knee jerk
4533.PED-11		2411	61	62	Reflex: ankle jerk
4534.PED-11	100	2411	63	63	Plantar response, right
4535.PED-11	101	2411	64	64	Plantar response, left
4536.PED-11	2	2411	65	65	Reflex: abdominal, superficial
4537.PED-11	3	2411	66	66	Reflex: tonic neck
4538.PED-11	4	2411	67	67	Reflex: Moro
4539.PED-11	7	2411	68	68	Reflex: grasp, palmar
4540.PED-11	9	2411	69	69	Sweating, observed
4541.PED-11	10	2411	70	70	Sweating, reported
4542.PED-11	12	2411	71	71	Urinary stream, observed
4543.PED-11	13	2411	72	72	Urinary stream, reported
4544.PED-11	14	2411	73	73	Reflex: anal, superficial
4545.PED-11	15	2411	74	74	Tone: rectal
4546.PED-11	16	2411	75	75	Neurological signs, other
4547.PED-11	17	2411	76	76	Neurological abnormalities
4548.PED-11	18	2411	77	77	Nonneurological abnormalities
4549.PED-11	19	2411	78	78	Examination conditions, unsatisfactory
4550.PED-11	20	2411	79	79	Disposition for further evaluation
4551.PED-11	21	2411	80	80	Form PED-5 attached
4552.......		3411	1	5	Card number (sequence, form type, form number, revision number)
4553.......		3411	6	14	NINDB case number
4554.PED-11	4	3411	15	16	Age
4555.PED-11	11	3411	17	17	Head, external
4556.PED-11	14	3411	18	18	Ears, nose, throat, eye
4557.PED-11	29	3411	19	19	Back
4558.PED-11	36	3411	20	20	Motor system
4559.PED-11	37	3411	21	22	Motor system, abnormal
4560.PED-11	43	3411	23	23	Posture and body attitude
4561.PED-11	44	3411	24	24	Sitting
4562.PED-11	45	3411	25	25	Creeping
4563.PED-11	48	3411	26	26	Standing
4564.PED-11	49	3411	27	27	Walking
4565.PED-11	51	3411	28	28	Response, accepts proffered objects
4566.PED-11	54	3411	29	29	Response, ring
4567.PED-11	55	3411	30	30	Response, cube
4568.PED-11	66	3411	31	31	Eye: cornea, right

Data Items Referencing Form PED-11, 1-Year Neurological Exam

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4569.PED-11	67	3411	32	32	Eye: cornea, left
4570.PED-11	71	3411	33	33	Eye: anterior chamber, right
4571.PED-11	72	3411	34	34	Eye: anterior chamber, left
4572.PED-11	74	3411	35	35	Eye: iris, right
4573.PED-11	75	3411	36	36	Eye: iris, left
4574.PED-11	77	3411	37	37	Eye: lens, right
4575.PED-11	78	3411	38	38	Eye: lens, left
4576.PED-11	80	3411	39	39	Eye: vitreous, right
4577.PED-11	81	3411	40	40	Eye: vitreous, left
4578.PED-11	85	3411	41	41	Eye: disc, right
4579.PED-11	86	3411	42	42	Eye: disc, left
4580.PED-11	88	3411	43	43	Eye: fundus, right
4581.PED-11	89	3411	44	44	Eye: fundus, left
4582.PED-11	93	3411	45	45	Squint, concomitant
4583.PED-11	96	3411	46	46	Gaze: conjugate
4584.PED-11	4	3411	47	47	Reflex: labyrinthine, deviation during right rotation
4585.PED-11	5	3411	48	48	Reflex: labyrinthine, nystagmus during right rotation
4586.PED-11	7	3411	49	49	Reflex: labyrinthine, deviation after right rotation
4587.PED-11	8	3411	50	50	Reflex: labyrinthine, nystagmus after right rotation
4588.PED-11	11	3411	51	51	Reflex: labyrinthine, deviation during left rotation
4589.PED-11	12	3411	52	52	Reflex: labyrinthine, nystagmus during left rotation
4590.PED-11	14	3411	53	53	Reflex: labyrinthine, deviation after left rotation
4591.PED-11	15	3411	54	54	Reflex: labyrinthine, nystagmus after left rotation
4592.PED-11	27	3411	55	55	Swallowing
4593.PED-11	32	3411	56	56	Voice quality
4594.PED-11	33	3411	57	57	Sternocleidomastoid muscle
4595.PED-11	38	3411	58	58	Reflex: jaw jerk, right
4596.PED-11	43	3411	59	59	Reflex: jaw jerk, left
4597.PED-11	50	3411	60	60	Reflex: cremasteric
4598.PED-11	55	3411	61	61	Skin: flushing, observed
4599.PED-11	56	3411	62	62	Skin: flushing, history
4600.PED-11	60	3411	63	63	Reflex: anal superficial
4601........		3411	64	80	Blank
5614....VAR			808	808	Pediatric exam present (1 yr)
5615....VAR	5		809	810	Age, 1 yr (wks)
5616....VAR	9		811	812	Head circumference (cms)
5617....VAR			811	814	Head circumference (coded)
5618....VAR			814	814	Neurological abnormalities at one year
5919....VAR	55		1125	1125	Development reported: locomotor: postural
5939....VAR	56		1126	1126	Development observed: locomotor: postural
5972....VAR	6		1105	1107	Weight, 1 yr (gms)
5980....VAR	7		1204	1205	Length: body, 1 yr (cms)
5981....VAR			1206	1207	Length: body (coded)

Data Items Referencing Form [illegible], 1-Year Neurological Exam

DATA ITEM ID	ITEM IN FILE	CARD NUM	FROM	TO	DATA ITEM NAME
[illegible]....W-6			74	74	Neurological examination completed, 1 yr

[illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION

[illegible] PATIENT [illegible]

NAME OF EXAMINER

TITLE OR POSITION

DATE OF EXAM — Mo. Day Year

AGE OF CHILD [illegible]

HEIGHT ______

BODY LENGTH [illegible] ______ cm.

LOWER SEGMENT [illegible] ______ cm.

HEAD CIRCUMFERENCE ______ cm.

CHEST CIRCUMFERENCE ______ cm.

NOTE: [illegible]

COMMENTS

HEAD – SHAPE AND CONTOUR

- Normal
- Other (describe)

ANTERIOR FONTANELLE

- Closed [illegible]
- Open [illegible]

SIZE

- AP ______ cm.
- LAT ______ cm.

TENSION

- Normal
- Other [illegible]

TRANSILLUMINATION

- Normal
- Other (describe)

FACIES

- Normal
- Hypertelorism
- [illegible]
- Other (describe)
- Cleft lip

EYES – STRUCTURE – EXTERNAL EXAMINATION [illegible]

- Normal
- Other (describe)

EYES – STRUCTURE – OPHTHALMOSCOPIC EXAMINATION [illegible]

- Normal
- Other (describe)

EARS – SIZE, SHAPE AND LOCATION

- Normal
- Other (describe)

EARS – OTOSCOPIC EXAMINATION

- Normal
- Unable to [illegible]
- Other (describe)

NOSE, MOUTH AND PHARYNX

- Normal
- Other (describe)

[illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

[illegible] PATIENT IDENTIFICATION

NECK

- Normal
- [illegible] Range of Motion
- [illegible]
- Other (Specify)

THORAX

- Normal
- Other (Specify)

RESPIRATIONS

- Normal
- Other (Specify)

LUNGS

- Normal
- Other (Specify)

HEART

- Normal
- [illegible]
- Thrill
- Murmur [illegible]
- Other (Specify)

FEMORAL PULSES

- Strong and Equal Bilaterally
- Other (Specify)

BLOOD PRESSURE

[illegible] ______ [illegible] ______

ABDOMEN AND CONTENTS

- Normal [illegible]
- Other (Specify)

LIVER

- Normal
- Other (Specify)

SPLEEN

- Normal
- Other (Specify)

KIDNEYS

- Not Palpable
- Palpable [illegible]

GENITALIA

- Normal
- Other (Specify)

SKIN

- Normal [illegible]
- [illegible]
- Cafe au lait Spots [illegible]
- [illegible]
- Other (Specify)
- Other [illegible]
- [illegible]

SPINE

- Normal
- Other (Specify)

NOTE: [illegible]

COMMENTS

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

PATIENT IDENTIFICATION

[illegible]

STATE OF CONSCIOUSNESS

[illegible]

AFFECTIVE RESPONSE

[illegible]

LOCOMOTOR AND POSTURAL DEVELOPMENT

[illegible]

ABNORMALITIES OF GAIT OR POSTURE

[illegible]

COMMENTS

PED-11

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

[illegible]

41. HAND PREFERENCE

[illegible]

42. SENSATION – EXTREMITIES AND TRUNK – LIGHT TOUCH

[illegible]

43. SENSATION – EXTREMITIES AND TRUNK – PIN PRICK

[illegible]

44. [illegible] MOVEMENTS OF FACE

[illegible]

45. PALPEBRAL FISSURES

[illegible]

46. LID CLOSURE

[illegible]

47. CORNEAL REFLEX

[illegible]

48. FOLLOWS LIGHT OR OBJECT

[illegible]

49. OPTOKINETIC NYSTAGMUS

[illegible]

PATIENT IDENTIFICATION

NOTE: [illegible]

COMMENTS

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

78. PUPILS – SHAPE AND SYMMETRY

79. PUPILS – REACTION TO LIGHT – DIRECT

80. PUPILS – REACTION TO LIGHT – CONSENSUAL

81. RESPONSE TO SOUND

82. GAG REFLEX

83. PALATE MOVEMENT

84. TONGUE

85. COMMENTS

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

PED-11

COLR-[illegible]
REV. [illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

106. PATIENT IDENTIFICATION

107. PALMAR GRASP REFLEX

- Absent or variable
- Reflex present and [illegible]
- Other (Describe)
- Unable to evaluate

108. SWEATING

109. Observed
- Present, normal
- Other (Describe)
- Unable to evaluate

*110. Reported
- Present, normal
- Other (Describe)
- Unable to evaluate

111. URINARY STREAM

112. Observed
- Good periodic stream
- Dribbling
- Other (Describe)
- Unable to evaluate

*113. Reported
- Good periodic stream
- Dribbling
- Other (Describe)
- Unable to evaluate

*114. SUPERFICIAL ANAL REFLEX
- Present, normal
- Other (Describe)
- Unable to evaluate

*115. RECTAL TONE
- Normal
- Other (Describe)

116. OTHER SIGNS, REFLEXES, TESTS, ETC.
- No
- Yes (Specify)

NOTE: Items marked with an asterisk * are required only if an abnormality is suspected on the basis of other tests. They are optional for otherwise normal cases. It is not necessary to indicate "Not Evaluated" for these.
All other items must be evaluated [illegible] reason given for failure.

122. COMMENTS

IMPRESSION

117. NEUROLOGICAL ABNORMALITIES
- None
- Neurologically Suspicious But No Definite Abnormalities (Describe [illegible] comments in detail)
- Neurologically Abnormal Only (Describe fully and give reasons)

118. NON-NEUROLOGICAL ABNORMALITIES (Check all that apply)
- None
- Minor Abnormalities or Deviations (Describe)
- Questionable Abnormalities (Describe)
- Definite Major Abnormalities (Describe)

119. UNSATISFACTORY CONDITIONS FOR EXAMINATION
- Absent
- Present (Specify)

120. DISPOSITION
- No Indication, At This Time, For Further Evaluation
- Further Evaluation Proposed Or Scheduled (Specify)

121. [illegible] ATTACHED (Medical [illegible], report of further studies, etc.)
- No
- Yes

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

PED-11 Rev. [illegible]
Page [illegible]

Form Item Numbers linked to Data Items on PED-11, 1-Year Neurological Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	5637....VAR		813	813	Head circumference (coded)
	5981....VAR		1206	1207	Length: body (coded)
	5638....VAR		814	814	Neurological abnormalities at one year
	6284....MHD		74	74	Neurological examination completed, 1 yr
	5634....VAR		808	808	Pediatric exam present (1 yr)
	4531.PED-11	2411	61	62	Reflex: ankle jerk
	4532.PED-11	2411	59	60	Reflex: knee jerk
1	4448.PED-11	1411	25	26	Birth date (day)
1	4447.PED-11	1411	23	24	Birth date (mo)
1	4449.PED-11	1411	27	28	Birth date (yr)
2	4536.PED-11	2411	65	65	Reflex: abdominal, superficial
3	4537.PED-11	2411	66	66	Reflex: tonic neck
4	3554.PED-11	3411	15	16	Age
4	4445.PED-11	1411	19	20	Form PED-11 date (day)
4	4444.PED-11	1411	17	18	Form PED-11 date (mo)
4	4446.PED-11	1411	21	22	Form PED-11 date (yr)
4	3584.PED-11	3411	47	47	Reflex: labyrinthine, deviation during right rotation
4	4538.PED-11	2411	67	67	Reflex: Moro
5	4443.PED-11	1411	15	16	Age
5	4496.PED-11	2411	15	16	Age
5	5635....VAR		809	810	Age, 1 yr (wks)
5	3585.PED-11	3411	48	48	Reflex: labyrinthine, nystagmus during right rotation
6	4450.PED-11	1411	29	30	Weight (lbs)
6	4451.PED-11	1411	31	32	Weight (oz)
6	5972....VAR		1185	1187	Weight, 1 yr (kgs)
7	4452.PED-11	1411	33	34	Length: body (cm)
7	5980....VAR		1204	1205	Length: body, 1 yr (cms)
7	4539.PED-11	2411	68	68	Reflex: grasp, palmar
7	3586.PED-11	3411	49	49	Reflex: labyrinthine, deviation after right rotation
8	4453.PED-11	1411	35	36	Length, lower segment (cm)
8	3587.PED-11	3411	50	50	Reflex: labyrinthine, nystagmus after right rotation
9	4454.PED-11	1411	37	38	Head circumference (cm)
9	5636....VAR		811	812	Head circumference (cms)
9	4540.PED-11	2411	69	69	Sweating, observed
10	4455.PED-11	1411	39	40	Chest circumference (cm)
10	4541.PED-11	2411	70	70	Sweating, reported
11	4456.PED-11	1411	41	41	Head, shape and contour
11	3588.PED-11	3411	51	51	Reflex: labyrinthine, deviation during left rotation
12	4457.PED-11	1411	42	42	Fontanelle, anterior, condition
12	3589.PED-11	3411	52	52	Reflex: labyrinthine, nystagmus during left rotation
12	4542.PED-11	2411	71	71	Urinary stream, observed
13	4458.PED-11	1411	43	44	Fontanelle, anterior, A-P dimensions (cm)

Form Item Numbers Linked to Data Items on PED-11, 1-Year Neurological Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
13	4555.PED-11	3411	17	17	Head, external
13	4541.PED-11	2411	72	72	Urinary stream, reported
14	4556.PED-11	3411	18	18	Ears; nose; throat; ENT
14	4459.PED-11	1411	45	46	Fontanelle, anterior, lateral dimension (cm)
14	4544.PED-11	2411	73	73	Reflex: anal, superficial
14	4590.PED-11	3411	53	53	Reflex: labyrinthine, deviation after left rotation
15	4460.PED-11	1411	47	47	Fontanelle, anterior, tension
15	4591.PED-11	3411	54	54	Reflex: labyrinthine, nystagmus after left rotation
15	4545.PED-11	2411	74	74	Tone; rectal
16	4461.PED-11	1411	48	48	Fontanelle, anterior, transillumination
16	4546.PED-11	2411	75	75	Neurological signs, other
17	4462.PED-11	1411	49	49	Facies
17	4547.PED-11	2411	76	76	Neurological abnormalities
18	4463.PED-11	1411	50	50	Eyes, external exam
18	4548.PED-11	2411	77	77	Non-neurological abnormalities
19	4549.PED-11	2411	78	78	Examination conditions, unsatisfactory
19	4464.PED-11	1411	51	51	Eyes; ophthalmoscopic
20	4550.PED-11	2411	79	79	Disposition for further evaluation
20	4465.PED-11	1411	52	52	Ears: size, shape, location
21	4466.PED-11	1411	53	53	Ears: otoscopic exam
21	4551.PED-11	2411	80	80	Form CP-5 attached
22	4467.PED-11	1411	54	54	Nose; mouth; pharynx
25	4468.PED-11	1411	55	55	Neck
26	4469.PED-11	1411	56	56	Thorax
27	4470.PED-11	1411	57	57	Respirations
27	4592.PED-11	3411	55	55	Swallowing
28	4471.PED-11	1411	58	58	Lungs
29	4557.PED-11	3411	19	19	Back
29	4472.PED-11	1411	59	59	Heart, normal
29	4476.PED-11	1411	63	63	Heart, other
29	4473.PED-11	1411	60	60	Heart, rhythm irregular
29	4474.PED-11	1411	61	61	Heart: murmur
29	4475.PED-11	1411	62	62	Heart: thrill
30	4477.PED-11	1411	64	64	Pulses: femoral
32	4478.PED-11	1411	65	65	Abdomen and contents
32	4593.PED-11	3411	56	56	Voice quality
33	4479.PED-11	1411	66	66	Liver
33	4594.PED-11	3411	57	57	Sternocleidomastoid muscle
34	4480.PED-11	1411	67	67	Spleen
35	4481.PED-11	1411	68	68	Kidneys
36	4482.PED-11	1411	69	69	Genitalia
36	4558.PED-11	3411	20	20	Motor system
37	4559.PED-11	3411	21	22	Motor system, abnormal

Form Item Numbers Linked to Data Items on PED-11, 1-Year Neurological Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
37	4483.PED-11	1411	70	70	Skin Appearance
38	4595.PED-11	3411	58	58	Reflex: jaw jerk, right
38	4484.PED-11	1411	71	71	Spine
42	4485.PED-11	1411	72	72	Musculoskeletal: shoulder girdle
43	4486.PED-11	1411	73	73	Musculoskeletal: arms; wrists
43	4560.PED-11	3411	23	23	Posture and body attitude
43	4596.PED-11	3411	59	59	Reflex: jaw jerk, left
44	4487.PED-11	1411	74	74	Musculoskeletal: hands
44	4561.PED-11	3411	24	24	Sitting
45	4562.PED-11	3411	25	25	Creeping
45	4488.PED-11	1411	75	75	Musculoskeletal: pelvic girdle
46	4489.PED-11	1411	76	76	Musculoskeletal: legs; ankles
47	4490.PED-11	1411	77	77	Musculoskeletal: feet
48	4491.PED-11	1411	78	78	Consciousness, state of
48	4563.PED-11	3411	26	26	Standing
49	4492.PED-11	1411	79	79	Affective response
49	4564.PED-11	3411	27	27	Walking
50	4597.PED-11	3411	60	60	Reflex: cremasteric
51	4493.PED-11	1411	80	80	Phonation, observed
51	4565.PED-11	3411	28	28	Response, accepts proffered objects
52	4497.PED-11	2411	17	17	Phonation, reported
54	5039....VAR		1126	1126	Development observed: locomotor; postural
54	4498.PED-11	2411	18	18	Development, observed: locomotor; postural
54	4566.PED-11	3411	29	29	Response, ring
55	5038....VAR		1125	1125	Development reported: locomotor; postural
55	4499.PED-11	2411	19	19	Development, reported: locomotor; postural
55	4567.PED-11	3411	30	30	Response, cube
55	4598.PED-11	3411	61	61	Skin: flushing, observed
56	4599.PED-11	3411	62	62	Skin: flushing, history
60	4502.PED-11	2411	22	22	Coordination: reaching
61	4501.PED-11	2411	23	23	Hand preference
62	4504.PED-11	2411	24	24	Sensation, light touch
63	4505.PED-11	2411	25	25	Sensation, pin prick
64	4506.PED-11	2411	26	26	Movement: face, spontaneous
65	4507.PED-11	2411	27	27	Palpebral fissures
66	4568.PED-11	3411	31	31	Eye: cornea, right
66	4508.PED-11	2411	28	28	Lid closure
67	4569.PED-11	3411	32	32	Eye: cornea, left
67	4509.PED-11	2411	29	29	Reflex: corneal
68	4510.PED-11	2411	30	30	Follows light or object
68	4600.PED-11	3411	63	63	Reflex: anal superficial
69	4511.PED-11	2411	31	31	Opticokinetic: nystagmus
71	4570.PED-11	3411	33	33	Eye: anterior chamber, right

Form Item Numbers linked to Data Items on PED-11, 1-Year Neurological Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
72	4571.PED-11	3411	34	34	Eye: anterior chamber, left
72	4512.PED-11	2411	32	32	Visual fields by confrontation
73	4513.PED-11	2411	33	33	Eyes, position at rest
74	4572.PED-11	3411	35	35	Eye: iris, right
75	4514.PED-11	2411	34	34	Eye weakness or paralysis, right
75	4573.PED-11	3411	36	36	Eye: iris, left
76	4515.PED-11	2411	35	35	Eye weakness or paralysis, left
77	4574.PED-11	3411	37	37	Eye: lens, right
77	4516.PED-11	2411	36	36	Nystagmus, spontaneous
78	4575.PED-11	3411	38	38	Eye: lens, left
78	4517.PED-11	2411	37	37	Eyes: pupils, shape and symmetry
79	4518.PED-11	2411	38	38	Eyes: pupils, reaction to light, direct
80	4576.PED-11	3411	39	39	Eye: vitreous, right
80	4519.PED-11	2411	39	39	Eyes: pupils, reaction to light, consensual
81	4577.PED-11	3411	40	40	Eye: vitreous, left
81	4520.PED-11	2411	40	40	Response: sound
82	4521.PED-11	2411	41	41	Reflex: jaw
83	4522.PED-11	2411	42	42	Movement: palate
84	4523.PED-11	2411	43	43	Tongue
85	4578.PED-11	3411	41	41	Eye: disc, right
86	4579.PED-11	3411	42	42	Eye: disc, left
87	4524.PED-11	2411	44	44	Movements, involuntary, abnormal
88	4580.PED-11	3411	43	43	Eye: fundus, right
89	4581.PED-11	3411	44	44	Eye: fundus, left
89	4525.PED-11	2411	45	46	Tone: extremity, upper
90	4526.PED-11	2411	47	48	Tone: extremity, lower
91	4527.PED-11	2411	49	50	Tone: neck flexor
92	4528.PED-11	2411	51	52	Tone: neck extensor
93	4582.PED-11	3411	45	45	Squint, concomitant
93	4529.PED-11	2411	53	54	Tone: trunk
95	4530.PED-11	2411	55	56	Reflex: biceps jerk
96	4583.PED-11	3411	46	46	Gaze: conjugate
96	4531.PED-11	2411	57	58	Reflex: triceps jerk
100	4534.PED-11	2411	63	63	Plantar response, right
101	4535.PED-11	2411	64	64	Plantar response, left

DEFINITION OF CODES

ONE YEAR NEUROLOGICAL EXAM
FORM PED-11 CARD 411

FIELD		CARD COLUMN
1.	**Card Number** Code: 1	1
2.	**Form Number** Code: 411	2-4
3.	**Revision Number** * Code: 0 - Form Dated: 11/59 1 - Form Dated: Rev. 5/61 2 - Form Dated: 11/59 (Exam age outside limits) 3 - Form Dated: Rev. 5/61 (Exam age outside limits)	5

Note: DO NOT USE REV. 2 AND 3 IN TABULATIONS UNLESS SPECIFICALLY REQUESTED.

FIELD		CARD COLUMN
4.	**NINDB Number** Item 1 Nine- Digit number for Patient Identification Code: As given	6-14
5.	**Age** Item 5 Code: 48-60 - Weeks as given (Revs. "0" and "1" only) Less than 48 - Weeks as given (Revs. "2" and "3" only) 61 and over - Weeks as given (Revs. "2" and "3" only)	15-16
6.	**Date of Examination** Item 4 Code: As given	17-22
7.	**Date of Birth** Item 1 Code: As given	23-28
8.	**Weight** Item 5 Code: 1100-3515 - As given in pounds and ounces 9999 - Unknown Additional codes reviewed and approved: 0800, 0900, 1000, 3700	29-32

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0", "1", "2" and "3".

DEFINITION OF CODES (Continued)

FORM PED-11
Card [illegible]

FIELD		CARD COLUMN
9.	**Body Length** Item 7 Code: 50 -90 - As given in cms. 99 - Unknown Additional codes reviewed and approved: [illegible]	33-34
10.	**Lower Segment** (Revs. "1" and "3" only) Item 8 Code: Blank - Not on Revs. "0" and "2" 15-40 - As given in cms. 99 - Unknown Additional codes reviewed and approved: [illegible], 50, 51, 53	35-36
11.	**Head Circumference** Item 9 Code: 35-55 - As given in cms. 99 - Unknown Additional codes reviewed and approved: 23, 3[illegible], 56-58,60,61,69,70	37-38
12.	**Chest Circumference** (Revs. "1" and "3" only) Item 10 Code: Blank - Not on Revs. "0" and "2" 35-55 - As given in cms. 99 - Unknown Additional codes reviewed and approved: 56-60, 67, 70	39-40
13.	**Head - Shape and Contour** Item 11 Code: 0 - Normal 8 - Other 9 - Not reported	41
14.	**Anterior Fontanelle** Item 12 Code: 0 - Closed 1 - Open 2 - Closed with abnormal configuration (Revs. "0" and "2" only) 9 - Not reported	42
15.	**AP Dimensions** (Revs. "1" and "3" only) Item 13 Code: Blank - Not on Revs. "0" and "2" X and blank - closed or not reported in col. 42 00 - Less than one cm. 01 - 08 - As given in cms. 99 - If not reported Additional codes reviewed and approved: [illegible], [illegible], [illegible], 18	43-44

FIELD		CARD COLUMN
16.	Lateral Dimension (Revisions "1" and "3" only) Item 14 Code: Same as in Field 15 except Blank - Closed or not reported in col. 42, not on Revs. "0" and "2" Additional codes reviewed and approved: [illegible]	45-6
17.	Tension (Revisions "1" and "3" only) Item 15 Code: Blank - Closed or not reported in col. 42, not on Revs. "0" and "2" 0 - Normal 8 - Other 9 - Not Reported	47
18.	Transillumination Item 16 Code: 0 - Normal 8 - Other 9 - Not reported	48
19.	Facies (Revisions "1" and "3" only) Item 17 Code: Blank - Not on Revs. "0" and "2" 0 - Normal 1 - Epicanthal folds 2 - Cleft lip 3 - Hypertelorism 7 - Combination of 2 or more codes 8 - Other 9 - Not reported	49
20.	Eyes - External Examination (Revs. "1" and "3" only) Item 18 Code: Blank - Not on Revs. "0" and "2" 0 - Normal 8 - Other 9 - Not reported	50
21.	Eyes - Ophthalmoscopic Examination (Revs. "1" and "3" only) Item 19 Code: Same as in Field 20	51

FIELD		CARD COLUMN
22.	Ears - Size, Shape, Location (Revisions "1" and "3" only) Item 20 Code: Same as in Field 20	52
23.	Ears - Otoscopic Examination (Revisions "1" and "3" only) Item 21 Code: Same as in Field 20	53
24.	Nose, Mouth and Pharynx (Revisions "1" and "3" only) Item 22 Code: Same as in Field 20	54
25.	Neck Item 25 Code: 0 - Normal 1 - Restricted range of motion (Revisions "1" and "3" only) 2 - Masses (Revisions "1" and "3" only) 7 - Combination of codes 1 and 2 (Revisions "1" and "3" only) 8 - Other 9 - Not reported	55
26.	Thorax Item 26 Code: Same as in Field 18	56
27.	Respirations (Revisions "1" and "3" only) Item 27 Code: Same as in Field 20	57
28.	Lungs Item 28 Code: Same as in Field 18	58

FIELD		CARD COLUMNS
29.	**Heart** Item 29 Five-digit code for: Normality (col. 59) Irregular Rhythm (col. 60) [illegible] (col. 61) [illegible] (col. 62) Other (col. 63) Code for each column (Revs. "1" and "3") 0 - No 1 - Yes Code for each column (Revs. "0" and "2") 10000 - Normal 00002 - Questionable 00003 - Abnormal 00000 - Not reported	59-63
30.	**Femoral Pulses** Item 30 Code: 1 - Strong and equal bilaterally 8 - Other 9 - Not reported	64
31.	**Abdomen and Contents** Item 32 Code: Same as in Field 18	65
32.	**Liver** Item 33 Code: Same as in Field 18	66
33.	**Spleen** Item 34 Code: Same as in Field 18	67
34.	**Kidneys** (Revisions "1" and "3" only) Item 35 Code: Blank - Not on Revs. "0" and "2" 0 - Not palpable 1 - Palpable 9 - Not reported	68
35.	**Genitalia** Item 36 Code: Same as in Field 18	69

FIELD | | CARD COLUMN

36. **Skin**
Item 37
Code: 0 - Normal
1 - Pigmented nevi (Revs. "1" and "3" only)
2 - Vascular nevi (Revs. "1" and "3" only)
3 - Other rashes (Revs. "1" and "3" only)
4 - Loose and wrinkled (Revs. "1" and "3" only)
5 - Cafe au lait (Revs. "1" and "3" only)
6 - Questionable or abnormal (Revs. "0" and "2" only)
7 - Combination of 2 or more codes (Revs. "1" and "3" only)
8 - Other (Revs. "1" and "3" only)
9 - Not reported

Card column: 70

37. **Spine** (Revisions "1" and "3" only)
Item 38
Code: Same as in Field 20

Card column: 71

38. **Shoulder Girdle**
Item 42
Code: 0 - Normal
8 - Other
9 - Not reported

Card column: 72

39. **Arms and Wrists**
Item 43
Code: Same as in Field 38

Card column: 73

40. **Hands**
Item 44
Code: Same as in Field 38

Card column: 74

41. **Pelvic Girdle**
Item 45
Code: Same as in Field 38

Card column: 75

FIELD		CARD COLUMN
42.	**Legs and Ankles** Item 46 Code: Same as in Field 38	76
43.	**Feet** Item 47 Code: Same as in Field 38	77
44.	**State of Consciousness** Item 48 Code: 0 - Alert and responding appropriately 8 - Other 9 - Not reported	78
45.	**Affective Response** Item 49 Code: 0 - Normal 8 - Other 9 - Not reported	79
46.	**Phonation Observed** Item 51 Code: 0 - Intelligible words 1 - Unintelligible words 2 - Crying only 8 - Other 9 - Not reported	80

DEFINITION OF CODES (Continued)

FORM PED-11
Card 2-11

FIELD		CARD COLUMNS
1.	Card Number Code: 2	1
2.	Basic Data * Code: Same as in columns 2-16 of Card 1	2-16
3.	Phonation Reported (Revision "1" only) Item 52 Code: Blank - Not on Rev. "1" 0 - Intelligible words 1 - Unintelligible sounds 2 - Crying only 8 - Other 9 - Not reported	17
4.	Locomotor and Postural Development - Observed (Revision "1" only) Item 54 Code: Blank - Not on Rev. "1" 0 - Walks unaided 1 - Walks supported 2 - Stands unaided 3 - Pulls to standing 4 - Stands supported 5 - Creeps 8 - None of above 9 - Not evaluated or not reported	18
5.	Locomotor and Postural Development Reported (Revision "1" only) Item 55 Code: Same as Field 4	19

* Unless specified, Field, Codes and Card Columns refer to Revision Number "0" and "1". Item numbers refer to Form Dated: Rev. 7 61

FIELD	CARD COLUMN

6. **Abnormalities of Gait or Posture** (Revision "1" only) — 20

Item 56
Code: Blank - Not on Rev. "0"
- 0 - Normal
- 1 - Retarded locomotor development
- 2 - Hemiparesis - hemiplegia
- 4 - Other weakness or paralysis
- 7 - Combination of codes
- 8 - Abnormal
- 9 - Not evaluated or not reported

7. **Prehensile Grasp** (Revision "1" only) — 21

Item 57
Code: Blank - Not on Rev. "0"
- 0 - Grasp with thumb and fingers
- 1 - Grasp with palm
- 2 - Raking without grasp
- 8 - Other
- 9 - Unable to evaluate or not reported

8. **Reaching Coordination** (Revision "1" only) — 22

Item 60
Code: Blank - Not on Rev. "0"
- 0 - Normal
- 1 - Dyskinesia
- 8 - Other
- 9 - Unable to evaluate or not reported

9. **Hand Preference** — 23

Item 61
Code: 0 - Variable
- 1 - Strongly right
- 2 - Strongly left
- 9 - Unable to evaluate or not reported

10. **Sensation - Light Touch** — 24

Item 62
Code: 0 - No abnormality detected
- 8 - Other
- 9 - Unable to evaluate or not reported

ITEM		CARD COLUMN
11.	Sensation - Pin Prick	25
	Item 63 Code: 0 - No abnormality detected 8 - Other 9 - Not reported
12.	Spontaneous Movements - Face	26
	Item 64 Code: 0 - Present and symmetrical 8 - Other 9 - Unable to evaluate or not reported
13.	Palpebral Fissures	27
	Item 65 Code: 0 - Wide and equal 8 - Other 9 - Unable to evaluate or not reported
14.	Lid Closure	28
	Item 66 Code: 0 - Normal and symmetrical 8 - Other 9 - Unable to evaluate or not reported
15.	Corneal Reflex	29
	Item 67 Code: 0 - Present and symmetrical 8 - Other 9 - Not reported
16.	Follows Light or Object	30
	Item 68 Code: 0 - Yes 1 - Questionable (Revision "1" only) 2 - Closes eyes (Revision "2" only) 3 - Other (Revision "2" only) 8 - No 9 - Unable to evaluate or not reported

FIELD		CARD COLUMN
17.	Opticokinetic Nystagmus	31
18.	Visual Fields by Confrontation	32
19.	Position of Eyes at Rest	33
20.	Weakness or Paralysis: Right Eye	34
21.	Weakness or Paralysis: Left Eye	35

17. Opticokinetic Nystagmus — 31

Item 69
Code: 0 - Present and symmetrical
1 - Questionable
2 - Absent
8 - Other
9 - Unable to evaluate or not reported

18. Visual Fields by Confrontation — 32

Item 72
Code: 0 - No abnormality detected
8 - Other
9 - Unable to evaluate or not reported

19. Position of Eyes at Rest — 33

Item 73
Code: 0 - Normal
8 - Other
9 - Unable to evaluate or not reported

20. Weakness or Paralysis: Right Eye — 34

Item 75
Code: 0 - None
1 - Right
2 - Left
3 - Upward
4 - Downward
5 - Other (Revision "1" only)
7 - Combination of codes (Revision "0" only)
9 - Unable to evaluate or not reported

21. Weakness or Paralysis: Left Eye — 35

Item 76
Code: Same as in Field 20

FIELD | CARD COLUMN

22. Spontaneous Nystagmus (Revision "1" only) — 36

Item 77
Code: Blank - Not on Rev. "0"
0 - None
1 - Central, bilateral
8 - Other
9 - Unable to evaluate or not reported

23. Pupils - Shape and Symmetry — 37

Item 78
Code: 0 - Normal
8 - Other
9 - Unable to evaluate or not reported

24. Pupils - Reaction to Light - Direct — 38

Item 79
Code: 0 - Normal
8 - Other
9 - Unable to evaluate or not reported

25. Pupils - Reaction to Light - Consensual — 39

Item 80
Code: 0 - Present and symmetrical
8 - Other
9 - Not reported

26. Response to Sound — 40

Item 81
Code: 0 - No abnormality detected
8 - Other
9 - Unable to evaluate or not reported

27. Gag Reflex — 41

Item 82
Code: 0 - Present
8 - Other
9 - Unable to evaluate or not reported

FIELD		CARD COLUMN
28.	Palate Movement	42

Item 83
Code: 0 - Present and symmetrical
8 - Other
9 - Unable to evaluate or not reported

29. Tongue — 43

Item 84
Code: 0 - Normal
8 - Other
9 - Unable to evaluate or not reported

30. Abnormal Involuntary Movements (Revision "1" only) — 44

Item 87
Code: Blank - Not on Rev. "0"
0 - None
1 - Choreoathetosis
2 - Dystonia
3 - Tremor
4 - Other
7 - Combination of Codes
9 - Unable to evaluate or not reported

31. Tone - Upper Extremity (Revision "1" only) — 45-46

Item 89
Two-digit code for:
Right (col. 45)
Code: Blank - Not on Rev. "0"
0 - Bilateral only
1 - Hypotonic
2 - Questionable hypotonicity
3 - Normal
4 - Questionable hypertonicity
5 - Hypertonic
9 - Unable to evaluate or not reported
Left or Bilateral (col. 46)
Code: Same as in col. 45 except
code "0" does not apply

FIELD		CARD COLUMN
32.	**Tone - Lower Extremity** Item 90 Code: Same as in Field 31	47-48
33.	**Tone - Neck Flexor** Item 91 Code: Same as in Field 31	49-50
34.	**Tone - Neck Extensor** Item 92 Code: Same as in Field 31	51-52
35.	**Tone - Trunk** Item 93 Code: Same as in Field 31	53-54
36.	**Deep Tendon Reflexes - Biceps Jerk** Item 95 Two-digit code for: Right (col. 55) Code: 0 - Bilateral only 1 - Hypoactive or absent 2 - Normal 3 - Increased 4 - Increased with clonus 9 - Unable to evaluate or not reported Left or Bilateral (col. 56) Code: Same as col. 55 except code "0" does not apply	55-56
37.	**Triceps Jerk** Item 96 Code: Same as in Field 36	57-58
38.	**Knee Jerk** Item 97 Code: Same as in Field 36	59-60

FIELD		CARD COLUMN
39.	**Ankle Jerk** Item 98 Code: Same as in Field 36	61-62
40.	**Plantar Response - Right** Item 100 Code: 0 - Variable 1 - Upward movement of great toe 2 - Upward movement of great toe and fanning of toes 3 - Flexion of toes 9 - Not reported	63
41.	**Plantar Response - Left** Item 101 Code: Same as in Field 40	64
42.	**Superficial Abdominal Reflex** Item 102 Code: 0 - Present and symmetrical 8 - Other 9 - Not reported	65
43.	**Tonic Neck Reflex** (Revision "1" only) Item 103 Code: Blank - Not on Rev. "0" 0 - No constant pattern 1 - Obtained with difficulty 2 - Obtained with ease 8 - Other 9 - Not reported	66
44.	**Moro Reflex** (Revision "1" only) Item 104 Code: Blank - Not on Rev. "0" 0 - No constant pattern 1 - Flexor and extensor components present and symmetrical 8 - Other 9 - Not reported	67

DEFINITION OF CODES (Continued)

FORM PED-11
Card 2[illegible]

FIELD		CARD COLUMN
45.	**Palmar Grasp Reflex** (Revision "1" only) Item 107 Code: Blank - Not on Rev. "0" 0 - Absent or variable 1 - Reflex present and symmetrical 8 - Other 9 - Unable to evaluate or not reported	68
46.	**Sweating - Observed** Item 109 Code: 0 - Present, normal 8 - Other 9 - Unable to evaluate or not reported	69
47.	**Sweating - Reported** Item 110 Code: Same as Field 46	70
48.	**Urinary Stream - Observed** Item 112 Code: 0 - Good periodic stream 1 - Dribbling 8 - Other 9 - Unable to evaluate or not reported	71
49.	**Urinary Stream - Reported** Item 113 Code: Same as Field 48	72
50.	**Superficial Anal Reflex** (Revision "1" only) Item 11[illegible] Code: Blank - Not on Rev. "0" 0 - Present, normal 8 - Other 9 - Unable to evaluate or not reported	73

DEFINITION OF CODES (Continued)

FORM PED-11
Card 2[illegible]

FIELD		CARD COLUMN

51. **Rectal Tone** (Revision "1" only) — 74

Item 115
Code: Blank - Not on Rev. "0"
0 - Normal
8 - Other
9 - Not reported

52. **Other Signs, Etc.** (Revision "1" only) — 75

Item 116
Code: Blank - Not on Rev. "0"
0 - No
1 - Yes
9 - Not reported

53. **Neurological Abnormalities** — 76

Item 117
Code: 0 - None
1 - Suspicious
2 - Abnormal
9 - Not reported

54. **Non-Neurological Abnormalities** — 77

Item 118
Code: 0 - None
1 - Minor
2 - Questionable
3 - Definite major (Revision "0" only)
4 - Definite major (Revision "1" only)
9 - Not reported

55. **Unsatisfactory Conditions** (Revision "1" only) — 78

Item 119
Code: Blank - Not on Rev. "0"
0 - Absent
1 - Present
9 - Not reported

FIELD		CARD COLUMNS
56.	Disposition Item 120 Code: 0 - No indication 8 - Further evaluation proposed 9 - Not reported	79
57.	HP-5 Attached (Revision "1" only) Item 121 Code: Blank - Not on Rev. "0" 0 - No 1 - Yes 9 - Not reported	80

DEFINITION OF CODES (Continued)

FORM PED-11
Card 3411

NOTE: This card should not be used in tabulations.

FIELD		CARD COLUMNS
1.	Card Number Code: 3	1
2.	Basic Data * Code: Same as in columns 2-16 of Card 1, except column 5 is Revs. "0" and "2" only.	2-16
3.	Head- External Anomalies Item 18 Code: 0 - Absent 1 - Questionable 2 - Present 9 - Not reported	17
4.	[illegible] Item 19 Code: 0 - Normal 1 - Questionable 2 - Abnormal 9 - Not reported	18
5.	Back Item 29 Code: 0 - Normal 1 - Questionable 2 - Abnormal 9 - Not reported	19
6.	Motor System Item 36 Code: 0 - Normal 1 - Questionable 2 - Abnormal 9 - Not reported	20

* Fields, Codes, Item Numbers and Card Columns refer to Revision "0".

FIELD		CARD COLUMN

7. Abnormal Motor System

Item 37 — 21-22

Code:
00 - Not required
01 - Absence of major muscle
02 - Underdevelopment of major muscle
03 - Hypertrophy of major muscle
04 - Atrophy, focal, of major muscle
05 - Weakness of major muscle
07 - Combinations of 01 through 05
11 - Dystonia
12 - Choreo-athetosis
13 - Tremor
14 - Rigidity
15 - Spasticity
16 - Flaccidity
17 - Combinations 11 through 16
77 - Combination of code or codes 01 through 05 with code or codes 11 through 16 or a combination of any code with 88
88 - Other
99 - Not reported

8. Posture and Body Attitude — 23

Item 43

Code:
0 - Normal
1 - Questionable
2 - Abnormal
9 - Not reported

9. Sitting — 24

Item 44

Code:
0 - Assumes without aid or support a normal sitting position
1 - Sits without support when placed in sitting position
2 - Sits with support
3 - Unable to sit
8 - Other
9 - Not reported

FIELD		CARD COLUMN
10.	Creeping	25
11.	Standing	26
12.	Walking	27
13.	Accepts Proffered Object	28

10. **Creeping** — Card column 25

Item -5
Code: 0 - Creeps normally
1 - Creeps but with abnormal motion
2 - Does not creep
8 - Other
9 - Not reported

11. **Standing** — Card column 26

Item -8
Code: 0 - Stands alone
1 - Pulls to stand using support
2 - Stands holding to support when placed in standing position
3 - Stands only with support from other person
4 - Unable to stand
8 - Other
9 - Not reported

12. **Walking** — Card column 27

Item -9
Code: 0 - Walks alone
1 - "Cruises" about room holding to furniture
2 - Walks when led
3 - Makes movement of progression when fully supported
4 - Unable to walk
5 - Abnormality of gait
8 - Other
9 - Not reported

13. **Accepts Proffered Object** — Card column 28

Item 51
Code: 0 - Opposes thumb and forefinger
1 - Whole hand
2 - Unable to accept
3 - Will not accept
8 - Other
9 - Not reported

DEFINITION OF CODES (Continued)

FORM PED-11
Card 3-11

FIELD

CARD COLUMN

14. **Ring Response** — 29

Item 54
Code: 1 - Dangles ring by string
2 - Pulls string adaptively to secure ring
3 - Secures ring by accidentally pulling string
4 - Attempts to secure ring unsuccessful
5 - No attempt to secure ring
8 - Other
9 - Child uncooperative-unsuccessful test and not reported

15. **Cube Response** — 30

Item 55
Code: 1 - Builds tower of cubes
2 - Puts 3 or more cubes in cup
3 - Unwraps cube
4 - Puts 1 cube in cup
5 - Attempts to secure 3rd cube
6 - None of above
9 - Uncooperative - unsuccessful test and not reported

16. **Right Eye - Cornea** — 31

Item 56
Code: 0 - Normal
1 - Questionable
2 - Abnormal
9 - Not done or not reported

17. **Left Eye - Cornea** — 32

Item 57
Code: Same as Field 16

FIELD		CARD COLUMNS
18.	Right Eye - Anterior Chamber Item 71 Code: Same as in Field 16	33
19.	Left Eye - Anterior Chamber Item 72 Code: Same as in Field 16	34
20.	Right Eye - Iris Item 74 Code: 0 - Normal 1 - Questionable 2 - Abnormal 9 - Not done or not reported	35
21.	Left Eye - Iris Item 75 Code: Same as in Field 20	36
22.	Right Eye - Lens Item 77 Code: Same as in Field 20	37
23.	Left Eye - Lens Item 78 Code: Same as in Field 20	38
24.	Right Eye - Vitreous Item 80 Code: Same as in Field 20	39
25.	Left Eye - Vitreous Item 81 Code: Same as in Field 20	40

FIELD		CARD COLUMN
26.	Right Eye - Optic Disc Item 85 Code: Same as in Field 20	41
27.	Left Eye - Optic Disc Item 86 Code: Same as in Field 20	42
28.	Right Eye - Fundus Item 88 Code: Same as in Field 20	43
29.	Left Eye - Fundus Item 89 Code: Same as in Field 20	44
30.	Concomitant Squint Item 93 Code: 0 - None 1 - Inward 2 - Outward 3 - R.E. up 4 - L.E. up 8 - Combination of codes 9 - Not reported	45
31.	Conjugate Gaze Item 96 Code: 0 - None 1 - To right 2 - To left 3 - Upward 4 - Downward 7 - Combination of codes 9 - Not reported	46

FIELD		CARD COLUMN
32.	**During Right Rotation: Deviation**	47
	Item 104 Code: 1 - None 2 - Right 3 - Left 9 - Not reported	
33.	**During Right Rotation: Nystagmus**	48
	Item 105 Code: Same as Field 32	
34.	**After Right Rotation: Deviation**	49
	Item 107 Code: Same as in Field 32	
35.	**After Right Rotation: Nystagmus**	50
	Item 108 Code: Same as in Field 32	
36.	**During Left Rotation: Deviation**	51
	Item 111 Code: Same as in Field 32	
37.	**During Left Rotation: Nystagmus**	52
	Item 112 Code: Same as in Field 32	
38.	**After Left Rotation: Deviation**	53
	Item 114 Code: Same as in Field 32	
39.	**After Left Rotation: Nystagmus**	54
	Item 115 Code: Same as in Field 32	

DEFINITION OF CODES (Continued)

FORM PED-11
Card 3411

FIELD

CARD COLUMN

40. **Swallowing** — Card column 55

Item 127
Code: 0 - Present
1 - Absent
2 - Impaired
8 - Other
9 - Not reported

41. **Voice Quality** — Card column 56

Item 132
Code: 0 - Normal
1 - Suspicious
8 - Other
9 - Not reported

42. **Palpitation of Sternocleidomastoid Muscle** — Card column 57

Item 133
Code: 0 - None
1 - To right
2 - To left
9 - Not reported

43. **Jaw Jerk - Right** — Card column 58

Item 138
Code: 0 - Absent
1 - Hypoactive
2 - Normal
3 - Increased
4 - Increased with clonus
9 - Not reported

44. **Jaw Jerk - Left** — Card column 59

Item 143
Code: Same as in Field 43

45. **Cremasteric Reflexes** — Card column 60

Item 150
Code: 0 - Present
1 - Absent
2 - Does not apply
9 - Not reported

FIELD		CARD COLUMN
46.	Flushing - Actually Seen	61
	Item 155 Code: 0 - Present 1 - Suspicious 2 - Present abnormally 3 - Absent 9 - Not reported	
47.	Flushing - History	62
	Item 156 Code: Same as in Field 46	
48.	Superficial Anal Reflex	63
	Item 158 Code: 0 - Normal 1 - Questionable 2 - Abnormal 9 - Not evaluated and not reported	

ONE YEAR NEUROLOGICAL EXAMINATION
FORM PED-11

Item # on Form*	Card # 1411	1 NINDB #	5 Age	4 Date of Exam	1 Date of Birth	6 Weight	7	8	9	10	13	14	[illegible]	29 Heart	[illegible]
			Age	Date of Exam	Date of Birth	Pounds / Ounces	Body Length	Lower Segment	Head Circumference	Chest Circumference	AP Dimensions (Anterior Fontanel)	Lateral Dimension (Anterior Fontanel)	Eyes / Ears [illegible]	Heart	[illegible]

* Item numbers refer to form dated: Rev. 5/61

PED-11 - 28

ONE YEAR NEUROLOGICAL EXAMINATION
FORM PED-11

ITEM # ON FORM #

1

5

CARD # 2411

NINDB*

AGE

PUPILS

TONE

UPPER EXTREMITY

LOWER EXTREMITY

NECK FLEXOR

NECK EXTENSOR

TRUNK

JERK

BICEPS

TRICEPS

KNEE

ANKLE

89 90 91 92 93 95 96 97 98

REFLEX

SWEATING

URINARY STREAM

* Item numbers refer to form dated: Rev. 5/61

PED-11 - 29

ONE YEAR NEUROLOGICAL EXAMINATION
FORM PED-11

ITEM # ON FORM *

CARD # 3411 **

NIHDB #

AGE

Abnormal motor system

EYE: CORNEA, ANTERIOR CHAMBER, IRIS, LENS, VITREOUS, OPTIC DISC, FUNDUS

LABYRINTHINE: RIGHT ROTATION (DURING, AFTER); LEFT ROTATION (DURING, AFTER)

BLANK

* Item numbers refer to form dated: 11/59
** This card should not be used in tabulations.

PED-11 - 30

ONE-YEAR NEUROLOGICAL EXAMINATION
(For Form PED-11, Rev. 5-61)

I Introduction

The purpose of the One-Year Neurological Examination is to evaluate, by physical examination techniques, the function of the child's central nervous system and to detect and describe abnormalities of other body systems. Information obtained from the examination is to be recorded for the following purposes:

A. To characterize the child as neurologically normal or other-than-normal *at the time of the examination.*

B. To identify manifestations of suspected or definite neurological abnormality.

C. To identify manifestations of abnormality of other body systems as determined by physical examination.

The One-Year Neurological Examination is designed as a screening examination which can be performed on all children in a systematic fashion. It is not intended to be a definitive diagnostic tool. Definitive diagnosis and assessment of the significance of abnormalities requires, in most instances, a review of the history of the child, consideration of the findings of previous examinations, and performance of further detailed examinations and laboratory studies.

The performance of further diagnostic studies and the integration of past history, present examination findings and further detail studies to arrive at a definitive diagnosis is desirable and strongly recommended, but is distinct and separate from the One-Year Neurological Examination.

This manual has been prepared for use as a guide to performing the examination and to assist in the proper recording of the information obtained. A movie, *The Neurological Examination of the One-Year Old*, is highly recommended for use in orientation and training for the performance of the One-Year Neurological Examination. This film, produced by Dr. Richmond Paine, is in 16 mm color sound. Viewing time is approximately 30 minutes. It may be purchased from Churchill-Wexler Film Productions, 801 N. Seward Street, Los Angeles 38, California, or be obtained on loan from NIH by request to Information Specialist, Perinatal Research Branch.

II General Instructions For Performing And Recording The Examination

A. **The Examiner.** The person performing the One-Year Neurological Examination should be a pediatrician with special interest and training in neurology or a neurologist with special interest and training in pediatrics.

B. **Time of Examination.** The examination should be done when the child is approximately one year of age, with an allowable range of 50 and 56 weeks of age. If examination within this age range is impossible, every effort should be made to perform the examination as closely as possible to the specified time.

C. **Definitive Diagnosis.** When an abnormality is detected by the screening examination, it is essential that further evaluation be made, if indicated and within the dictates of good medical practice, to arrive at a definitive diagnosis. Such further evaluation may include a review of the child's past history, a review and perhaps reassessment of the findings of the one year interval history and PED-11 examination, laboratory tests and consultation on the day of the one-year examination, and tests and reexamination scheduled for a later date.

It is desirable that a diagnostic summary, based on a review of the child's past history, the one-year interval history and PED-11 examination, and additional tests and observations as indicated, be done on every case.

Whether the child is normal or abnormal, the further evaluation and diagnostic summary is separate and distinct from the PED-11 examination. It may be done immediately following the PED-11 examination or at some later date, and should be reported on CP-5 record sheets. However, until such time as guidelines and criteria for routine case review, diagnostic work-up and summary have been developed and adopted by the Study, the decisions of if,

when, and how to conduct this further evaluation and summary rest with the local project.

D. **Elimination of Bias.** The examiner should not know the child's history or the findings of previous examinations prior to doing the examination. The examiner should not be the person taking the Interval History. However, after the routine history and the examination have been completed and recorded, the examiner may review the history and the case record. He may recheck any part of the history and examination. Findings derived from such re-examination should be recorded on a CP-5 sheet and attached to form PED-11. No change or addition to the original records is permitted. (See also discussion under Item 116 in Section III.)

Certain historical facts (walking, talking, urination, etc.) are included as optional items on form PED-11 and may be obtained and recorded in context during the examination.

E. **Construction of the Reporting Form.** The first portion of the form (Items 6 through 47) is a "review of systems" arrangement of general physical examination items. Item 37 "Skin" is out of order on purpose, since on the previous revision of this form it seemed to receive undue attention because of its position at the top of the list. The second section of the form (Items 48 to 116) is a series of items of observation of central nervous system function. These are arranged in approximate order of performance under ideal conditions. Since two of the attributes of a one-year-old child are uncooperativeness and unpredictability it is obvious that the sequence of the examination will often have little relation to the sequence of the items on the form PED-11.

The third section of the form (Items 117 to 121) is for summarizing the conditions and conclusions of the examination.

The form is set up for convenience in recording normal findings. For most items any other-than-normal finding requires description. An abnormal response is indexed by a check mark in the appropriate box, and described in narrative or outline fashion in the blank space on the right-hand side of the page. The itemized instructions in section III will specify those items that need no further comment even for an abnormal response.

F. **Completeness of Examination and Recording.** There are a number of items on the form which are specified (by indentation and prefix asterisk) as being optional. All items except "Comments" sections and those items preceded by an asterisk must contain an entry. If all of the required items are carefully evaluated the optimum compromise between an adequate screening examination for a normal child and the fatigue limit of both child and examiner will have been approached. However, if abnormality is suspected, there are many other procedures and observations which should be included as part of the neurological examination. For convenience in recording, some of the more frequently performed tests of this type are included on the reporting form in sequence with the related required items. Some neurologists may wish to do these on all children and would like to request that everyone do them routinely. However, compelling practical considerations make it necessary to designate certain of these tests "optional".

III SPECIFIC INSTRUCTIONS FOR PERFORMING AND RECORDING THE EXAMINATION

Item 1, Patient Identification. This is to be completed using the child's name plate, containing at least the following information: Child's name, NINDB number, date of birth, birth weight, race and sex.

Item 2, Name of Examiner. Record the examiner's surname and initials, or full name if necessary, for positive identification.

Item 3, Title or Position. Record the professional training status of the examiner as neurologist, pediatrician, pediatric neurologist, etc.

Item 4, Date of Examination. Record the date of examination using the sequence, month, day, year.

Item *5, Age of Child. This is an optional item and no recording or explanation is necessary if it is not completed. It is recommended that it be completed and used for local quality control purposes. This item will be computed and used in the analysis of the data. Therefore, if it is completed and used locally please use the following method of computation: 1) Determine the age of the child in calendar days. 2) Divide the age in days by seven. 3) Delete the fraction and report the age as weeks completed.

Item 6, Weight. It is desirable that weight be recorded in metric units. However, if an English system scale is used, report weight in pounds and ounces rather than converting to grams.

Item 7, Body Length (Crown-Heel). The total body length (crown to heel) should be measured as carefully as possible with the child either in supine or standing position. A metric rule should be used and the length reported in centimeters.

Item *8, Lower Segment (Symphysis-Heel). This is an optional item and no recording or explanation is necessary if it is not completed. This measurement should be obtained if the examiner considers the child's size or habitus to be unusual. It is desirable, but not required, that this measurement be obtained on all children.

Item 9, Head Circumference. The head circumference is measured with a flexible tape applied firmly over the supra-orbital ridges anteriorly and that part of the occiput posteriorly which gives the maximum circumference. Record in centimeters.

Item *10, Chest Circumference. This is an optional item and no recording or explanation is necessary if it is not completed. This measurement should be obtained if the examiner considers the child's size, habitus or head circumference to be unusual. It is desirable, but not required, that this measurement be obtained on all children.

Item 11, Head—Shape and Contour. Evaluate the shape and contour of the head by inspection and palpation. Asymmetry, prematurely closed or unusually wide sutures, prominences and depressions as well as more dramatic abnormalities of shape and size should be described.

Item 12, Anterior Fontanelle. If the fontanelle is closed or its maximum diameter is less than 1 cm. by palpation, check the box "Closed" and skip Items 13, 14 and 15. If the anterior fontanelle is open (1 cm. or more by palpation) check the box "Open" and complete Items 13, 14 and 15. In Items 13 and 14 record the A-P and lateral dimensions respectively of the anterior fontanelle as determined by palpation. Precise measurement with a metric rule is not necessary, but the size should be reported in centimeters not in fingerbreadths. If the fontanelle is open, the tension should be evaluated and recorded in Item 15.

Item *16, Transillumination. This is an optional test and no recording or explanation is necessary if it is not performed. However, it is strongly recommended that this test be performed on every child.

The transillumination test should be done in total darkness. A standard flashlight with a flexible opaque rubber adapter should be applied closely to the head in several areas so that all parts of the skull may be illuminated. A faint halo of light extending less than 2 cm. from the outer margin of the opaque shield should be considered normal. Areas of increased or decreased transillumination should be clearly described.

Item 17, Facies. For convenience in recording, this item includes slightly more than is usually subsumed under the term "Facies."

The general appearance of the child's face as determined by a multitude of factors including the hairline, the shape and position of the ears, the size and position of the eyes and lids, and the shape and size of the nose, mouth, tongue and jaw should be evaluated by inspection. For convenience in recording, check boxes are provided on the form for recording certain common unusual or abnormal findings. Workable definitions of epicanthal folds, cleft lip and hypertelorism are difficult to provide. These should be reported as a clinical judgment and do not require further comment. Unusual appearance in general, or

specific abnormalities other than the three listed, should be reported by a check mark in the box "Other" and clearly described. More than one category in this item may be checked if applicable.

Unusual shape and location of the ears, ptosis of the eyelids and facial paralysis are to be recorded elsewhere and should not be recorded under this item if they are isolated findings.

Item 18, Eyes-Structure—External Examination. The structure of the eyes as determined by external examination, including the retinal red reflex should be reported here. This is an evaluation of static anatomy. Such dynamic functions as lid closure, pupil reflexes and extra-ocular movements are to be reported elsewhere.

Item *19, Eyes-Structure—Ophthalmoscopic Examination. This is an optional item and no recording or explanation is necessary if it is not completed. A careful ophthalmoscopic examination should be done on every child in whom there is a suspicion of visual or CNS abnormality. It is recommended, but not required, that this examination be performed on all children.

In order to be recorded here as "Normal" the ophthalmoscopic examination must be carefully done. This includes dilating the pupils and performing the examination in a dark room. Do not make a recording of "Normal" if an examination is negative without these preparations. Abnormalities detected by an ophthalmoscopic examination performed without these preparations may be reported here. It is recommended that referral be made for further evaluation on such cases. The referral should be indicated under Item 120.

Item 20, Ears—Size, Shape and Location. Evaluate the size, shape and location of the ears. Any abnormalities should be described.

Item *21, Ears—Otoscopic Examination. This is an optional item and no recording or explanation is necessary if it is not completed.

Item 22, Nose, Mouth and Pharynx. Nose is included in this item for completeness in case an abnormality is noted, but rhinoscopy is not recommended as a routine procedure. The mouth and throat should be inspected for motor function as well as acute and static abnormalities. For consistency in separating the recording of static anatomy from neurological function, movements of the tongue and palate and the gag reflex are to be recorded on page 5. Cleft lip is recorded under Item 17. Cleft palate should be reported here. Mild, acute upper respiratory infection is important to the child's welfare but not to this research examination and need not be reported. (It should be reported as an explanatory comment under 119 if it adversely affected the completeness of the examination or the character of the child's response.)

Item 23, Comments. Record comments or descriptions concerning the numbered items. Be careful to identify the comment with the number of the item it concerns.

Item 24, Patient Identification. Same as Item 1.

Item 25, Neck. Evaluate by inspection, palpation and manipulation. Many structures, including cervical spine and soft tissues are subsumed under this category. Abnormalities of muscle tone *per se* are to be recorded under Items 91-92 and should not be recorded here unless restricted range of motion results. Enlarged lymph nodes associated with acute respiratory infection may be important to the child's welfare but not to this research examination and need not be reported.

Item 26, Thorax. Evaluate the thoracic cage. Do not include cardiac or respiratory findings under this item.

Item 27, Respirations. Evaluate the rhythm, symmetry and character of the respirations with the child in as near a resting state as possible.

Item 28, Lungs. Evaluate by auscultation and percussion.

Item 29, Heart. Evaluate by palpation and auscultation. Murmurs should be described as to character, grade of intensity (use 4-point scale), point of maximum intensity, distribu-

tion, transmission and postural variation. Do not report normal sinus arrhythmia but describe other types of irregular rhythm.

Item *30, Femoral Pulses. This is an optional item and no recording or explanation is necessary if it is not completed. Evaluation of the strength and symmetry of the femoral pulses should be done if there is suspicion of an anomaly of the heart or great vessels, and it is recommended that it be done as part of the routine screening test for such anomalies.

Item *31, Blood Pressure. This item is optional and no recording or explanation is necessary if it is not completed. If abnormalities of the heart or of the femoral pulses are detected, it is desirable that blood pressure be measured in both upper and lower extremities.

Item 32, Abdomen and Contents. Evaluate the abdominal wall and contents by inspection, palpation and percussion. Report here masses, distention, marked diastasis recti, inguinal and femoral hernias, complicated umbilical hernias, fluid, etc. Do not report uncomplicated umbilical hernias or mild diastasis recti.

Abnormalities of the liver, spleen and kidneys are to be recorded under Items 33-35 and should not be included under this item.

Item 33, Liver. For the purpose of this examination, normal liver size is defined as not more than 2 cm. below the costal margin in the right midclavicular line. If liver size is greater or consistency is unusual, record under "Other" and describe.

Item 34, Spleen. For the purpose of this examination, normal spleen size is defined as not more than 1 cm. below the costal margin in the left anterior axillary line. If spleen size is greater or consistency is unusual, record under "Other" and describe.

Item 35, Kidneys. The size and location of a palpable kidney should be described.

Item 36, Genitalia. Evaluate by palpation and inspection. Do not report circumcision. Any questionable abnormality should be reported.

Item 37, Skin. The examination should include evaluation of the color and texture of the skin as well as a search for specific lesions. For the purpose of this examination "Stork-bites", Mongolian spots, and diaper rash are to be considered normal findings and should not be reported. "Storkbites" are defined as those capillary clusters or nonelevated hemangiomas found frequently on the nape of the neck, bridge of the nose or eyelids in infants. If Café au lait spots are prominent or over six in number the number should be reported and the size, shape and depth of pigment described. Rashes, other than uncomplicated ammoniacal dermatitis should be reported. Specify character, location and size of nevi. Sacral ("pilonidal") sinus or dimple should be reported under Item 38 rather than here.

Item 38, Spine. Evaluate the vertebral column and overlying soft tissues by inspection, palpation and manipulation. Abnormalities of cervical vertebrae should be reported here as well as under Item 25 but the detailed description need not be repeated. Sacral ("pilonidal") sinus or dimple should be reported here.

Item 39, Comments. Same as Item 23.

Item 40, Patient Identification. Same as Item 1.

Items 41-47, Musculoskeletal System. Evaluate the structure and functional integrity of this system in each of the six areas listed on the form. This item is not intended to reflect the function of the central nervous system (this is covered elsewhere) but rather is an observation of the anatomy and mobility. Such things as club foot, congenital amputation, absence or atrophy of a muscle and hypermobile joints are to be reported here.

Item 48, State of Consciousness. This represents the examiner's subjective impression of the child's state of consciousness or awareness of the surroundings. Normal sleepiness *per se* should not be recorded here.

Item 49, Affective Response. This represents the examiner's subjective impression of the child's affect. Unusual affect may be characterized by such phrases as unusually placid, hyperirritable, dull, etc.

Items 50-52, Phonation. The child's ability to communicate verbally should be evaluated. "Observed", "Intelligible words" means the examiner heard the child make sounds which have a denotative meaning either to the mother or the examiner. It is not necessary that these be dictionary or English words. Babbling or crying noises are to be considered "unintelligible" sounds, even if they have a connotative meaning.

Item #52 "Reported" is an optional item and no recording or explanation is necessary if it is not completed. It is recommended that, if the examiner does not hear the child say intelligible words during the examination, he ask the mother if the child uses words. Since the mother's concept of words may be somewhat different than the examiner's, the mother should be asked to give examples.

Items 53-55, Locomotor and Postural Development. Observe the child's locomotor ability and report the highest level of development attained according to the self-explanatory categories on the form. Under Item 54, "Observed" report the highest level of performance in the examining situation. Item #55, "Reported" is optional and no recording or explanation is necessary if it is not completed. It is recommended that a history of the child's locomotor development, including creeping, be obtained if the child does not at least walk with support during the examination.

Item 56, Abnormalities of Gait or Posture. This item represents the examiner's evaluation of the quality of the child's posture and locomotor performance. Abnormalities recorded under this item will usually be included in the neurological diagnosis (Item 117) and the description of the abnormality may be written opposite Item 117 rather than writing it twice. If this is done there should be a comment opposite Item 56 such as "see description under Item 117".

Item 57, Prehensile Grasp. Observe the child's grasp of a small object such as a one-inch plastic cube. At least three trials should be made. The most mature pattern should be reported. Many possible distinctions in grasp pattern are grouped for simplicity. Samples of characteristics of the three grasp pattern groups are illustrated.

Grasp using thumb and finger(s), palm free

Grasp with palm

Raking without grasp

Redrawn from Halverson 1931

Item 58, Comments. Same as Item 23.

Item 59, Patient Identification. Same as Item 1.

Item 60, Reaching Coordination. Observe the child's manual skill and coordination in reaching for an object. Dyskinesia (impairment of power of voluntary movement, resulting in fragmentary or incomplete movements) should be distinguished from simple lack of cooperation. The latter should be reported under "Unable to evaluate." Unusual degree of past pointing, tremor, etc., should be reported under "Other."

Item 61, Hand Preference. Observe the child for definite expression of hand preference during the examination. As a rough guide line, consider that more than three-quarters of the reaching and fine motor activity during the examination performed by one hand is an expression of strong preference for that hand. This should be based on observation not on history. History of the child's hand preference and handedness in the family may be reported under "Comments," but should not influence the reporting of this item.

Item 62, Sensation — Extremities and Trunk — Light Touch. This is a screening test for the integrity of cutaneous sensation. Stimulate two to four different places on each extremity and on each side of the trunk and face using a cotton swab or gentle finger stroke.

Item *63, Sensation — Extremities and Trunk — Pin Prick. This is an optional item and no recording or explanation is necessary if it is not completed.

It is recommended that this further test for cutaneous sensation be performed if the previous test or other signs suggest disturbance of the somatic sensory system.

Item 64, Spontaneous Movements of Face. Observe for weakness or asymmetry of the child's facial movements in both the resting and active states. Clearly indicate laterality if there is unilateral or asymmetrical weakness.

Item 65, Palpebral Fissures. Observe the child for asymmetry, excessive widening or unusual narrowing of the palpebral fissures in both the resting and active states. Clearly indicate laterality if there is unilateral or asymmetrical abnormality. "Wide and equal" means normal. Excessively wide, even if symmetrical, should be reported as "Other".

Item 66, Lid Closure. Evaluate the strength and symmetry of lid closure by attempting to raise the upper lids while the child is attempting to maintain closure of the lids.

Item *67, Corneal Reflex. This is an optional item and no recording or explanation is necessary if it is not completed. Lightly touch on the cornea with a wisp of cotton and observe for lid blinking or withdrawal.

Item 68, Follows Light or Object. The integrity of the child's visual perception and acuity sufficient to fixate on and follow a light or object are evaluated. Extraocular motor function abnormality is to be reported in Items 72-76 and should not be reported here.

Item 69, Opticokinetic Nystagmus. A further test of visual perception and acuity is the observation for nystagmus induced by a series of images moving across the visual field. This series of objects may be stripes on a motor-driven drum, numbers and lines on a measuring tape, alternate dark and light stripes on a piece of adhesive tape, letters on a rotating unpainted coffee can, etc. The objects should be centered roughly 3 to 5 degrees apart (2 to 3 inches at 3 feet, 1 to 1½ inches at 18 inches) and must move across the field of vision slowly enough to allow the child to fixate (roughly 15° of arc per second = approximately 1 foot per second tangent to the visual field at 3 feet or 6 inches per second at 18 inches). Many types of apparatus, and a wide range of object size and angular velocity have been used in testing opticokinetic nystagmus in normal and abnormal subjects ranging in age from a few minutes to several decades. The recommendations here for apparatus are liberal, and for size and velocity are about median of those employed in reported studies.

Questionable asymmetrical or absent opticokinetic nystagmus in a child who is not totally uncooperative is probably of sufficient significance to warrant further investigation of the child's visual system.

Item 70, Comments. Same as Item 23.

Item 71, Patient Identification. Same as Item 1.

Item 72, Visual Fields by Confrontation. A screening test for the integrity of the temporal visual field in each eye should be performed. The child's attention should be directed forward by an appropriate stimulus. A light or attractive silent object is advanced carefully from behind the child into the temporal visual field on each side in alternation.

Item 73, Position of Eyes at Rest. Observe for the presence of extra-ocular muscle weakness or imbalance with the child's eyes at rest (distant focus). The presence or absence of asymmetrical weakness or imbalance is determined by observing the relation of the corneal light reflex to the pupil margins on the two sides. The presence or absence of conjugate deviation is determined by observing the relation of the pupils or iris margins to the palpebral fissures.

Items 74-76, Weakness or Paralysis of Individual Eye Movements. Evaluate the child's ability to move the eyes right, left, up and down. Report the presence or absence of weakness or paralysis of movements in any direction in each eye.

Item 77, Spontaneous Nystagmus. Observe for the presence of spontaneous nystagmus with the eyes at rest. Nystagmus evoked by forceful deviation of the eyes to either side should not be reported.

Item 78, Pupils—Shape and Symmetry. Evaluate the size and shape of the pupils at rest. Unusual degree of symmetrical dilation or constriction as well as asymmetry of size or irregular shape of pupils should be noted.

Item 79, Pupils—Reaction to Light—Direct. Evaluate the reflex constriction of the pupil in response to a bright light. Unusually slow response or asymmetrical rate or magnitude of reaction should be reported.

Item *80, Pupils—Reaction to Light—Consensual. This is an optional item and no recording or explanation is necessary if it is not completed. It is recommended that the consensual light reflex be tested if there is any suspicion of abnormality of the visual system.

Item 81, Response to Sound. A screening test for the integrity of the child's auditory system should be performed. It is recommended that the examiner's arms be placed symmetrically on opposite sides of the child's head and a sound stimulus created by one or the other hand in alternation. The recommended stimuli are a cricket or cog-wheel toy for low tones and rustling the fingers together for higher tones.

Item *82, Gag Reflex. This is an optional item and no recording or explanation is necessary if it is not performed. It is recommended that an attempt be made to elicit the gag reflex by stimulation of the pharyngeal wall while examining the mouth and pharynx.

Item 83, Palate Movement. The movement of the soft palate and tonsillar pillar should be noted during the examination of the mouth and pharynx. If asymmetry is noted, it is strongly recommended that the gag reflex be carefully tested and other tests of lower cranial nerve function be performed.

Item 84, Tongue. Evaluate the movements of the tongue, looking particularly for weakness, asymmetry in structure or movement, and fasciculation.

Item 85, Comments. Same as Item 23.

Item 86, Patient Identification. Same as Item 1.

Item 87, Abnormal Involuntary Movements. Total body or localized involuntary movements such as tremor, fasciculation, chorea, athetosis, dystonia, etc., should be reported as such under this item. A clear description of the character and area of involvement is desired.

Items 88-93, Tone. Muscle tone should be evaluated in each of the five areas listed on the form. Express tone as a numerical value using the five-point scale defined on the form. Flaccid paralysis should be coded with hypotonicity (1) and spastic paralysis with hypertonicity (5). If tone is symmetrical, record only in "Bilateral" blank. If asymmetrical in any area, record in both "Right" and "Left" blanks for that area.

Items 94-98, Deep Tendon Reflexes. Evaluate the biceps, triceps, knee and ankle tendon reflexes. It is recommended that the reflexes be tested while the child is sitting on the mother's lap. For the purpose of this examination the magnitude of the response will be graded according to a five-point scale ranging from 0 = absent to 4 = increased with clonus.

For the purpose of this examination each reflex will be considered by itself and will be graded according to the examiner's experience with this reflex in other children. Therefore, although the triceps jerk will usually be much less intense than the knee jerk in a particular child, if the triceps jerk is of the same intensity as the examiner usually observes when doing this test on other children, it should be coded 2 = "Normal" rather than 1 = "Hypoactive". If a particular reflex is symmetrical, record only in "Bilateral" blank. If a particular reflex is asymmetrical, record in both "Right" and "Left" blanks for that reflex.

Items 99-101, Plantar Response. This reflex is elicited by stroking the lateral or fibular side of the sole of the child's foot. The reflex movements of the toes of the stimulated foot should be noted. If the same response is not obtained on at least 2 out of 3 trials, report as "Variable".

Item *102, Superficial Abdominal Reflex. This is an optional item and no recording or explanation is necessary if it is not completed. It is recommended that this test be performed if there is any suspicion of abnormality of cutaneous sensation or spinal cord disease.

Item *103, Tonic Neck Reflex. This is an optional item and no recording or explanation is necessary if it is not completed.

Item *104, Moro Reflex. This is an optional item and no recording or explanation is necessary if it is not completed.

Item 105, Comments. Same as item 23.

Item 106, Patient Identification. Same as Item 1.

Item 107, Palmar Grasp Reflex. Test for the presence of an obligatory palmar grasp reflex by stroking the ulnar side of the palm of the child's hand. If a definite grasp reflex is obtained on at least 2 out of 3 trials on both sides, report as "Reflex Present and Symmetrical". If a definite grasp reflex is obtained at least 2 out of 3 times on one side but not on the other, report as "Other" as describe the asymmetry.

Items 108-110, Sweating. This is a screening observation for the integrity of the autonomic nervous system function. Total absence or asymmetry should be detectable during the examination. A history of sweating (Item *110–Reported) is optional and no recording or explanation is necessary if it is not completed. It is recommended that abnormalities suspected on the basis of this examination be further investigated by history.

Items 111-113, Urinary Stream. Another screening observation for the integrity of the autonomic nervous system is the observation of the urinary stream. Dribbling or very frequent voiding of small amounts may be observed during the examination. The history of bladder function (Item *113–Reported) is optional and no recording or explanation is necessary if it is not completed. It is recommended that abnormalities suspected on the basis of this examination be further investigated by history.

Item *114, Superficial Anal Reflex. This is an optional item and no recording or explanation is necessary if it is not completed. It is recommended that the superficial anal reflex be tested in those cases that have suspicion of impaired enervation in the lower spinal cord segments.

The reflex is elicited by tactile stimulation of the perianal skin.

Item *115, Rectal Tone. This is an optional item and no recording or explanation is necessary if it is not completed. It is recommended that the rectal tone be evaluated by a digital examination if there is any question of impairment of enervation in the lower spinal cord segments.

Item 116, Other Signs, Reflexes, Tests, Etc. If other neurological examination items or screening tests are performed as an integral part of this examination, they will properly be included in the synthesis of the IMPRESSION, and should be mentioned briefly. If any were performed, check the box "Yes" and list the additional signs or tests included. If none were performed, check the box "No".

Additional tests performed on referral or follow-up, and repeat or additional examination performed after review of the history case record are not to be included in the synthesis of the IMPRESSION, and should not be recorded on this page. Such additional follow-up tests or biased examination results should be reported on a CP-5 sheet and attached to this form as extra information.

Item 117, Neurological Abnormalities. If the examiner considers the child to be completely normal neurologically the first box "None" should be checked.

If, on the basis of his examination, the examiner has reason to feel that the child is not completely normal neurologically, but cannot be classified as a definite clinical syndrome or "Neurologically Abnormal Child," the second box "Neurologically Suspicious..." should be checked.

If the examiner is able to state a definite or provisional diagnosis of a recognized syndrome, or feels the child is definitely neurologically abnormal but doesn't at this time fit into any diagnostic category, the third box "Neurologically Abnormal Child" should be checked.

Descriptions of suspected or definite neurological abnormalities deserve the most careful attention to completeness and specificity.

For the purpose of this examination, report under "Neurological Abnormalities" conditions, which may not in themselves be neurological but are often related to CNS disorders, such as abnormalities of skull size and shape, spinal anomalies, hemangiomas on the face and head, positional deformities of the feet and unusual facies.

Item 118, Non-neurological Abnormalities. (Check all that apply.) This item calls for the examiner to summarize and comment on all abnormalities or deviations from the ideal, with a few exceptions. These exceptions are:

(1) Neurological abnormalities noted and described in Item 117.

(2) Mongolian spots and "stork bites".

(3) Small or uncomplicated umbilical hernias.

(4) Uncomplicated diaper rash or other minor acute skin conditions.

(5) Minor acute upper respiratory infections.

If the examiner considers the child to be completely normal, aside from any of the exceptions listed in the preceding paragraph, the first box "None" should be checked.

The second box "Minor Abnormalities or Deviations" should be checked if there is definitely present any deviation from the ideal state (other than the exclusions listed above) which is considered by the examiner to be of questionable or little significance. Examples of conditions in this category are:

(1) Pigmented nevi.

(2) Supernumerary digits.

(3) Undescended testes or hydrocele.

If there is a suggestion of an abnormality which cannot be definitely ruled in or out by the physical examination and, which the examiner feels may be of significance to the child's health if present, the third category "Questionable Abnormalities" should be checked. Examples of situations which should be classified in this category are:

(1) Suspicion of congenital heart disease.

(2) Suspicion of malabsorption syndrome.

If there is definitely present an abnormality which the examiner feels is of major importance to the child's health, the third category "Definite Major Abnormalities" should be checked. This should include conditions which the examiner can state only as provisional diagnoses, provided he is reasonably confident that his impression will be corroborated by further studies or subsequent examinations.

Item 119, Unsatisfactory Conditions for Examination. This provides the examiner with the opportunity to specify any unsatisfactory conditions which may have existed during the examination such as, unusually irritable child, interfering mother, etc.

Item 120, Disposition. Indicate whether findings on this examination indicate further examinations or tests. If further evaluation has been proposed or scheduled indicate what type.

Item 121, CP-5 Attached. Check whether or not supplemental information accompanies the form. This may include CP-5 sheets reporting follow-up tests, the results of referral or biased examinations and medical editors comments. Hopefully, on abnormal cases, this would include a complete diagnosis based on the PED-11 examination, the interval history, the case record, appropriate X-ray and laboratory studies and consultation.

Item 122, Comments. Same as Item 23.

[illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION

1. Patient Identification

[illegible]

2. Examined By	3. Status	4. Do Not Use This Space
5. Time of Examination (24 hr. clock)	6. Date of Examination Mo./Day/Yr.	7. Weight
8. Height	9. Head Circumference	

10. Skin
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)

11. Head – Shape
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)

12. Head – Fontanelles and Sutures
- 0 Closed with normal configuration
- 1 Closed with abnormal configuration (describe)
- 2 Open (name structure or structures and describe size and configuration)

13. Head – External Anomalies – Not Listed Above ([illegible], hemangioma, ... etc.)
- 0 Absent
- 1 Questionable abnormality (describe)
- 2 Present (describe)

14. Transillumination
- 0 Absent
- 1 Questionable abnormality (describe)
- 2 Present (describe)
- 9 Not done (explain)

15. Identify comments by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

16. Patient Identification

17. Neck
- ☐ Normal (0)
- ☐ Questionable abnormality (describe) (1)
- ☐ Abnormal (If abnormal, check condition or conditions in item No. 18; describe fully) (2)

18.
- ☐ Stiffness — flexion and extension only (1)
- ☐ Stiffness — all movements (2)
- ☐ Abnormally short or long (3)
- ☐ Pterygium colli (4)
- ☐ Torticollis (5)
- ☐ Other (describe) (6)

19. ENT
- ☐ Normal (0)
- ☐ Questionable abnormality (describe) (1)
- ☐ Abnormal (describe) (2)

20. Chest
- ☐ Normal (0)
- ☐ Questionable abnormality (describe) (1)
- ☐ Abnormal (describe) (2)

21. Lungs
- ☐ Normal (0)
- ☐ Questionable abnormality (describe) (1)
- ☐ Abnormal (describe) (2)

22. Heart
- ☐ Normal (0)
- ☐ Questionable Abnormality (describe) (1)
- ☐ Abnormal (describe) (2)

23. Abdomen
- ☐ Normal (0)
- ☐ Questionable Abnormality (describe) (1)
- ☐ Abnormal (describe) (2)

24. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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ONE-YEAR NEUROLOGICAL EXAMINATION (Continued)

25. Patient identification

superseded by
[illegible]-3301-11
rev. 5-61

26. Liver (If palpable give size in cms below CM)
- ☐ 0 Palpable-normal (state size)
- ☐ 1 Not Palpable
- ☐ 2 Palpable-questionable abnormality (describe)
- ☐ 3 Palpable-abnormal (describe and state size)

27. Spleen (If palpable give size in cms below CM)
- ☐ 0 Palpable-normal (state size)
- ☐ 1 Not Palpable
- ☐ 2 Palpable-questionable abnormality (describe)
- ☐ 3 Palpable-abnormal (describe and state size)

28. Anogenital Region
- ☐ 0 Normal
- ☐ 1 Questionable abnormality (describe)
- ☐ 2 Abnormal (describe)

29. Back
- ☐ 0 Normal
- ☐ 1 Questionable abnormality (describe)
- ☐ 2 Abnormal (If abnormal, check condition or conditions in item No. 30, and describe fully giving location and character)

30.
- ☐ 1 Meningomyelocele or [illegible]
- ☐ 2 Abnormal length — short or long
- ☐ 3 Abnormal configuration — kyphosis, scoliosis, increased lordosis, etc.
- ☐ 4 Sacral sinus
- ☐ 5 Gibbus
- ☐ 6 Restricted movement
- ☐ 9 Other (describe)

31. Peripheral Pulses (radial, femoral, carotid)
- ☐ 0 Strong and symmetrical in all areas
- ☐ 1 Questionably diminished or asymmetrical (describe)
- ☐ 2 Diminished or asymmetrical (describe)

32. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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[illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION (Continued)

33. Patient identification

superseded by CDC R-3004-1 Nov-5-61

34. Extremities

- [ ] Normal
- [ ] Questionable abnormality (describe)
- [ ] Abnormal (if abnormal, check condition or conditions in item No. 35; describe fully giving location and character)

35.
- [ ] Absence or incomplete development
- [ ] Asymmetry
- [ ] Congenital malformation
- [ ] Acquired deformity
- [ ] Contracture
- [ ] Dislocating or hypermobile joints
- [ ] Other

36. Motor System

- [ ] Normal
- [ ] Questionable abnormality (describe)
- [ ] Abnormal (if abnormal, describe conditions in item No. 37, giving full description, location, and character)

37.
- [ ] Absence of major muscle or muscle groups
- [ ] Underdevelopment of major muscle or muscle groups
- [ ] Hypertrophy of major muscle or muscle groups
- [ ] Atrophy, local, of major muscle or muscle groups
- [ ] Weakness of major muscle or muscle groups
- [ ] Dystonia
- [ ] Choreo-athetosis
- [ ] Tremor
- [ ] Rigidity
- [ ] Spasticity
- [ ] Flaccidity
- [ ] Other

38. State of Consciousness

- [ ] Alert and responding to appropriate stimuli
- [ ] Other (describe)

39. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not conducting any item.

[illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

40. Patient Identification

[illegible]

41. Affective Response
- 0 Normal
  - 1 Questionable abnormality *(describe)*
  - 2 Abnormal *(describe)*

42. Phonation *(check highest level of development; check only one)*
- 1 Intelligible words heard by examiner
- 2 Unintelligible sounds other than crying heard by examiner
- 3 Crying only
- 4 No sounds heard, but examiner believes sounds or words possible *(explain)* – e.g. unfavorable examination situation, etc.
- [illegible] No sounds heard
- 8 Other sounds heard
- 9 Other *(describe)*

43. Posture and Body Attitude
- 0 Normal
  - 1 Questionable abnormality *(describe)*
  - 2 Abnormal *(describe)*

44. Sitting *(check highest level of development; check only one)*
- 0 Assumes without aid or support a normal sitting position
  - 1 Sits without support when placed in sitting position
  - 2 Sits with support
  - 3 Unable to sit
  - 9 Other *(describe)*

45. Creeping *(check highest level of development; check only one)*
- 0 Creeps uniformly
  - 1 Creeps but with abnormal manner *(describe)*
  - 2 Does not creep *(state apparent reason if known)*
  - 9 Other *(describe)*

46. Identify remarks by number of item. Every abnormality which is checked ✓ should have some description. Give reason for not evaluating any item.

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[illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

47. Patient identification

[illegible handwritten annotation]

48. Standing (check highest level of development; check only one)

- ☐ 0 Stands alone
- ☐ 1 Pulls to stand using support
- ☐ 2 Stands holding to support when placed in standing position
- ☐ 3 Stands only with support from other person
- ☐ 4 Unable to stand
- ☐ 9 Other (describe)

49. Walking (check highest level of development; check only one)

- ☐ 0 Walks alone
- ☐ 1 "Cruising" about room holding to furniture
- ☐ 2 Walks when led
- ☐ 3 Makes movements of progression when fully supported
- ☐ 4 Unable to walk
- ☐ 5 Abnormality of gait (describe)
- ☐ 9 Other (describe)

50. Hand Preference

- ☐ 1 Right
- ☐ 2 Left
- ☐ 3 None
- ☐ 9 Other (describe)

51. Attempts Pick-up of Object (check highest level of development; check only one)

- ☐ 0 Opposes thumb and forefinger
- ☐ 1 Whole hand
- ☐ 2 Unable to attempt (give reasons if apparent)
- ☐ 3 Will not attempt (give reasons if apparent)
- ☐ 9 Other (describe)

52. Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reason for not evaluating any item.

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ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

33. Pattern Identification

[illegible]

34. Ring Response (check highest level of development; check only one)
- [ ] Dangles ring by string
- [ ] Pulls string adaptively to secure ring
- [ ] Secures ring by incidentally pulling string
- [ ] Attempts to secure ring unsuccessful
- [ ] No attempt to secure ring
- [ ] Other (describe)
- [ ] Child uncooperative — unsuccessful test

35. Cube Response (check highest level of development; check only one)
- [ ] Builds tower of cubes
- [ ] Puts 2 or more cubes in cup
- [ ] Unmasks cube
- [ ] Puts one cube in cup
- [ ] Attempts to secure 3rd cube
- [ ] None of above
- [ ] Uncooperative — unsuccessful test

36. Sensation – Touch (check all that apply)
- [ ] Normal in all areas
  - [ ] Questionable abnormality
  - [ ] Diminished (describe and list areas - drawing preferred)
  - [ ] Absent (describe and list all areas - drawing preferred)

37. Sensation – Pin Prick (check all that apply)
- [ ] Normal in all areas
  - [ ] Diminished (describe and list areas - drawing preferred)
  - [ ] Absent (des...   and list areas - drawing preferred)

38. Response to Light
- [ ] Follows
  - [ ] Closes eyes (blinks)
  - [ ] None
  - [ ] Other (describe)

39. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Also reason for not evaluating any item.

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

60. Patient Identification

superseded by COL R-30[illegible] Apr. 5-61

61. Visual Fields (by presenting objects or threatening movements)

- [ ] 0 Probably normal bilaterally
- [ ] 1 Questionable defect (describe)
- [ ] 2 Abnormal (describe and locate as specifically as possible)

62. Pupils – Shape

- [ ] 0 Round, regular and equal bilaterally
- [ ] 8 Other (describe or draw)

63. Pupils – Reaction to Light (direct)

- [ ] 0 Normal bilaterally
- [ ] 1 Questionable abnormality (describe)
- [ ] 2 Absent bilaterally
- [ ] 3 Asymmetrical (describe)

64. Pupils – Reaction to Light (consensual)

- [ ] 0 Present bilaterally
- [ ] 1 Questionable abnormality (describe)
- [ ] 2 Absent bilaterally
- [ ] 3 Asymmetrical (describe)

In each of the following eye items, check first "normal bilaterally" or "other". If "normal bilaterally" is checked, no other recording is to be made. If "other" is checked, a recording must be made in the appropriate box below under each eye.

65. Eye – Cornea

- [ ] 00 Normal bilaterally
- [ ] Other (indicate below)

66. Right	67. Left
[ ] 0 Normal	[ ] 0 Normal
[ ] 1 Questionable abnormality (describe)	[ ] 1 Questionable abnormality (describe)
[ ] 2 Abnormal (describe)	[ ] 2 Abnormal (describe)
[ ] 9 Not done (state reason)	[ ] 9 Not done (state reason)

68. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

69. Patient Identification

70. Eye – Anterior Chamber
- 00 Normal bilaterally
- Other (indicate below)

71. Right
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

72. Left
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

73. Eye – Iris
- 00 Normal bilaterally
- Other (indicate below)

74. Right
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

75. Left
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

76. Eye – Lens
- 00 Normal bilaterally
- Other (indicate below)

77. Right
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

78. Left
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

79. Eye – Vitreous
- 00 Normal bilaterally
- Other (indicate below)

80. Right
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

81. Left
- 0 Normal
- 1 Questionable abnormality (describe)
- 2 Abnormal (describe)
- 9 Not done (state reason)

82. Identify remarks by number of item. Every abnormality which is checked (2) should have some description. Give reason for not conducting any item.

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ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

83. Patient identification

84. Eye – Optic Disc
- [ ] Normal bilaterally
- [ ] Other (indicate below)

85. Right
- [ ] Normal
- [ ] Questionable abnormality (describe)
- [ ] Abnormal (describe)
- [ ] Not done (state reason)

86. Left
- [ ] Normal
- [ ] Questionable abnormality (describe)
- [ ] Abnormal (describe)
- [ ] Not done (state reason)

87. Eye – Fundus
- [ ] Normal bilaterally
- [ ] Other (indicate below)

88. Right
- [ ] Normal
- [ ] Questionable abnormality (describe)
- [ ] Abnormal (describe)
- [ ] Not done (state reason)

89. Left
- [ ] Normal
- [ ] Questionable abnormality (describe)
- [ ] Abnormal (describe)
- [ ] Not done (state reason)

90. Position of Eyes at Rest

91. Right
- [ ] Central
- [ ] Other (describe)

92. Left
- [ ] Central
- [ ] Other (describe)

93. Concomitant Squint
- [ ] None
- [ ] Inward
- [ ] Outward
- [ ] R.E. up
- [ ] L.E. up
- [ ] Other combinations (describe)

94. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

95. Patient identification

superseded by
[illegible]
[illegible]

96. Weakness or Paralysis of Conjugate Gaze
- 0 None
- 1 To right
- 2 To left
- 3 Upward
- 4 Downward

97. Weakness or Paralysis of Individual Eye Movement (check all that apply)

98. Right
- 0 None
- 1 Right
- 2 Left
- 3 Up
- 4 Down

99. Left
- 0 None
- 1 Right
- 2 Left
- 3 Up
- 4 Down

100. Optokinetic Nystagmus
- 0 Present
- 1 Diminished (describe)
- 2 Absent
- 6 Other (describe)
- 7 Not tested (state reason)

101. Labyrinthine (The child is to be held vertically at arms length by examiner. The examiner then rotates with the child to first his own right and then his own left. In recording this item, the examiner's rotation is relative to the child's rotation. Eye movements are recorded in relation to the child's own right and left.)

	None	Right	Left
102. Right Rotation			
103. During Rotation			
104. Deviation	0	2	3
105. Nystagmus	0	2	3
106. After Rotation			
107. Deviation	1	2	3
108. Nystagmus	1	2	3
109. Left Rotation			
110. During Rotation			
111. Deviation	1	2	3
112. Nystagmus	1	2	3
113. After Rotation			
114. Deviation	1	2	3
115. Nystagmus	1	2	3

116. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

117. Patient Identification

118. Spontaneous Movements of Face
- __ Present and symmetrical (0)
- __ Questionable abnormality (describe) (1)
- __ Absent (2)
- __ Asymmetrical (describe) (3)

119. Palpebral Fissures
- __ Wide and equal (0)
- __ Questionable abnormality (describe) (1)
- __ Abnormally narrowed bilaterally (describe) (2)
- __ Asymmetrical (describe) (3)

120. Lid Closure

121. Right	122. Left
__ Normal (0)	__ Normal (0)
__ Questionable (describe) (1)	__ Questionable (describe) (1)
__ Absent (describe) (2)	__ Absent (describe) (2)

123. Corneal Reflex (optional — mandatory only if associated neuro-ocular abnormalities present)

124. Right	125. Left
__ Present (0)	__ Present (0)
__ Questionable (describe) (1)	__ Questionable (describe) (1)
__ Absent (2)	__ Absent (2)
__ Not Done (9)	__ Not Done (9)

126. Apparent Response to Sound (hearing)
- __ Normal (0)
- __ Questionable (describe) (1)
- __ Abnormal (describe) (2)

127. Swallowing
- __ Present (0)
- __ Absent (1)
- __ Abnormal (describe) (2)
- __ Other (describe) (9)

128. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

129. Patient identification

130. Gag reflex (optional — [illegible])
- Present
  - Diminished (describe)
  - Absent
  - Not done

131. Palate
- Midline
  - Questionable (describe)
  - Other (describe)

132. Voice Quality
- Normal
  - Suspicious (describe)
  - Other (describe)

133. Palpation of Sternocleidomastoid Muscles
Head deviation
- None
- To right
- To left

134. Tongue
- Normal and Protrudes in Midline

Abnormal (check all that apply and describe)
- Deviation to right
- Deviation to left
- Atrophy
- Fasciculations
- Other (describe)

135. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

[illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

136. Patient Identification

137. Deep Tendon Reflexes (evaluate according to the following code)

Code: 0 Absent; 1 Hypoactive; 2 Normal; 3 Increased; 4 Increased with clonus

Right	0	1	2	3	4		Left	0	1	2	3	4
138.						Jaw Jerk	143.					
139.						Biceps Jerk	144.					
140.						Triceps Jerk	145.					
141.						Knee Jerk	146.					
142.						Ankle Jerk	147.					

148. Superficial Reflexes — Present — Absent

149. Abdominal ___ ___

150. Cremasteric ___ ___ ___ Does Not Apply

151. Plantar Response

152. Right
- ___ No movement
- ___ Upward movement of great toe
- ___ Upward movement of great toe and fanning of toes
- ___ Flexion of toes

153. Left
- ___ No movement
- ___ Upward movement of great toe
- ___ Upward movement of great toe and fanning of toes
- ___ Flexion of toes

154. Rooting (check one)

155. Actively seen by examiner
- ___ Present
- ___ Suspicious (describe)
- ___ Present abnormally (describe)
- ___ Absent

156. History
- ___ Present
- ___ Suspicious (describe)
- ___ Present abnormally (describe)
- ___ Absent

157. Sucking

158. Actively seen by examiner
- ___ Present
- ___ Suspicious (describe)
- ___ Present abnormally (describe)
- ___ Absent

159. History
- ___ Present
- ___ Suspicious (describe)
- ___ Present abnormally (describe)
- ___ Absent

160. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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(PED-11) 11-59 PAGE [illegible]

ONE-YEAR NEUROLOGICAL EXAMINATION
(Continued)

161. Patient Identification

162. Urinary Stream

163. Actually seen by examiner

- Good periodic stream
- Other (describe)
- Not evaluated

164. History

- Good periodic stream
- Other (describe)
- Not evaluated

165. Urinary Dribbling

166. Actually seen by examiner

- Absent
- Questionable (describe)
- Present (describe)

167. History

- Absent
- Questionable (describe)
- Present (describe)

168. Superficial Anal Reflex and Rectal Tone (to be done only if history of [illegible] present)

- Normal
- Questionable abnormality
- Abnormal (describe)
- Not evaluated

169. Impression

- Neurologically normal child
- Neurologically suspicious but no definite abnormalities (describe reasons for this statement in detail)
- Neurologically abnormal child (describe fully and give reasons for diagnosis)

170. Associated Non-neurological Abnormalities (check all that apply)

- None
- Minor abnormalities or deviations (describe)
- Questionable abnormalities (describe)
- Definite major abnormalities (describe)

171. Disposition

- Normal – no indication for further neurological exams at this time
- Other (describe)

172. Conditions of Examination

- Normal and satisfactory
- Unsatisfactory (describe)

173. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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Public Health Service

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PED-12 Summary of the first Year of Life After the Duration Summarized on PED-8

Form PED-12 was used to summarize the diagnoses and major events of the first year of life after the period summarized on PED-8, the Newborn Diagnostic Summary. Implemented in June 1963, the form was never revised. Data from PED-12 are recorded on five cards in the master file (Table PED-12.1).

TABLE PED-12.1 Cards and Data Records by Revision for Form PED-12

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-12: Specific Conditions	1412		
		0	49,503
			49,503
PED-12: Additional Conditions >9	2412		
		0	894
			894
PED-12: Additional Conditions >18	3412		
		0	89
			89
PED-12: Additional Conditions >27	4412		
		0	14
			14
PED-12: Additional Conditions >36	5412		
		0	2
			2
	total for form		50,502

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4602.......		1412	1	5	Card number (sequence, form type, form number, revision number)
4603.......		1412	6	14	NINCDS case number
4604.PED-12	6	1412	15	16	Information source
4605.PED-12	9	1412	17	17	Behaviour information (A.16) or: social/environmental information (d), inadequate
4606.PED-12	11	1412	18	18	Neurologic abnormality: summary, number
4607.PED-12	11	1412	19	19	CNS conditions; skeletal conditions: summary, number
4608.PED-12	11	1412	20	20	Musculoskeletal abnormality: summary, number
4609.PED-12	11	1412	21	21	Eye conditions: summary, number
4610.PED-12	11	1412	22	22	Ear conditions: summary, number
4611.PED-12	11	1412	23	23	Mouth conditions; respiratory tract, upper, conditions: summary, number
4612.PED-12	11	1412	24	24	Thoracic conditions: summary, number
4613.PED-12	11	1412	25	25	Respiratory tract, lower, abnormality: summary, number
4614.PED-12	11	1412	26	26	Cardiovascular conditions: summary, number
4615.PED-12	11	1412	27	27	Alimentary tract conditions: summary, number
4616.PED-12	11	1412	28	28	Liver abnormality; bile duct abnormality; spleen abnormality: summary, number
4617.PED-12	11	1412	29	29	Genitourinary conditions: summary, number
4618.PED-12	11	1412	30	30	Neoplastic diseases; tumors: summary, number
4619.PED-12	11	1412	31	31	Hematologic conditions: summary, number
4620.PED-12	11	1412	32	32	Skin; malformations and conditions of: summary, number
4621.PED-12	11	1412	33	33	Syndromes: summary, number
4622.PED-12	11	1412	34	34	Endocrine diseases; metabolic diseases: summary, number
4623.PED-12	11	1412	35	35	Infections; infestations: summary, number
4624.PED-12	11	1412	36	36	Trauma; physical agents; toxicosis: summary, number
4625.PED-12	11	1412	37	37	Homeostasis disturbances: summary, number
4626.PED-12	11	1412	38	38	Medical conditions, other: summary, number
4627.PED-12	11	1412	39	39	Procedures: summary, number
4628.PED-12	11	1412	40	40	Social conditions; environmental conditions, summary, number
4629.......		1412	41	42	Blank
4630.PED-12	1.9	1412	43	46	A-V canal, code: 478
4630.PED-12	C.11	1412	43	46	Abduction (feet) or forefoot, code: 234
4630.PED-12	C.11	1412	43	46	Abduction with contractures: hip, code: 235
4630.PED-12	1.9	1412	43	46	Aberrant; pulmonary artery, right, code: 420
4630.PED-12	C.11	1412	43	46	Abnormal shape and implantation: toes, code: 236
4630.PED-12	A.14.h	1412	43	46	Abnormal: fingers, thumbs or toes, code: 120
4630.PED-12	F.8	1412	43	46	Abnormality: nasal cartilage, bone, including septum, code: 365
4630.PED-12	C.6	1412	43	46	Absence or hypoplasia of: femur, code: 311
4630.PED-12	H.14	1412	43	46	Absence or hypoplasia of: fibula, code: 285
4630.PED-12	C.6	1412	43	46	Absence or hypoplasia of: finger or fingers, code: 305
4630.PED-12	C.6	1412	43	46	Absence or hypoplasia of: foot, code: 306

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4610.PED-12	B.14	1412	41	46	Absence or hypoplasia of: forearm, code: 286
4610.PED-12	C.6	1412	41	46	Absence or hypoplasia of: hand, code: 304
4610.PED-12	B.14	1412	41	46	Absence or hypoplasia of: humerus, code: 287
4610.PED-12	L.8	1412	41	46	Absence or hypoplasia of: kidney, code: 171
4610.PED-12	C.6	1412	41	46	Absence or hypoplasia of: lower extremity, code: 308
4610.PED-12	C.6	1412	41	46	Absence or hypoplasia of: mandible, code: 321
4610.PED-12	C.6	1412	41	46	Absence or hypoplasia of: pectoralis major, code: 301
4610.PED-12	B.14	1412	41	46	Absence or hypoplasia of: radius, code: 288
4610.PED-12	B.14	1412	41	46	Absence or hypoplasia of: rib or ribs, code: 290
4610.PED-12	C.6	1412	41	46	Absence or hypoplasia of: ribs or spine, code: 319
4610.PED-12	C.5	1412	41	46	Absence or hypoplasia of: talus, code: 324
4610.PED-12	B.14	1412	41	46	Absence or hypoplasia of: tibia, code: 284
4610.PED-12	C.6	1412	41	46	Absence or hypoplasia of: toe or toes, code: 307
4610.PED-12	B.14	1412	41	46	Absence or hypoplasia of: ulna, code: 289
4610.PED-12	C.6	1412	41	46	Absence or hypoplasia of: upper extremity, code: 309
4610.PED-12	L.5	1412	41	46	Accessory auricle, code: 360
4610.PED-12	P.9	1412	41	46	Achondroplasia, code: 706
4610.PED-12	C.11	1412	41	46	Adduction, contracture, or tightness: hip, code: 237
4610.PED-12	C.11	1412	41	46	Adduction: heel, code: 239
4610.PED-12	J.6	1412	41	46	Adrenal hypoplasia, code: 715
4610.PED-12	V.1	1412	41	46	Adrenogenital syndrome, codes: 689, 690
4610.PED-12	J.1	1412	41	46	Albinism, code: 721
4610.PED-12	J.11	1412	41	46	Alimentary tract conditions, other noninfectious, codes: 519, 520
4610.PED-12	N.5.c(1)	1412	41	46	Anemia, iron deficiency, hemoglobin 5 to 8 gm percent, codes: 635, 636
4610.PED-12	N.5.a(1)	1412	41	46	Anemia, iron deficiency, hemoglobin less than 5 gm percent, codes: 627, 628
4610.PED-12	N.5.b(2)	1412	41	46	Anemia, other, hemoglobin 5 to 8 gm percent, codes: 637, 638
4610.PED-12	N.5.a(2)	1412	41	46	Anemia, other, hemoglobin less than 5 gm percent, codes: 629, 630
4610.PED-12	V.6	1412	41	46	Anesthesia, general, codes: 951, 952
4610.PED-12	D.6	1412	41	46	Aniridia, code: 361
4610.PED-12	D.6	1412	41	46	Anisocoria, code: 343
4610.PED-12	I.9	1412	41	46	Aortic dextroposition, code: 404
4610.PED-12	I.9	1412	41	46	Aortic arch, double, code: 204
4610.PED-12	I.9	1412	41	46	Aortic arch, right, code: 498
4610.PED-12	I.9	1412	41	46	Aortic stenosis, code: 477
4610.PED-12	C.10	1412	41	46	Aortie valve, bi-valvular, code: 394
4610.PED-12	N.1	1412	41	46	Arthrogryposis multiplex, codes: 315, 316
4610.PED-12	N.1	1412	41	46	Asthma, codes: 431, 432
4610.PED-12	A.4	1412	41	46	Astrocytoma, code: 102
4610.PED-12	H.5	1412	41	46	Ataxia, codes: 021, 022
4610.PED-12	L.8	1412	41	46	Atelectasis, code: 407
4610.PED-12	L.8	1412	41	46	Atonic bladder, code: 169

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Question Summarized on PED-8

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4630.PED-12	I.9	1412	43	46	Atrial septal defect, code: 456
4630.PED-12	E.5	1412	43	46	Auditory canal, external: abnormal, deformed or absent, code: 359
4630.PED-12	P.9	1412	43	46	Battered child-baby, code: 705
4630.PED-12	A.16.m	1412	43	46	Behavior, atypical, other, codes: 195, 196
4630.PED-12	A.16.j	1412	43	46	Behavior, atypical: abnormalities of behavior control, codes: 161, 162
4630.PED-12	A.16.i	1412	43	46	Behavior, atypical: apathy, codes: 179, 180
4630.PED-12	A.16.h(1)	1412	43	46	Behavior, atypical: breath holding with unconciousness, codes: 173, 174
4630.PED-12	A.16.h(2)	1412	43	46	Behavior, atypical: breath holding without unconciousness, codes: 175, 176
4630.PED-12	A.16.d	1412	43	46	Behavior, atypical: disruption of rhythmic patterns, codes: 155, 156
4630.PED-12	A.16.b	1412	43	46	Behavior, atypical: failure to develop appropriate social responses, codes: 151, 152
4630.PED-12	A.16.c	1412	43	46	Behavior, atypical: failure to form rhythmic patterns, codes: 153, 154
4630.PED-12	A.16.l	1412	43	46	Behavior, atypical: hyperactivity to sensory stimuli, codes: 177, 178
4630.PED-12	A.16.a	1412	43	46	Behavior, atypical: maladaptive responses, codes: 149, 150
4630.PED-12	A.16.v	1412	43	46	Behavior, atypical: phobia, codes: 181, 182
4630.PED-12	A.16.i(2)	1412	43	46	Behavior, atypical: pica, other, codes: 185, 186
4630.PED-12	A.16.i(1)	1412	43	46	Behavior, atypical: pica, paint or plaster, codes: 183, 184
4630.PED-12	A.16.e	1412	43	46	Behavior, atypical: regression in behavior, codes: 157, 158
4630.PED-12	A.16.f	1412	43	46	Behavior, atypical: stereotyped behavior, codes: 159, 160
4630.PED-12	K.1	1412	43	46	Biliary atresia, codes: 531, 532
4630.PED-12	K.3	1412	43	46	Biliary cirrhosis, code: 540
4630.PED-12	L.5	1412	43	46	Bladder neck obstruction, code: 565
4630.PED-12	L.5	1412	43	46	Bladder outflow: urethral obstruction, codes: 563, 564
4630.PED-12	V.1	1412	43	46	Blood: transfusions, codes: 941, 942
4630.PED-12	M.1	1412	43	46	Bone cyst, code: 193
4630.PED-12	E.3	1412	43	46	Branchial cleft anomaly, codes: 353, 354
4630.PED-12	G.5	1412	43	46	Breast hypertrophy, code: 423
4630.PED-12	S.2	1412	43	46	Broken: toe, code: 931
4630.PED-12	S.3	1412	43	46	Burns, infant hospitalized, codes: 871, 872
4630.PED-12	O.7	1412	43	46	Cafe au lait spots, codes: 669, 670
4630.PED-12	C.11	1412	43	46	Calcaneous varus, code: 241
4630.PED-12	I.9	1412	43	46	Cardiac arrest, code: 479
4630.PED-12	I.7	1412	43	46	Cardiac decompensation, codes: 469, 470
4630.PED-12	I.6	1412	43	46	Cardiac enlargement, codes: 467, 468
4630.PED-12	I.5	1412	43	46	Cardiac rate disorder, codes: 465, 466
4630.PED-12	I.4	1412	43	46	Cardiac rhythm disorder, codes: 463, 464
4630.PED-12	I.9	1412	43	46	Cardiovascular diagnosis, specific, code: 474

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4630.PED-12	I.1	1412	43	46	Cardiovascular diseases congenital: acyanotic, codes: 457, 458
4630.PED-12	I.4	1412	43	46	Cardiovascular diseases congenital: anomalous origin right subclavian from aortic arch, code: 473
4630.PED-12	I.2	1412	43	46	Cardiovascular diseases congenital: cyanotic, codes: 459, 460
4630.PED-12	I.8	1412	43	46	Cardiovascular diseases: cyanotic episodes, severe, codes: 471, 472
4630.PED-12	I.9	1412	43	46	Cardiovascular diseases and conditions, corrected transposition, code: 485
4630.PED-12	I.10	1412	43	46	Cardiovascular diseases and conditions, other, codes: 483, 484
4630.PED-12	O.3	1412	43	46	Cataract, codes: 333, 334
4630.PED-12	O.3	1412	43	46	Cataracts, acidosis, abnormal renal functions, mental retardation, code: 728
4630.PED-12	C.11	1412	43	46	Cavus deformity feet, talipes cavus, code: 452
4630.PED-12	J.11	1412	43	46	Cecum, duplication, code: 527
4630.PED-12	J.10	1412	43	46	Chalasia, codes: 517, 518
4630.PED-12	K.12.6	1412	43	46	Chickenpox, codes: 815, 816
4630.PED-12	K.12.7	1412	43	46	Childhood diseases, other, codes: 819, 820
4630.PED-12	F.6	1412	43	46	Choanal atresia, code: 396
4630.PED-12	F.8	1412	43	46	Choanal stenosis, code: 397
4630.PED-12	K.3	1412	43	46	Choledochal cyst, code: 541
4630.PED-12	L.3	1412	43	46	Chordee, codes: 555, 556
4630.PED-12	U.1	1412	43	46	Chorioretinitis, codes: 329, 330
4630.PED-12	V.8	1412	43	46	Chromosome studies, codes: 965, 966
4630.PED-12	F.4	1412	43	46	Cleft gum, code: 374
4630.PED-12	F.3	1412	43	46	Cleft lip, code: 372
4630.PED-12	F.1	1412	43	46	Cleft palate, code: 368
4630.PED-12	F.2	1412	43	46	Cleft uvula, code: 370
4630.PED-12	P.9	1412	43	46	Cleidocranial dysostosis, code: 708
4630.PED-12	C.11	1412	43	46	Clinodactyly, code: 233
4630.PED-12	L.4	1412	43	46	Clitoris, enlarged, code: 561
4630.PED-12	B.14	1412	43	46	CNS malformations and related skeletal conditions, other, codes: 279, 280
4630.PED-12	B.14	1412	43	46	CNS malformations and related skeletal conditions: cerebral sinus thrombosis, code: 282
4630.PED-12	B.14	1412	43	46	CNS malformations and related skeletal conditions: platybasia, code: 283
4630.PED-12	B.14	1412	43	46	CNS malformations and related skeletal conditions: skull, bony defect, code: 281
4630.PED-12	N.3	1412	43	46	Coagulation defect, codes: 613, 614
4630.PED-12	I.9	1412	43	46	Coarctation: aorta, code: 480
4630.PED-12	I.9	1412	43	46	Coarctation: pulmonary artery, right, code: 429
4630.PED-12	U.6	1412	43	46	Coloboma, code: 346
4630.PED-12	J.11	1412	43	46	Colostomy, ileostomy, code: 523
4630.PED-12	A.17	1412	43	46	Coma, codes: 205, 206

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4610.PED-12	I.9	1412	41	46	Common ventricle (tri-loculare biatriatum), code: 486
4610.PED-12	C.11	1412	41	46	Congenital adduction: wrists and abnormal thumbs, code: 249
4610.PED-12	C.11	1412	41	46	Congenital ankylosis elbow with dislocation head radius and abnormal hand, code: 247
4610.PED-12	H.14	1412	41	46	Congenital lues, code: 819
4610.PED-12	P.9	1412	41	46	Congenital rubella syndrome, code: 710
4610.PED-12	A.14.h	1412	41	46	Congenital contractures: hamstrings, code: 122
4610.PED-12	A.14.h	1412	41	46	Constrictive bands above: ankle, code: 125
4610.PED-12	A.14.h	1412	41	46	Contractures: toes, finger, fingers, or thumb, code: 124
4610.PED-12	C.11	1412	41	46	Contractures elbows or knees or extremity, code: 717
4610.PED-12	I.9	1412	41	46	Cor biloculare, code: 481
4610.PED-12	D.4	1412	41	46	Corneal opacity, codes: 135, 136
4610.PED-12	A.14.h	1412	41	46	Coxa valga, code: 126
4610.PED-12	A.14.h	1412	41	46	Coxa vara, code: 127
4610.PED-12	P.9	1412	41	46	Cranial facial dysostosis, code: 121
4610.PED-12	A.12.a	1412	41	46	Cranial nerve abnormality, facial, codes: 101, 102
4610.PED-12	A.12.b	1412	41	46	Cranial nerve abnormality, other, codes: 103, 104
4610.PED-12	B.5	1412	41	46	Craniosynostosis, codes: 243, 244
4610.PED-12	J.1	1412	41	46	Cretinism, code: 715
4610.PED-12	P.9	1412	41	46	Crib death, code: 709
4610.PED-12	L.7	1412	41	46	Cystic kidney, codes: 575, 576
4610.PED-12	H.14	1412	41	46	Cytomegalic inclusion disease, code: 840
4610.PED-12	F.2	1412	41	46	Dehydration, requiring parenteral fluid therapy, codes: 903, 904
4610.PED-12	F.7	1412	41	46	Delayed, edentulous, no dentition, retarded eruption, code: 387
4610.PED-12	D.5	1412	41	46	Detached retina, code: 188
4610.PED-12	A.6.c	1412	41	46	Development, delayed mental, codes: 033, 034
4610.PED-12	A.5.a	1412	41	46	Development, delayed motor, codes: 031, 032
4610.PED-12	I.9	1412	41	46	Dextro cardia, situs inversus, levorotation, code: 489
4610.PED-12	J.4	1412	41	46	Diabetes, code: 711
4610.PED-12	[illegible]	1412	41	46	Diaphragm anomaly, codes: 405, 406
4610.PED-12	[illegible]	1412	41	46	Diaphragm, eventration, code: 408
4610.PED-12	[illegible]	1412	41	46	Diaphragmatic hernia, epigastric hiatus, code: 407
4610.PED-12	U.1-4	1412	41	46	Diseases and conditions, other specified, codes: 929, 930
4610.PED-12	B.2	1412	41	46	Dislocated: knee, code: 123
4610.PED-12	F.7	1412	41	46	Drowning, code: 921
4610.PED-12	J.11	1412	41	46	Duodenal atresia, code: 525
4610.PED-12	J.11	1412	41	46	Duodenal bands: congenital, code: 524
4610.PED-12	J.11	1412	41	46	Duodenal ulcer, code: 526
4610.PED-12	A.3	1412	41	46	Dyskinesia, codes: 019, 020
4610.PED-12	E.5	1412	41	46	Ear conditions, other noninfectious, codes: 357, 358
4610.PED-12	E.4	1412	41	46	Ear drum: (tympanic membrane) perforated, codes: 355, 356
4610.PED-12	E.2	1412	41	46	Ear pinna deformed, codes: 351, 352
4610.PED-12	E.1	1412	41	46	Ears low set, codes: 349, [illegible]

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4630.PED-12	O.8	1412	41	46	Eczema, codes: 671, 672
4630.PED-12	V.9	1412	41	46	Electroencephalography (EEG), codes: 967, 968
4630.PED-12	T.1	1412	41	46	Electrolyte imbalance, codes: 905, 906
4630.PED-12	M.2	1412	41	46	Emphysema, codes: 433, 434
4630.PED-12	D.8	1412	41	46	Encephalocele, codes: 257, 258
4630.PED-12	I.9	1412	41	46	Endocardial cushion defect, code: 690
4630.PED-12	J.4	1412	41	46	Endocrine diseases, other; metabolic diseases, other, codes: 329, 710
4630.PED-12	M.1	1412	41	46	Eosinophilic granuloma, code: 590
4630.PED-12	F.6	1412	41	46	Epiglottis malformation: angulated epiglottis, code: 379
4630.PED-12	F.6	1412	41	46	Epiglottis malformation: laryngeal stridor, code: 380
4630.PED-12	F.6	1412	41	46	Epiglottis malformation: laryngomalacia, code: 382
4630.PED-12	F.6	1412	41	46	Epiglottis malformation: larynx malformation, codes: 377, 378
4630.PED-12	G.9	1412	41	46	Epiglottis malformation: tracheomalacia, code: 381
4630.PED-12	L.4	1412	41	46	Epiniocele, code: 165
4630.PED-12	A.1.9	1412	41	46	Epispadias, code: 562
4630.PED-12	J.11	1412	41	46	Equinovarus, code: 414
4630.PED-12	A.10.c(2)	1412	41	46	Esophageal atresia, code: 520
4630.PED-12	A.10.a(1)	1412	41	46	Esotropia, bilateral, codes: 059, 060
4630.PED-12	J.11	1412	41	46	Esotropia, unilateral, codes: 057, 058
4630.PED-12	B.6	1412	41	46	Esophageal varices, code: 530
4630.PED-12	A.10.c(2)	1412	41	46	Exophthalmos, proptosis, code: 207
4630.PED-12	A.10.c(1)	1412	41	46	Exotropia, bilateral, codes: 065, 066
4630.PED-12	E.5	1412	41	46	Exotropia, unilateral, codes: 063, 064
4630.PED-12	A.10.e	1412	41	46	External ear absent-trauma, code: 162
4630.PED-12	C.6	1412	41	46	Extra ocular movement disorders, other, codes: 069, 070
4630.PED-12	C.11	1412	41	46	Extremity or parts absence or hypoplasia of, codes: 301, 302
4630.PED-12	D.6	1412	41	46	Extremity, hypertrophy, code: 657
4630.PED-12	P.8	1412	41	46	Eye conditions, other noninfectious, codes: 339, 340
4630.PED-12	P.9	1412	41	46	Failure to thrive, codes: 699, 700
4630.PED-12	J.2	1412	41	46	Familial dysautonomia, code: 711
4630.PED-12	J.2	1412	41	46	Fibrocystic disease of pancreas: (cystic fibrosis), codes: 719, 720
4630.PED-12	I.3	1412	41	46	Fibroplastosis, codes: 461, 462
4630.PED-12	V.2	1412	41	46	Fluid administration: parenteral, codes: 943, 944
4630.PED-12	S.2	1412	41	46	Fractures: vertebra, code: 932
4630.PED-12	S.2	1412	41	46	Fractures, other, codes: 859, 860
4630.PED-12	S.2	1412	41	46	Fractures: clavicle, code: 864
4630.PED-12	S.2	1412	41	46	Fractures: dislocation: elbow, code: 865
4630.PED-12	S.2	1412	41	46	Fractures: dislocation: hip, code: 866
4630.PED-12	S.2	1412	41	46	Fractures: dislocation: shoulder, code: 867
4630.PED-12	S.2	1412	41	46	Fractures: finger, code: 862
4630.PED-12	S.2	1412	41	46	Fractures: humerus, radius, ulna, arm, code: 861

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-H

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4630.PFD-12	S.2	1412	41	46	Fractures: leg, femur, tibia, fibula, code: 863
4630.PFD-12	S.2	1412	41	46	Fractures: pelvis, code: 868
4630.PFD-12	S.2	1412	41	46	Fractures: rib or ribs, code: 869
4630.PFD-12	S.2	1412	41	46	Fractures: torn cartilage: left elbow, code: 870
4630.PFD-12	U.4	1412	41	46	G-6 - P.D. deficiency (glucose 6 phosphate dehydrogenase), code: 724
4630.PFD-12	U.3	1412	41	46	Galactosemia, code: 726
4630.PFD-12	M.1	1412	41	46	Ganglion, code: 148
4630.PFD-12	J.11	1412	41	46	Gastric perforation, traumatic, code: 545
4630.PFD-12	L.4	1412	41	46	Genitalia, external abnormality, other, codes: 557, 558
4630.PFD-12	L.8	1412	41	46	Genitourinary conditions, other noninfectious, codes: 577, 578
4630.PFD-12	D.6	1412	41	46	Glaucoma, code: 147
4630.PFD-12	M.1	1412	41	46	Glioma brain, code: 600
4630.PFD-12	U.3	1412	41	46	Glycogen storage disease, code: 725
4630.PFD-12	P.2	1412	41	46	Gonadal dysgenesis, codes: 687, 688
4630.PFD-12	N.6	1412	41	46	Granulocytopenia, code: 648
4630.PFD-12	S.1.C	1412	41	46	Head trauma, bloody spinal fluid, codes: 853, 854
4630.PFD-12	S.1.E	1412	41	46	Head trauma, subdural hematoma, codes: 857, 858
4630.PFD-12	S.1.3	1412	41	46	Head trauma, vomiting three times, codes: 855, 856
4630.PFD-12	S.1.A	1412	41	46	Head trauma, with unconsciousness, codes: 849, 850
4630.PFD-12	S.1.D	1412	41	46	Head trauma: fractured skull, codes: 851, 852
4630.PFD-12	A.11	1412	41	46	Hearing impairment, codes: 113, 114
4630.PFD-12	M.1	1412	41	46	Hemangioma beneath periosteum-forehead, code: 597
4630.PFD-12	M.1	1412	41	46	Hemangioma-orbit, code: 598
4630.PFD-12	J.1	1412	41	46	Hemangioma: cavernous, codes: 661, 662
4630.PFD-12	O.1	1412	41	46	Hemangioma: portwine, codes: 657, 658
4630.PFD-12	O.2	1412	41	46	Hemangioma: strawberry, codes: 659, 660
4630.PFD-12	N.6	1412	41	46	Hematologic conditions, other, codes: 645, 646
4630.PFD-12	C.11	1412	41	46	Hemihypertrophy, code: 718
4630.PFD-12	C.6	1412	41	46	Hemimelia, code: 321
4630.PFD-12	C.6	1412	41	46	Hemivertebrae, code: 322
4630.PFD-12	N.1	1412	41	46	Hemoglobinopathy, codes: 601, 602
4630.PFD-12	N.1	1412	41	46	Hemoglobinopathy: A-C, code: 603
4630.PFD-12	N.1	1412	41	46	Hemoglobinopathy: A-S, code: 604
4630.PFD-12	N.1	1412	41	46	Hemoglobinopathy: S-S, code: 606
4630.PFD-12	N.1	1412	41	46	Hemoglobinopathy: sickle cell anemia, code: 607
4630.PFD-12	N.1	1412	41	46	Hemoglobinopathy: sickle cell disease, code: 608
4630.PFD-12	N.1	1412	41	46	Hemoglobinopathy: sickle cell trait or positive prep, code: 618
4630.PFD-12	N.2.D	1412	41	46	Hemolytic disease: acquired, codes: 611, 612
4630.PFD-12	N.2.A	1412	41	46	Hemolytic disease: congenital, codes: 609, 610
4630.PFD-12	N.3	1412	41	46	Hemophilia, code: 615
4630.PFD-12	H.13	1412	41	46	Hemorrhage, intracranial, other, codes: 271, 272
4630.PFD-12	N.4	1412	41	46	Hemorrhage, major, specified site, codes: 619, 620

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Discharge Summarized on PED-8

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4610.PFU-12	H.6	1412	41	46	Henoch Schoenlein purpura, code: 647
4610.PFU-12	J.1	1412	41	46	Hernia, codes: 493, 494
4610.PFU-12	G.1	1412	41	46	Hiatal hernia, code: 409
4610.PFU-12	C.5	1412	41	46	Hip dislocation or dysplasia, congenital, codes: 299, 300
4610.PFU-12	F.7	1412	41	46	Hemeostasis, other disturbances, codes: 919, 920
4610.PFU-12	L.8	1412	41	46	Horseshoe kidney, code: 566
4610.PFU-12	P.7	1412	41	46	Hurler's syndrome, codes: 697, 698
4610.PFU-12	H.1	1412	41	46	Hydranencephaly, codes: 229, 230
4610.PFU-12	H.4	1412	41	46	Hydrocephalus, codes: 231, 232
4610.PFU-12	L.4	1412	41	46	Hydrocolpos, code: 584
4610.PFU-12	L.6	1412	41	46	Hydronephrosis, code: 574
4610.PFU-12	H.5	1412	41	46	Hydrothorax, code: 450
4610.PFU-12	L.6	1412	41	46	Hydroureter, megaloureter, code: 571
4610.PFU-12	L.4	1412	41	46	Hymen, imperforate, code: 588
4610.PFU-12	I.4	1412	41	46	Hyperthermia, 106 F or over, codes: 911, 912
4610.PFU-12	U.4	1412	41	46	Hypocalcemia, code: 734
4610.PFU-12	U.4	1412	41	46	Hypocalcemia-Hyperphosphatemia, code: 732
4610.PFU-12	U.4	1412	41	46	Hypocalcemic tetany, code: 731
4610.PFU-12	N.6	1412	41	46	Hypogammaglobulinemia, code: 649
4610.PFU-12	I.9	1412	41	46	Hypoplastic ventricle, right, code: 427
4610.PFU-12	N.3	1412	41	46	Hypoprothrombinemia, code: 617
4610.PFU-12	L.2	1412	41	46	Hypospadias, code: 554
4610.PFU-12	I.5	1412	41	46	Hypothermia, below 94 F, codes: 913, 914
4610.PFU-12	J.1	1412	41	46	Hypothyroidism, codes: 713, 714
4610.PFU-12	A.2.a	1412	41	46	Hypotonia with deep tendon reflexes, codes: 015, 016
4610.PFU-12	A.2.b	1412	41	46	Hypotonia without deep tendon reflexes, codes: 017, 018
4610.PFU-12	F.6.a	1412	41	46	Hypoxia episode with unconsciousness, codes: 915, 916
4610.PFU-12	F.6.b	1412	41	46	Hypoxia episode without unconsciousness, codes: 917, 918
4610.PFU-12	J.11	1412	41	46	Imperforate anus code: 498
4610.PFU-12	J.3	1412	41	46	Inborn errors of metabolism, codes: 721, 722
4610.PFU-12	P.9	1412	41	46	Infantile cortical hyperostosis (Caffey's disease), code: 706
4610.PFU-12	K.5	1412	41	46	Infection and inflammation: bone and joint, codes: 781, 782
4610.PFU-12	K.1.c	1412	41	46	Infection and inflammation: bronchiolitis, codes: 765, 766
4610.PFU-12	K.2	1412	41	46	Infection and inflammation: CNS, codes: 741, 742
4610.PFU-12	K.2.a	1412	41	46	Infection and inflammation: CNS, other, codes: 749, 750
4610.PFU-12	K.3.b	1412	41	46	Infection and inflammation: croup, severe, codes: 763, 764
4610.PFU-12	K.10	1412	41	46	Infection and inflammation: ear, codes: 803, 804
4610.PFU-12	K.2.c	1412	41	46	Infection and inflammation: encephalitis, codes: 747, 748
4610.PFU-12	K.9	1412	41	46	Infection and inflammation: eye, codes: 801, 802
4610.PFU-12	K.7.a	1412	41	46	Infection and inflammation: gastrointestinal, diarrhea requiring hospitalization, codes: 785, 786
4610.PFU-12	K.7.b	1412	41	46	Infection and inflammation: gastrointestinal, other, codes: 787, 788

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Operation Summarized on PFU-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4610.PFU-12	H.4	1412	41	46	Infection and inflammation: genitourinary tract, codes: 779, 780
4610.PFU-12	H.6	1412	41	46	Infection and inflammation: heart, codes: 783, 784
4610.PFU-12	H.8	1412	41	46	Infection and inflammation: liver, codes: 799, 800
4610.PFU-12	H.2.a	1412	41	46	Infection and inflammation: meningitis, bacterial, codes: 743, 744
4610.PFU-12	H.2.b	1412	41	46	Infection and inflammation: meningitis, nonbacterial, codes: 745, 746
4610.PFU-12	H.3.a	1412	41	46	Infection and inflammation: pneumonia, codes: 761, 762
4610.PFU-12	H.3.b	1412	41	46	Infection and inflammation: respiratory, other, codes: 767, 768
4610.PFU-12	H.1	1412	41	46	Infection and inflammation: septicemia, codes: 739, 740
4610.PFU-12	H.11	1412	41	46	Infection and inflammation: skin, codes: 805, 806
4610.PFU-12	H.13	1412	41	46	Infection, unusually recurrent or chronic, codes: 831, 832
4610.PFU-12	H.14	1412	41	46	Infection/inflammation, other, codes: 837, 838
4610.PFU-12	J.1	1412	41	46	Inguinal hernia, code: 495
4610.PFU-12	J.4	1412	41	46	Intestinal obstruction, codes: 515, 516
4610.PFU-12	F.7	1412	41	46	Intracranial pressure, increased, code: 822
4610.PFU-12	J.3	1412	41	46	Intussusception, codes: 503, 504
4610.PFU-12	D.6	1412	41	46	Iris cysts, medullated nerve fibers, pupillary membrane, code: 107
4610.PFU-12	K.2.b	1412	41	46	Jaundice, acquired after nursery period, codes: 535, 536
4610.PFU-12	K.2.a	1412	41	46	Jaundice, persistent beyond nursery period, codes: 533, 534
4610.PFU-12	M.1	1412	41	46	Juvenile xanthogranuloma, code: 187
4610.PFU-12	L.8	1412	41	46	Kidney, non-functioning upper pole right, ectopic ureter, code: 171
4610.PFU-12	L.6	1412	41	46	Kidney, surgical removal, code: 562
4610.PFU-12	L.6	1412	41	46	Kidney: crossed ectopia, code: 424
4610.PFU-12	P.4	1412	41	46	Klinefelter's syndrome, code: 651
4610.PFU-12	P.9	1412	41	46	Klippel-Feil syndrome, code: 654
4610.PFU-12	L.4	1412	41	46	Labia, fusion or adhesions, code: 571
4610.PFU-12	M.1	1412	41	46	Leukemia, code: 546
4610.PFU-12	M.1	1412	41	46	Lipoma, code: 180
4610.PFU-12	M.1	1412	41	46	Liposarcoma, code: 189
4610.PFU-12	P.4	1412	41	46	Letterer-Siwe disease, code: 655
4610.PFU-12	K.3	1412	41	46	Liver abnormality; bile duct abnormality; spleen abnormality, codes: 537, 538
4610.PFU-12	K.14	1412	41	46	Liver, laceration, code: 848
4610.PFU-12	P.4	1412	41	46	Lowe's syndrome, code: 656
4610.PFU-12	H.4	1412	41	46	Lung anomaly, codes: 417, 418
4610.PFU-12	H.4	1412	41	46	Lung, [illegible] right, code: 439
4610.PFU-12	H.4	1412	41	46	Lung, fusion lobes, code: 440
4610.PFU-12	H.5	1412	41	46	Lung: collapsed lobe, code: 448
4610.PFU-12	H.5	1412	41	46	Lung: herniation, code: 449
4610.PFU-12	J.6	1412	41	46	Lymphangioma, codes: 667, 668
4610.PFU-12	M.1	1412	41	46	Macrocephaly, codes: 225, 226
4610.PFU-12	F.8	1412	41	46	Macroglossia, code: 198

Data Items Referencing Form PFD-12, Summary of 1st Year of Life After Duration Summarized on PFD-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4610.PFD-12	J.4	1412	41	46	Malrotation, codes: 513, 514
4610.PFD-12	P.4	1412	41	46	Marfan's syndrome, codes: 691, 692
4610.PFD-12	H.12.c	1412	41	46	Measles, codes: 811, 812
4610.PFD-12	G.4	1412	41	46	Meatal stenosis, urethral meatus stenosis, code: 581
4610.PFD-12	J.11	1412	41	46	Meckel's diverticulum, code: 199
4610.PFD-12	H.1	1412	41	46	Mediastinal neuroblastoma, code: 190
4610.PFD-12		1412	41	46	Medical conditions, specific, nfs (check age n = 45)
4610.PFD-12	J.5	1412	41	46	Meconium, codes: 507, 539
4610.PFD-12	D.6	1412	41	46	Megalocornea, code: 198
4610.PFD-12	D.9	1412	41	46	Meningomyelocele, meningocele, codes: 259, 260
4610.PFD-12	J.11	1412	41	46	Mesenteric cysts, code: 530
4610.PFD-12	J.4	1412	41	46	Metabolic acidosis cause unknown, code: 718
4610.PFD-12	C.3	1412	41	46	Metatarsus adductus, codes: 295, 296
4610.PFD-12	K.6	1412	41	46	Methemoglobinemia, code: 559
4610.PFD-12	D.2	1412	41	46	Microcephaly, codes: 227, 228
4610.PFD-12	F.5	1412	41	46	Micrognathia, codes: 175, 176
4610.PFD-12	D.5	1412	41	46	Microphthalmia, codes: 177, 178
4610.PFD-12	I.9	1412	41	46	Mitral valve, congenital blood cysts, code: 430
4610.PFD-12	P.1	1412	41	46	Mongolism (Down syndrome), codes: 395, 888
4610.PFD-12	A.7	1412	41	46	Motor activity, depression, codes: 035, 036
4610.PFD-12	A.5	1412	41	46	Motor disorders, atrophic and flaccid monoplegia, code: 025
4610.PFD-12	A.5	1412	41	46	Motor disorders, flaccid paralysis from wrist down, code: 026
4610.PFD-12	A.5	1412	41	46	Motor disorders, other, codes: 021, 024
4610.PFD-12	H.12.d	1412	41	46	Mumps, codes: 811, 814
4610.PFD-12	E.11	1412	41	46	Musculoskeletal abnormality, other noninfectious, codes: 317, 318
4610.PFD-12	H.1	1412	41	46	Myoepithelial hamartoma ileum, code: 594
4610.PFD-12	P.8	1412	41	46	Nail patella syndrome, code: 611
4610.PFD-12	D.6	1412	41	46	Nasolacrimal duct stenosis, code: 185
4610.PFD-12	J.11	1412	41	46	Necrotizing ileus, of colon, code: 601
4610.PFD-12	H.1	1412	41	46	Neoplastic disease, tumors, specified, codes: 588, 589
4610.PFD-12	P.9	1412	41	46	Neurofibromatosis, code: 512
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, other, codes: 215, 216
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, anoxic brain damage, code: 217
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, cerebral thrombosis, code: 222
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, cranium effusion, code: 218
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, episode apnea with cyanosis, code: 219
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, dysgenesis of nervous cord, medulla, horn cells ant., code: 223
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, pseudo-tumor cerebri, code: 221
4610.PFD-12	A.18	1412	41	46	Neurologic abnormality, severe CNS damage, etiology unknown, code: [illegible]
4610.PFD-12	O.4	1412	41	46	Nevus, hairy pigmented, codes: 663, 664
4610.PFD-12	O.5	1412	41	46	Nevus, pigmented, codes: 665, 666

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4610.PED-12	A.11.1	1412	41	46	Nystagmus, bilateral roving or wandering, code: 097
4610.PED-12	A.11.1	1412	41	46	Nystagmus, central, code: 090
4610.PED-12	A.11.b(2)	1412	41	46	Nystagmus, character jerky, codes: 087, 088
4610.PED-12	A.11.b(1)	1412	41	46	Nystagmus, character pendular, codes: 085, 086
4610.PED-12	A.11.c(1)	1412	41	46	Nystagmus, direction horizontal, codes: 089, 090
4610.PED-12	A.11.c(1)	1412	41	46	Nystagmus, direction rotatory, codes: 093, 094
4610.PED-12	A.11.c(2)	1412	41	46	Nystagmus, direction vertical, codes: 091, 092
4610.PED-12	A.11.a(1)	1412	41	46	Nystagmus, involvement bilateral with gaze only, codes: 083, 084
4610.PED-12	A.11.a(1)	1412	41	46	Nystagmus, involvement bilateral, codes: 081, 082
4610.PED-12	A.11.a(2)	1412	41	46	Nystagmus, involvement unilateral with gaze only, codes: 079, 080
4610.PED-12	A.11.a(1)	1412	41	46	Nystagmus, involvement unilateral, codes: 077, 078
4610.PED-12	A.11.4	1412	41	46	Nystagmus, other, codes: 095, 096
4610.PED-12	A.11.1	1412	41	46	Nystagmus, type unspecified, code: 098
4610.PED-12	D.6	1412	41	46	Optic atrophy, code: 190
4610.PED-12	D.9	1412	41	46	Osteogenesis imperfecta, code: 712
4610.PED-12	J.4	1412	41	46	Osteoporosis, code: 738
4610.PED-12	L.8	1412	41	46	Ovary or ovaries, cystic, code: 541
4610.PED-12	L.8	1412	41	46	Ovary, fallopian tube, incarcerated, code: 187
4610.PED-12	J.11	1412	41	46	Pancreas, annular, code: 522
4610.PED-12	J.11	1412	41	46	Pancreas, ectopic jejunal, code: 528
4610.PED-12	J.11	1412	41	46	Pancreatic duct stenosis, code: 530
4610.PED-12	J.11	1412	41	46	Pancreatitis, acute, code: 521
4610.PED-12	A.1.6	1412	41	46	Paresis, hemi, left: cerebral spastic, codes: 001, 002
4610.PED-12	A.1.5	1412	41	46	Paresis, hemi, right: cerebral spastic, codes: 001, 002
4610.PED-12	A.1.1	1412	41	46	Paresis, monoplegia spastic, code: 011
4610.PED-12	A.1.1	1412	41	46	Paresis, other: cerebral spastic, codes: 009, 010
4610.PED-12	A.1.2	1412	41	46	Paresis, paral cerebral spastic, codes: 007, 008
4610.PED-12	A.1.b	1412	41	46	Paresis, tetral cerebral spastic, codes: 005, 006
4610.PED-12	A.1.1	1412	41	46	Paresis, upper extremities spastic, code: 012
4610.PED-12	I.9	1412	41	46	Patent ductus, code: 492
4610.PED-12	?.1	1412	41	46	Pectus excavatum, codes: 417, 418
4610.PED-12	C.4	1412	41	46	Penial-synorlasia, code: 588
4610.PED-12	A.14.a	1412	41	46	Peripheral nerve abnormality, brachial plexus, codes: 115, 116
4610.PED-12	A.14.b	1412	41	46	Peripheral nerve abnormality, foot drop, code: 118
4610.PED-12	A.14.b	1412	41	46	Peripheral nerve abnormality, other, codes: 117, 118
4610.PED-12	H.12.f	1412	41	46	Pertussis: whooping cough, codes: 817, 818
4610.PED-12	C.6	1412	41	46	Phocomelia, code: 320
4610.PED-12	D.5	1412	41	46	Pierre Robin syndrome, codes: 401, 402
4610.PED-12	G.4	1412	41	46	Pigeon breast, codes: 419, 420
4610.PED-12	G.10	1412	41	46	Pilonidal sinus, codes: 261, 262
4610.PED-12	H.4	1412	41	46	Pneumatocele, code: 461
4610.PED-12	H.5	1412	41	46	Pneumomediastinum, code: 452
4610.PED-12	G.3	1412	41	46	Pneumothorax, codes: 415, 416

Data items referencing form [illegible]

DATA ITEM ID	ITEM ID FORM	CARD NUM	COLS	FR	DATA ITEM NAME
4630.PFD-12	C.7	1412	43	46	Polydactyly, code: 313
4630.PFD-12	B.7	1412	43	46	Porencephaly, codes: 255, 256
4630.PFD-12	E.5	1412	43	46	Preauricular skin tag, code: 351
4630.PFD-12	V.10	1412	43	46	Procedures, other, codes: 959, 930
4630.PFD-12	L.4	1412	43	46	Pseudohermaphroditism, code: 587
4630.PFD-12	D.6	1412	43	46	Ptosis, code: 348
4630.PFD-12	I.9	1412	43	46	Pulmonary atresia, code: 263
4630.PFD-12	H.4	1412	43	46	Pulmonary cyst, code: 442
4630.PFD-12	I.9	1412	43	46	Pulmonary drainage, anomalous, code: 476
4630.PFD-12	I.9	1412	43	46	Pulmonary hypertension, code: 491
4630.PFD-12	I.9	1412	43	46	Pulmonary stenosis, code: 487
4630.PFD-12	D.6	1412	43	46	Pupil, fixed dilated, code: 292
4630.PFD-12	J.6	1412	43	46	Pyloric stenosis, codes: 504, 510
4630.PFD-12	P.9	1412	43	46	Rachondactyly, code: 328
4630.PFD-12	J.11	1412	43	46	Rectal fistula, code: 547
4630.PFD-12	J.11	1412	43	46	Rectal prolapse, code: 497
4630.PFD-12	L.4	1412	43	46	Recto-labial fistula, code: 410
4630.PFD-12	L.8	1412	43	46	Recto-vaginal fistula, code: 544
4630.PFD-12	D.6	1412	43	46	Removal of eye, surgical, code: 141
4630.PFD-12	L.8	1412	43	46	Renal vein, bilateral thrombosis, code: 579
4630.PFD-12	L.8	1412	43	46	Renal vein, bilateral; thrombosis, code: 170
4630.PFD-12	T.7	1412	43	46	Respiratory arrest, code: 923
4630.PFD-12	H.5	1412	43	46	Respiratory tract abnormality, lower, other noninfectious, codes: 445, 446
4630.PFD-12	F.8	1412	43	46	Respiratory tract, upper and mouth conditions, other, codes: 393, 394
4630.PFD-12	L.3	1412	43	46	Retention cyst; kidney, code: 168
4630.PFD-12	D.6	1412	43	46	Retinal hemorrhage, code: 290
4630.PFD-12	M.1	1412	43	46	Retinoblastoma, code: 591
4630.PFD-12	D.2	1412	43	46	Retrolental fibroplasia, codes: 331, 332
4630.PFD-12	G.2	1412	43	46	Rib anomaly, codes: 413, 414
4630.PFD-12	G.2	1412	43	46	Rib congenital malformation, number or form, code: 415
4630.PFD-12	G.4	1412	43	46	Rickets, code: 640
4630.PFD-12	K.12.a	1412	43	46	Roseola, codes: 807, 808
4630.PFD-12	K.12.b	1412	43	46	Rubella; German measles, codes: 809, 810
4630.PFD-12	F.8	1412	43	46	Saddle nose, code: 399
4630.PFD-12	G.4	1412	43	46	Salt losing; nephropathy, code: 641
4630.PFD-12	C.11	1412	43	46	Scoliosis, lordosis, kyphosis, code: 326
4630.PFD-12	L.4	1412	43	46	Scrotum, bifid, code: 550
4630.PFD-12	L.4	1412	43	46	Scrotum; hypoplasia, code: 587
4630.PFD-12	A.15.b	1412	43	46	Seizure states, focal motor, total number, codes: 133, 136
4630.PFD-12	A.15.a(1)	1412	43	46	Seizure states, generalized (grand mal) only with fever and less than 15 minute duration, codes: 129, 130

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4630.PED-12	A.15.a(2)	1412	43	46	Seizure states, generalized (grand mal), other, codes: 131, 132
4630.PED-12	A.15.c	1412	43	46	Seizure states, infantile myoclonic, codes: 135, 136
4630.PED-12	A.15.d	1412	43	46	Seizure states, other, codes: 137, 138
4630.PED-12	T.1	1412	43	46	Shock, requiring hospitalization, codes: 901, 902
4630.PED-12	B.11	1412	43	46	Sinuses, midline, other, codes: 263, 264
4630.PED-12	J.11	1412	43	46	Situs inversus-abdomen, code: 546
4630.PED-12	[illegible].9	1412	43	46	Skin conditions and malformations, other noninfectious, codes: 673, 674
4630.PED-12	B.6	1412	43	46	Skull, other abnormal shape, codes: 249, 250
4630.PED-12	W.5	1412	43	46	Social/environmental conditions, other, codes: 989, 990
4630.PED-12	W.3	1412	43	46	Social/environmental conditions: emotional environment, unfavorable, codes: 985, 986
4630.PED-12	W.2	1412	43	46	Social/environmental conditions: foster home, codes: 983, 984
4630.PED-12	W.4	1412	43	46	Social/environmental conditions: hospitalization prolonged or recurrent, codes: 987, 988
4630.PED-12	W.1	1412	43	46	Social/environmental conditions: parents or parent surrogate, loss of one or both, codes: 981, 982
4630.PED-12	P.6	1412	43	46	Spasmus nutans, codes: 695, 696
4630.PED-12	A.8.b	1412	43	46	Spinal cord disease, flaccid, codes: 039, 040
4630.PED-12	A.8.a	1412	43	46	Spinal cord disease, spastic, codes: 037, 038
4630.PED-12	V.3	1412	43	46	Spinal puncture, codes: 945, 946
4630.PED-12	K.3	1412	43	46	Spleen, accessory, code: 539
4630.PED-12	A.10.b	1412	43	46	Strabismus, alternating internal, codes: 061, 062
4630.PED-12	A.10.d	1412	43	46	Strabismus, alternating external, codes: 067, 068
4630.PED-12	A.1.d	1412	43	46	Streeter's dysplasia, code: 013
4630.PED-12	I.9	1412	43	46	Subaortic stenosis, code: 442
4630.PED-12	H.12	1412	43	46	Subdural hematoma or effusion, codes: 269, 270
4630.PED-12	V.4	1412	43	46	Subdural puncture, codes: 947, 948
4630.PED-12	M.1	1412	43	46	Subepidermal fibroma, code: 592
4630.PED-12	S.2	1412	43	46	Subluxation-thumbs, code: 928
4630.PED-12	I.9	1412	43	46	Subtricuspid atresia, code: 165
4630.PED-12	V.7	1412	43	46	Surgery, codes: 953, 954
4630.PED-12	S.4.d	1412	43	46	Symptomatic intoxication, other, codes: 895, 896
4630.PED-12	S.4.d	1412	43	46	Symptomatic intoxication: carbon monoxide, code: 897
4630.PED-12	S.4.b(2)	1412	43	46	Symptomatic intoxication: hydrocarbon, camphor oil, code: 891
4630.PED-12	S.4.b(2)	1412	43	46	Symptomatic intoxication: hydrocarbon, furniture polish, code: 890
4630.PED-12	S.4.b.(1)	1412	43	46	Symptomatic intoxication: hydrocarbon, kerosene, codes: 885, 886
4630.PED-12	S.4.b(2)	1412	43	46	Symptomatic intoxication: hydrocarbon, O'cedar furniture polish, code: 889
4630.PED-12	S.4.b(2)	1412	43	46	Symptomatic intoxication: hydrocarbon, other, codes: 887, 888
4630.PED-12	S.4.c	1412	43	46	Symptomatic intoxication: lead, other, codes: 893, 894
4630.PED-12	S.4.a	1412	43	46	Symptomatic intoxication: salicylate, codes: 883, 884
4630.PED-12	C.8	1412	43	46	Syndactyly, code: 112

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DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4630.PED-12	P.9	1412	43	46	Syndromes, other, codes: 701, 702
4630.PED-12	D.6	1412	43	46	Synechia, code: 367
4630.PED-12	C.11	1412	43	46	Tail, bilateral vertical, code: 239
4630.PED-12	C.4	1412	43	46	Talipes calcaneovalgus, codes: 297, 298
4630.PED-12	C.2	1412	43	46	Talipes equinovarus, codes: 293, 294
4630.PED-12	C.11	1412	43	46	Talipes valgus, code: 881
4630.PED-12	C.11	1412	43	46	Talipes varus, code: 880
4630.PED-12	F.7	1412	43	46	Teeth, abnormal, codes: 385, 386
4630.PED-12	F.7	1412	43	46	Teeth, anomalous shape, malformed, code: 388
4630.PED-12	F.7	1412	43	46	Teeth, extra supernumerary, code: 389
4630.PED-12	F.7	1412	43	46	Teeth, fused, code: 390
4630.PED-12	F.7	1412	43	46	Teeth, hypoplasia of enamel, pitting, code: 391
4630.PED-12	F.7	1412	43	46	Teeth, notched, code: 392
4630.PED-12	L.4	1412	43	46	Testicle, infarction and/or gangrene, code: 572
4630.PED-12	L.1.b	1412	43	46	Testicle, undescended bilateral, codes: 551, 552
4630.PED-12	L.1.a	1412	43	46	Testicle, undescended unilateral, codes: 549, 550
4630.PED-12	L.4	1412	43	46	Testicle: hypoplasia or atrophy, code: 585
4630.PED-12	L.4	1412	43	46	Testicular torsion: epididymus torsion, code: 581
4630.PED-12	L.4	1412	43	46	Testis, constrictive band, right, code: 371
4630.PED-12	I.9	1412	43	46	Tetralogy of Fallot, code: 412
4630.PED-12	G.4	1412	43	46	Thelarche, premature, code: 639
4630.PED-12	G.5	1412	43	46	Thoracic conditions, other, codes: 421, 422
4630.PED-12	N.3	1412	43	46	Thrombocytopenia, code: 516
4630.PED-12	C.11	1412	43	46	Thumb, bilateral claw, code: 245
4630.PED-12	F.8	1412	43	46	Thyroglossal duct cyst, code: 690
4630.PED-12	C.9	1412	43	46	Torticollis, codes: 313, 314
4630.PED-12	K.14	1412	43	46	Toxoplasmosis, code: 861
4630.PED-12	F.8	1412	43	46	Tracheo-esophageal fistulae, code: 401
4630.PED-12	I.9	1412	43	46	Transposition of great vessels, code: 366
4630.PED-12	P.9	1412	43	46	Treacher-Collins syndrome, code: 613
4630.PED-12	I.9	1412	43	46	Tricuspid atresia, code: 426
4630.PED-12	P.9	1412	43	46	Trisomy 18, code: 607
4630.PED-12	M.1	1412	43	46	Tumor replacing right upper dental ridge and adjacent palate, code: 593
4630.PED-12	J.1	1412	43	46	Umbilical hernia, code: 436
4630.PED-12	L.8	1412	43	46	Ureter, double, code: 163
4630.PED-12	L.4	1412	43	46	Urethral meatus, double, code: 567
4630.PED-12	L.8	1412	43	46	Urinary tract obstruction, money: hydronephrosis: hydroureter, codes: 540, 518
4630.PED-12	L.4	1412	43	46	Urogenital sinus, code: 582
4630.PED-12	L.8	1412	43	46	Vagina and uterus, double, code: 164
4630.PED-12	I.9	1412	43	46	Vascular ring, code: 367
4630.PED-12	H.4	1412	43	46	Vena cava: thrombosis inferior, code: 444

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4630.PED-12	I.9	1412	43	46	Ventricular hypertrophy, right, code: 411
4630.PED-12	V.5	1412	43	46	Ventricular puncture, codes: 949, 950
4630.PED-12	I.9	1412	43	46	Ventricular septal defect, code: 475
4630.PED-12	C.1	1412	43	46	Vertebral abnormality, codes: 291, 292
4630.PED-12	J.7	1412	43	46	Visceral perforation, codes: 511, 512
4630.PED-12	A.9.b(1)(N)	1412	43	46	Visual impairment, partial bilateral nonocular, codes: 051, 052
4630.PED-12	A.9.b(1)(A)	1412	43	46	Visual impairment, partial bilateral ocular, codes: 049, 050
4630.PED-12	A.9.b(2)(N)	1412	43	46	Visual impairment, partial unilateral nonocular, codes: 055, 056
4630.PED-12	A.9.b(2)(A)	1412	43	46	Visual impairment, partial unilateral ocular, codes: 053, 054
4630.PED-12	A.9.a(1)(N)	1412	43	46	Visual impairment, total bilateral nonocular, codes: 043, 044
4630.PED-12	A.9.a(1)(A)	1412	43	46	Visual impairment, total bilateral ocular, codes: 041, 042
4630.PED-12	A.9.a(2)(N)	1412	43	46	Visual impairment, total unilateral nonocular, codes: 047, 048
4630.PED-12	A.9.a(2)(A)	1412	43	46	Visual impairment, total unilateral ocular, codes: 045, 046
4630.PED-12	J.2	1412	43	46	Volvulus, codes: 501, 502
4630.PED-12	J.4	1412	43	46	Vomiting, persistent, codes: 505, 506
4630.PED-12	P.4	1412	43	46	Waterhouse-Friderichson syndrome, code: 634
4630.PED-12	C.11	1412	43	46	Webbed neck, code: 882
4630.PED-12	U.6	1412	43	46	Wedge defect-superior palpebra, code: 701
4630.PED-12	P.9	1412	43	46	Werdnig-Hoffmann syndrome, code: 642
4630.PED-12	M.1	1412	43	46	Wilms' tumor, code: 191
4630.PED-12	P.9	1412	43	46	Wolf-Parkinson-White syndrome, code: 703
4631.PED-12		1412	47	78	Medical conditions, specific, repeat of card 4121 col 43-46 for conditions 2 through 9
4632........		1412	79	80	Blank
4633.PED-12		2412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 10 - 18
4634.PED-12		3412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 19 - 27
4635.PED-12		4412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 28 - 36
4636.PED-12		5412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 37 - 45
5089....VAR			184	184	Gonorrhea, culture positive
5090....VAR			185	185	Gonorrhea, smear positive
5639....VAR	II		815	815	PED-12: switch, data availability, any info in variable file locations 816-1090 1=no, 2=yes
5640....VAR	A.1.a		816	816	Paresis, hemi, right: cerebral spastic
5641....VAR	A.1.a		817	817	Paresis, hemi, left: cerebral spastic
5642....VAR	A.1.b		818	818	Paresis, tetra: cerebral spastic
5643....VAR	A.1.c		819	819	Paresis, para: cerebral spastic
5644....VAR	A.1.d		820	820	Paresis, other: cerebral spastic
5645....VAR	A.2.a		821	821	Hypotonia with deep tendon reflexes
5646....VAR	A.2.b		822	822	Hypotonia without deep tendon reflexes

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DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5647....VAR	A.3		823	823	Dyskinesia
5648....VAR	A.4		824	824	Ataxia
5649....VAR	A.5		825	825	Motor disorders, other
5650....VAR	A.6.a		826	826	Developmental, delayed motor
5651....VAR	A.6.b		827	827	Developmental, delayed mental
5652....VAR	A.7		828	828	Motor activity, regression
5653....VAR	A.8.a		829	829	Spinal cord disease, spastic
5654....VAR	A.8.b		830	830	Spinal cord disease, flaccid
5655....VAR	A.9.a(1)(A)		831	831	Visual impairment, total bilateral ocular
5656....VAR	A.9.a(1)(B)		832	832	Visual impairment, total bilateral nonocular
5657....VAR	A.9.a(2)(A)		833	833	Visual impairment, total unilateral ocular
5658....VAR	A.9.a(2)(B)		834	834	Visual impairment, total unilateral nonocular
5659....VAR	A.9.b(1)(A)		835	835	Visual impairment, partial bilateral ocular
5660....VAR	A.9.b(1)(B)		836	836	Visual impairment, partial bilateral nonocular
5661....VAR	A.9.b(2)(A)		837	837	Visual impairment, partial unilateral ocular
5662....VAR	A.9.b(2)(B)		838	838	Visual impairment, partial unilateral nonocular
5663....VAR	A.10.a(1)		839	839	Esotropia, unilateral
5664....VAR	A.10.a(2)		840	840	Esotropia, bilateral
5665....VAR	A.10.b		841	841	Strabismus, alternating internal
5666....VAR	A.10.c(1)		842	842	Exotropia, unilateral
5667....VAR	A.10.c(2)		843	843	Exotropia, bilateral
5668....VAR	A.10.d		844	844	Strabismus, alternating external
5669....VAR	A.10.e		845	845	Extra ocular movement disorders, other
5670....VAR	A.11.a(1)		846	846	Nystagmus, involvement unilateral
5671....VAR	A.11.a(2)		847	847	Nystagmus, involvement unilateral with gaze only
5672....VAR	A.11.b(1)		848	848	Nystagmus, involvement bilateral
5673....VAR	A.11.b(2)		849	849	Nystagmus, involvement bilateral with gaze only
5674....VAR	A.11.b(1)		850	850	Nystagmus, character pendular
5675....VAR	A.11.b(2)		851	851	Nystagmus, character jerky
5676....VAR	A.11.c(1)		852	852	Nystagmus, direction horizontal
5677....VAR	A.11.c(2)		853	853	Nystagmus, direction vertical
5678....VAR	A.11.c(3)		854	854	Nystagmus, direction rotatory
5679....VAR	A.11.d		855	855	Nystagmus, other
5680....VAR	A.12.a		856	856	Cranial: nerve abnormality, facial
5681....VAR	A.12.b		857	857	Cranial: nerve abnormality, other
5682....VAR	A.13		858	858	Hearing impairment
5683....VAR	A.14.a		859	859	Peripheral: nerve abnormality, brachial plexus
5684....VAR	A.14.b		860	860	Peripheral: nerve abnormality, other
5685....VAR	A.15.a(1)		861	861	Seizure states, generalized (grand mal) only with fever and less than 15 minute duration
5686....VAR	A.15.a(2)		862	862	Seizure states, generalized (grand mal), other
5687....VAR	A.15.b		863	863	Seizure states, focal motor, total number
5688....VAR	A.15.c		864	864	Seizure states, infantile myoclonic

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DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5689....VAR	A.15.4		865	865	Seizure states, other
5690....VAR	A.16.a		866	866	Behavior disorder, maladaptive responses
5691....VAR	A.16.b		867	867	Behavior, atypical: maladaptive responses, failure to develop appropriate social responses
5692....VAR			868	868	Behavior, atypical: maladaptive responses, failure to form rhythmic patterns
5693....VAR	A.16.d		869	869	Behavior, atypical: maladaptive responses, disruption of rhythmic patterns
5694....VAR	A.16.e		870	870	Behavior, atypical: maladaptive responses, regression in behavior
5695....VAR	A.16.f		871	871	Behavior, atypical: maladaptive responses, stereotyped behavior
5696....VAR	A.16.g		872	872	Behavior, atypical: maladaptive responses, abnormalities of behavior control
5697....VAR	A.16.h(1)		873	873	Behavior, atypical: maladaptive responses, breath holding with unconciousness
5698....VAR	A.16.h(2)		874	874	Behavior, atypical: maladaptive responses, breath holding without unconciousness
5699....VAR	A.16.i		875	875	Behavior, atypical: maladaptive responses, hyperactivity to sensory stimuli
5700....VAR	A.16.j		876	876	Behavior, atypical: maladaptive responses, apathy
5701....VAR	A.16.k		877	877	Behavior, atypical: maladaptive responses, phobia
5702....VAR	A.16.l(1)		878	878	Behavior, atypical: maladaptive responses, pica, painter plaster
5703....VAR	A.16.l(2)		879	879	Behavior, atypical: maladaptive responses, pica, other
5704....VAR	A.16.m		880	880	Behavior, atypical: maladaptive responses, other
5705....VAR	A.17		881	881	Coma
5706....VAR	A.18		882	882	Neurologic abnormality, other
5707....VAR	B.1		883	883	Macrocephaly
5708....VAR	B.2		884	884	Microcephaly
5709....VAR	B.3		885	885	Hydranencephaly
5710....VAR	B.4		886	886	Hydrocephaly
5711....VAR	B.5		887	887	Craniosynostosis
5712....VAR	B.6		888	888	Skull, other abnormal shape
5713....VAR	B.7		889	889	Porencephaly
5714....VAR	B.8		890	890	Encephlocele
5715....VAR	B.9		891	891	Meningomyeloceles: meningocele
5716....VAR	B.10		892	892	Pilonidal sinus
5717....VAR	B.11		893	893	Sinuses, midline, other
5718....VAR	B.12		894	894	Subdural hematoma or effusion
5719....VAR	B.13		895	895	Hemorrhage, intracranial, other
5720....VAR	B.14		896	896	CNS malformations and related skeletal conditions, other
5721....VAR	C.1		897	897	Vertebral abnormality
5722....VAR	C.2		898	898	Talipes equinovarus
5723....VAR	C.3		899	899	Metatarus adductus
5724....VAR	C.4		900	900	Talipes calcaneovalgus

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DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5725....VAR	C.5		901	901	Hip dislocation or dysplasia, congenital
5726....VAR	C.6		902	902	Extremity: hypoplasia or absence
5727....VAR	C.7		903	903	Polydactyly
5728....VAR	C.8		904	904	Syndactyly
5729....VAR	C.9		905	905	Torticollis
5730....VAR	C.10		906	906	Arthrogryposis multiplex
5731....VAR	C.11		907	907	Musculoskeletal abnormality, other noninfectious
5732....VAR	D.1		908	908	Chorioretinitis
5733....VAR	D.2		909	909	Retrolental fibroplasia
5734....VAR	D.3		910	910	Cataract
5735....VAR	D.4		911	911	Corneal opacity
5736....VAR	D.5		912	912	Microphthalmia
5737....VAR	D.6		913	913	Eye conditions, other noninfectious
5738....VAR	E.1		914	914	Ears low set
5739....VAR	E.2		915	915	Ear pinna deformed
5740....VAR	E.3		916	916	Branchial cleft anomaly
5741....VAR	E.4		917	917	Ear drum: (tympanic membrane) perforated
5742....VAR	E.5		918	918	Ear conditions, other noninfectious
5743....VAR	F.1		919	919	Cleft palate
5744....VAR	F.2		920	920	Cleft uvula
5745....VAR	F.3		921	921	Cleft lip
5746....VAR	F.4		922	922	Cleft gum
5747....VAR	F.5		923	923	Micrognathia
5748....VAR	F.6		924	924	Epiglottis malformation; larynx malformation
5749....VAR	F.7		925	925	Teeth, abnormal
5750....VAR	F.8		926	926	Respiratory tract, upper: mouth conditions, other
5751....VAR	G.1		927	927	Diaphragm anomaly
5752....VAR	G.2		928	928	Rib anomaly
5753....VAR	G.3		929	929	Pectus excavatum
5754....VAR	G.4		930	930	Pigeon breast
5755....VAR	G.5		931	931	Thoracic conditions, other
5756....VAR	H.1		932	932	Asthma
5757....VAR	H.2		933	933	Emphysema
5758....VAR	H.3		934	934	Pneumothorax
5759....VAR	H.4		935	935	Lung anomaly
5760....VAR	H.5		936	936	Respiratory tract abnormality, lower, other noninfectious
5761....VAR	I.1		937	937	Cardiovascular disease: congenital: acyanotic
5762....VAR	I.2		938	938	Cardiovascular disease: congenital: cyanotic
5763....VAR	I.3		939	939	Fibroelastosis
5764....VAR	I.4		940	940	Cardiac rhythm disorder
5765....VAR	I.5		941	941	Cardiac rate disorder
5766....VAR	I.6		942	942	Cardiac enlargement
5767....VAR	I.7		943	943	Cardiac decompensation

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5768....VAR	I.8		944	944	Cardiovascular disease: cyanotic episodes, severe
5769....VAR	I.9		945	945	Cardiovascular diagnosis, specific
5770....VAR	I.10		946	946	Cardiovascular diseases and conditions, other
5771....VAR	J.1		947	947	Hernia
5772....VAR	J.2		948	948	Volvulus
5773....VAR	J.3		949	949	Intussusception
5774....VAR	J.4		950	950	Vomiting, persistent
5775....VAR	J.5		951	951	Megacolon
5776....VAR	J.6		952	952	Pyloric stenosis
5777....VAR	J.7		953	953	Visceral perforation
5778....VAR	J.8		954	954	Malrotation
5779....VAR	J.9		955	955	Intestinal obstruction
5780....VAR	J.10		956	956	Chalasia
5781....VAR	J.11		957	957	Alimentary tract conditions, other noninfectious
5782....VAR	K.1		958	958	Biliary atresia
5783....VAR	K.2.a		959	959	Jaundice acquired, persistent beyond nursery period
5784....VAR	K.2.b		960	960	Jaundice acquired after nursery period
5785....VAR	K.3		961	961	Liver abnormality; bile duct abnormality; spleen abnormality
5786....VAR	L.1.a		962	962	Testicle, undescended unilateral
5787....VAR	L.1.b		963	963	Testicle, undescended bilateral
5788....VAR	L.2		964	964	Hypospadias
5789....VAR	L.3		965	965	Chordee
5790....VAR	L.4		966	966	Genitalia, external abnormality, other
5791....VAR	L.5		967	967	Bladder outflow; urethral obstruction
5792....VAR	L.6		968	968	Urinary tract: obstruction, upper; hydronephrosis; hydroureter
5793....VAR	L.7		969	969	Cystic kidney
5794....VAR	L.8		970	970	Genitourinary conditions, other noninfectious
5795....VAR	M.1		971	971	Neoplastic disease: tumors, specified
5796....VAR	N.1		972	972	Hemoglobinopathy
5797....VAR	N.2.a		973	973	Hemolytic disease, congenital
5798....VAR	N.2.b		974	974	Hemolytic disease, acquired
5799....VAR	N.3		975	975	Coagulation defect
5800....VAR	N.4		976	976	Hemorrhage, major, specified site
5801....VAR	N.5.a(1)		977	977	Anemia, iron deficiency, hemoglobin less than 5 gm percent
5802....VAR	N.5.a(2)		978	978	Anemia, other, hemoglobin less than 5 gm percent
5803....VAR	N.5.b(1)		979	979	Anemia, iron deficiency, hemoglobin 5 up to 8 gm percent
5804....VAR	N.5.b(2)		980	980	Anemia, other, hemoglobin 5 up to 8 gm percent
5805....VAR	N.6		981	981	Hematologic conditions, other
5806....VAR	O.1		982	982	Hemangioma: portwine
5807....VAR	O.2		983	983	Hemangioma: strawberry
5808....VAR	O.3		984	984	Hemangioma: cavernous
5809....VAR	O.4		985	985	Nevus, hairy pigmented
5810....VAR	O.5		986	986	Nevus, pigmented

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5H11....VAR	J.6		987	987	Lymphangioma
5H12....VAR	J.7		988	988	Cafe au lait spots
5H13....VAR	O.8		989	989	Eczema
5H14....VAR	O.9		990	990	Skin conditions and malformations, other noninfectious
5H15....VAR	P.1		991	991	Mongolism: (Down syndrome)
5H16....VAR	P.2		992	992	Gonadal dysgenesis
5H17....VAR	P.3		993	993	Adrenogenital syndrome
5H18....VAR	P.4		994	994	Marfan syndrome
5H19....VAR	P.5		995	995	Pierre Robin syndrome
5H20....VAR	P.6		996	996	Spasmus nutans
5H21....VAR	P.7		997	997	Hurler syndrome
5H22....VAR	J		998	998	Failure to thrive
5H23....VAR	P.9		999	999	Syndromes, other
5H24....VAR	J.1		1000	1000	Hypothyroidism
5H25....VAR	J.2		1001	1001	Fibrocystic disease of pancreas: (cystic fibrosis)
5H26....VAR	J.3		1002	1002	Inborn errors of metabolism
5H27....VAR	J.4		1003	1003	Endocrine diseases, other: metabolic diseases, other
5H28....VAR	K.1		1004	1004	Infection and inflammation: septicemia
5H29....VAR	K.2		1005	1005	Infection and inflammation: CNS
5H30....VAR	K.2.a		1006	1006	Infection and inflammation: meningitis, bacterial
5H31....VAR	K.2.b		1007	1007	Infection and inflammation: meningitis, nonbacterial
5H32....VAR	K.2.c		1008	1008	Infection and inflammation: encephalitis
5H33....VAR	K.2.d		1009	1009	Infection and inflammation: CNS, other
5H34....VAR	K.3.a		1010	1010	Infection and inflammation: pneumonia
5H35....VAR	K.3.b		1011	1011	Infection and inflammation: croup, severe
5H36....VAR	K.3.c		1012	1012	Infection and inflammation: bronchiolitis
5H37....VAR	K.3.d		1013	1013	Infection and inflammation: respiratory, other
5H38....VAR	K.4		1014	1014	Infection and inflammation: genitourinary tract
5H39....VAR	K.5		1015	1015	Infection and inflammation: bone and joint
5H40....VAR	K.6		1016	1016	Infection and inflammation: heart
5H41....VAR	K.7.a		1017	1017	Infection and inflammation: gastrointestinal, diarrhea requiring hospitalization
5H42....VAR	K.7.b		1018	1018	Infection and inflammation: gastrointestinal, other
5H43....VAR	K.8		1019	1019	Infection and inflammation: liver
5H44....VAR	K.9		1020	1020	Infection and inflammation: eye
5H45....VAR	K.10		1021	1021	Infection and inflammation: ear
5H46....VAR			1022	1022	Infection and inflammation: skin
5H47....VAR	K.12.a		1023	1023	Roseola
5H48....VAR	K.12.b		1024	1024	Rubella: German measles
5H49....VAR	K.12.c		1025	1025	Measles
5H50....VAR	K.12.d		1026	1026	Mumps
5H51....VAR	K.12.e		1027	1027	Chickenpox
5H52....VAR	K.12.f		1028	1028	Pertussis: whooping cough

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5853....VAR	R.12.?		1029	1029	Childhood diseases, other
5854....VAR	R.11		1030	1030	Infection: unusually recurrent or chronic
5855....VAR	R.14		1031	1031	Infection/inflammation, other
5856....VAR	S.1.a		1032	1032	Head trauma, with unconsciousness
5857....VAR	S.1.b		1033	1033	Head trauma: fractured skull
5858....VAR	S.1.c		1034	1034	Head trauma, bloody spinal fluid
5859....VAR	S.1.d		1035	1035	Head trauma, vomiting three times
5860....VAR	S.1.e		1036	1036	Head trauma, subdural hematoma
5861....VAR	S.2		1037	1037	Fractures, other
5862....VAR	S.3		1038	1038	Burns, infant hospitalized
5863....VAR	S.4.a		1039	1039	Symptomatic intoxication: salicylate
5864....VAR	S.4.b.(1)		1040	1040	Symptomatic intoxication: hydrocarbon, kerosene
5865....VAR	S.4.b(2)		1041	1041	Symptomatic intoxication: hydrocarbon, other
5866....VAR	S.4.c		1042	1042	Symptomatic intoxication: lead, other
5867....VAR	S.4.d		1043	1043	Symptomatic intoxication, other
5868....VAR	T.1		1044	1044	Shock, requiring hospitalization
5869....VAR	T.2		1045	1045	Dehydration, requiring parenteral fluid therapy
5870....VAR	T.3		1046	1046	Electrolyte imbalance
5871....VAR	T.4		1047	1047	Hyperthermia, 106 F or over
5872....VAR	T.5		1048	1048	Hypothermia, below 94 F
5873....VAR	T.6.a		1049	1049	Hypoxia episode with unconsciousness
5874....VAR	T.6.b		1050	1050	Hypoxia episode without unconsciousness
5875....VAR	T.7		1051	1051	Homeostasis, other disturbances
5876....VAR	U.1-4		1052	1052	Diseases and conditions, other specified
5877....VAR	V.1		1053	1053	Blood: transfusions
5878....VAR	V.2		1054	1054	Fluid administration: parenteral
5879....VAR	V.3		1055	1055	Spinal puncture
5880....VAR	V.4		1056	1056	Subdural puncture
5881....VAR	V.5		1057	1057	Ventricular puncture
5882....VAR	V.6		1058	1058	Anesthesia, general
5883....VAR	V.7		1059	1059	Surgery
5884....VAR	V.8		1060	1060	Chromosome studies
5885....VAR	V.9		1061	1061	Electroencephalography (EEG)
5886....VAR	V.10		1062	1062	Procedures, other
5887....VAR	W.1		1063	1063	Social/environmental conditions, loss of one or both parents or parent surrogate
5888....VAR	W.2		1064	1064	Social/environmental conditions: foster home
5889....VAR	W.3		1065	1065	Social/environmental conditions unfavorable emotional environment
5890....VAR	W.4		1066	1066	Social/environmental conditions: hospitalization prolonged or recurrent
5891....VAR	W.5		1067	1067	Social/environmental conditions, other
5892....VAR	11.A		1068	1068	Neurologic abnormality, number of, PED-12 sect A
5893....VAR	11.B		1069	1069	Central nervous system conditions; skeletal conditions, number of, PED-12 sect B

Data Items Referencing Form PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5894....VAR	11.C		1070	1070	Musculoskeletal abnormality, number of, PED-12 sect C
5895....VAR	11.D		1071	1071	Eye conditions, number of, PED-12 sect D
5896....VAR	11.E		1072	1072	Ear conditions, number of, PED-12 sect E
5897....VAR	11.F		1073	1073	Oral conditions; respiratory tract, upper, conditions, number of, PED-12 sect F
5898....VAR	11.G		1074	1074	Thoracic conditions, number of, PED-12 sect G
5899....VAR	11.H		1075	1075	Respiratory tract abnormality, lower, number of, PED-12 sect H
5900....VAR	11.I		1076	1076	Cardiovascular conditions, number of, PED-12 sect I
5901....VAR	11.J		1077	1077	Alimentary tract conditions, number of, PED-12 sect J
5902....VAR	11.K		1078	1078	Liver abnormality; bile duct abnormality; spleen abnormality, number of, PED-12 sect K
5903....VAR	11.L		1079	1079	Genitourinary conditions, number of, PED-12 sect L
5904....VAR	11.M		1080	1080	Neoplastic disease; tumors, number of, PED-12 sect M
5905....VAR	11.N		1081	1081	Hematologic conditions, number of, PED-12 sect N
5906....VAR	11.O		1082	1082	Skin conditions and malformations, number of, PED-12 sect O
5907....VAR	11.P		1083	1083	Syndromes, number of, PED-12 sect P
5908....VAR	11.Q		1084	1084	Endocrine diseases; metabolic diseases, number of, PED-12 sect Q
5909....VAR	11.R		1085	1085	Infection; inflammation, number of, PED-12 sect R
5910....VAR	11.S		1086	1086	Trauma; physical agents; toxicoses, number of, PED-12 sect S
5911....VAR	11.T		1087	1087	Homeostasis, disturbances, number of, PED-12 sect T
5912....VAR	11.U		1088	1088	Diseases and conditions, other, number of, PED-12 sect U
5913....VAR	11.V		1089	1089	Procedures, number of, PED-12 sect V
5914....VAR	11.W		1090	1090	Social/environmental conditions, number of, PED-12 sect W
6247....W-5			11	11	Malformation; congenital, stn, 1 year, source of information, PED-12
6259....W-6			15	17	Cerebral palsy; paresis, hemi, left (1 yr, interim, 7 yr)
6260....W-6			18	20	Cerebral palsy; paresis, hemi, right (1 yr, interim, 7 yr)
6261....W-6			21	23	Cerebral palsy; paresis, mono, arm, left (1 yr, interim, 7 yr)
6262....W-6			24	26	Cerebral palsy; paresis, mono, arm, right (1 yr, interim, 7 yr)
6263....W-6			27	29	Cerebral palsy; paresis, mono, leg, left (1 yr, interim, 7 yr)
6264....W-6			30	32	Cerebral palsy; paresis, mono, leg, right (1 yr, interim, 7 yr)
6265....W-6			33	35	Cerebral palsy; paraparesis (1 yr, interim, 7 yr)
6266....W-6			36	38	Cerebral palsy; quadriplegia; diplegia (1 yr, interim, 7 yr)
6267....W-6			39	41	Cerebral palsy; quadriplegia, other (1 yr, interim, 7 yr)
6268....W-6			42	44	Cerebral palsy; ataxia (1 yr, interim, 7 yr)
6269....W-6			45	47	Cerebral palsy; diplegia, atonic (1 yr, interim, 7 yr)
6270....W-6			48	50	Cerebral palsy; dyskinesia (1 yr, interim, 7 yr)
6271....W-6			51	53	Facial; palsy (1 yr, interim, 7 yr)
6272....W-6			54	56	Brachial plexus; palsy (1 yr, interim, 7 yr)
6273....W-6			57	59	Cerebral palsy; maladroit (1 yr, interim, 7 yr)
6274....W-6			60	62	Cerebral palsy, mixed (1 yr, interim, 7 yr)
6275....W-6			63	65	Cerebral palsy; hypotonic (1 yr, interim, 7 yr)
6276....W-6			66	66	Spasmus nutans, 1 yr

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DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
6279....W-6			68	68	Cerebral palsy, progressive disease, any cond
6280....W-6			70	70	Cerebral palsy, other, 1 yr

PED-12

SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

A. NEUROLOGIC ABNORMALITY

NONE

1. CEREBRAL SPASTIC PARESIS

a. Hemi

b. Tetra

c. Para

d. Other, specify

2. HYPOTONIA

a. Hypotonia with deep tendon reflexes

b. Hypotonia without deep tendon reflexes

3. DYSKINESIA

4. ATAXIA

5. OTHER MOTOR DISORDERS, SPECIFY

6. DELAYED DEVELOPMENT

a. Motor

b. Mental

7. REGRESSION IN MOTOR ACTIVITY

A. NEUROLOGIC ABNORMALITY

B. CORD DISEASE

a. Spastic

b. Flaccid

9. VISUAL IMPAIRMENT

a. Total

1. BILATERAL

2. UNILATERAL

b. Partial

1. BILATERAL

2. UNILATERAL

PED-12

PED-12 SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

A. NEUROLOGIC ABNORMALITY (Cont.)

10. EXTRA OCULAR MOVEMENTS

a. Esotropia

1. UNILATERAL

2. BILATERAL

b. Alternating internal strabismus

c. Exotropia

1. UNILATERAL

2. BILATERAL

d. Alternating external strabismus

e. Other, specify

11. NYSTAGMUS

a. Spontaneous

1. UNILATERAL

2. UNILATERAL WITH GAZE ONLY

3. BILATERAL

4. BILATERAL WITH GAZE ONLY

b. Character

1. PENDULAR

2. JERKY

c. Direction

1. HORIZONTAL

2. VERTICAL

3. ROTATORY

d. Other, specify

12. CRANIAL NERVE ABNORMALITY (other than CI, III, IV, VI, VIII)

a. Facial (VII)

b. Other, specify

A. NEUROLOGIC ABNORMALITY (Cont.)

13. HEARING IMPAIRMENT

14. PERIPHERAL NERVE ABNORMALITY (other than cranial nerves)

a. Brachial plexus

b. Other, specify

15. SEIZURE STATES

a. Generalized (grand mal)

Estimate total number

1) ONLY WITH FEVER AND LESS THAN 15 MINUTES DURATION

2) OTHER

b. Focal motor

Estimate total number

c. Infantile myoclonic seizures

d. Other, specify

16. ATYPICAL BEHAVIOR — INFORMATION INADEQUATE

a. Maladaptive responses

b. Failure to develop social responses or inappropriate social behavior for age

c. Failure to form rhythmic patterns

d. Disruption of rhythmic patterns

e. Regression in behavior

f. Stereotyped behavior

g. Abnormalities of behavior control, specify

h. Breath holding

1) WITH UNCONSCIOUSNESS

2) WITHOUT UNCONSCIOUSNESS

i. Hypersensitivity to sensory stimuli

j. Apathy

k. Phobia

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PED-12 SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

1. PATIENT IDENTIFICATION

A. NEUROLOGIC ABNORMALITY (Cont.)

16. ATYPICAL BEHAVIOR (Continued)
- l. Pica
  - (1) PAINT OR PLASTER
  - (2) OTHER, SPECIFY
- m. Other, specify
17. COMA, specify cause
18. OTHER, SPECIFY

B. RELATED CENTRAL NERVOUS SYSTEM AND SKELETAL CONDITIONS

NONE

1. MACROCEPHALY
2. MICROCEPHALY
3. HYDRANENCEPHALY
4. HYDROCEPHALY
   - a. Specify cause
   - b. Specify anatomic lesion
5. CRANIOSYNOSTOSIS. Specify involved sutures
6. OTHER ABNORMAL SHAPE OF SKULL. Specify
7. PORENCEPHALY
8. ENCEPHALOCELE
9. MENINGOMYELOCELE/MENINGOCELE
10. PILONIDAL SINUS (not dimple)
11. OTHER MIDLINE SINUSES, SPECIFY
12. SUBDURAL HEMATOMA OR EFFUSION
13. OTHER INTRACRANIAL HEMORRHAGE. Specify site
14. OTHER, SPECIFY (do not code spina bifida occulta or convulsions)

C. MUSCULOSKELETAL ABNORMALITY (do not list diastasis recti)

NONE

1. VERTEBRAL ABNORMALITY (do not code spina bifida occulta)
2. TALIPES EQUINOVARUS
3. METATARSUS ADDUCTUS (varus)
4. TALIPES CALCANEOVALGUS
5. CONGENITAL DISLOCATION OR DYSPLASIA OF THE HIP
6. ABSENCE OR HYPOPLASIA OF EXTREMITY OR PART, SPECIFY
7. POLYDACTYLY
8. SYNDACTYLY
9. TORTICOLLIS
10. ARTHROGRYPOSIS MULTIPLEX (amyoplasia congenita)
11. OTHER NON-INFECTIOUS, SPECIFY

D. EYE CONDITIONS

NONE

1. CHORIORETINITIS
2. RETROLENTAL FIBROPLASIA
3. CATARACT
4. CORNEAL OPACITY
5. MICROPHTHALMIA
6. OTHER NON-INFECTIOUS, SPECIFY

E. EAR CONDITIONS

NONE

1. LOW SET EARS
2. DEFORMED EAR PINNA
3. BRANCHIAL CLEFT ANOMALY (preauricular sinus, etc.)
4. PERFORATED EAR DRUM
5. OTHER NON-INFECTIOUS, SPECIFY

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PED-12

COLR-[illegible]

I. PATIENT IDENTIFICATION

PED-12

SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

F. UPPER RESPIRATORY TRACT AND MOUTH CONDITIONS

NONE ☐

1. CLEFT PALATE
2. CLEFT UVULA
3. CLEFT LIP
4. CLEFT GUM
5. MICROGNATHIA
6. MALFORMATION OF THE EPIGLOTTIS AND LARYNX, SPECIFY
7. ABNORMALITY OF TEETH, SPECIFY
8. OTHER NON-INFECTIOUS, SPECIFY

G. THORACIC CONDITIONS (except neoplasms and cardiovascular conditions)

NONE ☐

1. ANOMALY OF DIAPHRAGM, SPECIFY
2. ANOMALY OF RIBS, SPECIFY
3. PECTUS EXCAVATUM
4. PIGEON BREAST
5. OTHER, SPECIFY

H. LOWER RESPIRATORY TRACT ABNORMALITY

NONE ☐

1. ASTHMA
2. EMPHYSEMA
3. PNEUMOTHORAX
4. ANOMALY OF LUNG, SPECIFY
5. OTHER NON-INFECTIOUS, SPECIFY

I. CARDIOVASCULAR CONDITIONS

NONE ☐

1. ACYANOTIC CHD
2. CYANOTIC CHD
3. FIBROELASTOSIS
4. DISORDERS OF RHYTHM
5. DISORDERS OF RATE
6. CARDIAC ENLARGEMENT
7. DECOMPENSATION
8. SEVERE CYANOTIC EPISODES
9. SPECIFIC C-V DIAGNOSIS (code also under [illegible])
10. OTHER [illegible] SPECIFY

J. ALIMENTARY TRACT CONDITIONS

NONE ☐

1. HERNIA [illegible] SPECIFY
2. VOLVULUS
3. INTUSSUSCEPTION
4. PERSISTENT VOMITING
5. MEGACOLON
6. PYLORIC STENOSIS
7. VISCERAL PERFORATION
8. MALROTATION
9. INTESTINAL OBSTRUCTION
10. CHALASIA
11. OTHER NON-INFECTIOUS, SPECIFY

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I. PATIENT IDENTIFICATION

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SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

K. ABNORMALITY OF LIVER, BILE DUCTS, AND/OR SPLEEN

NONE ☐

1. BILIARY ATRESIA
2. JAUNDICE
   a. Persistent beyond duration summarized on PED-8
   b. Acquired after duration summarized on PED-8
3. OTHER NON-INFECTIOUS, SPECIFY

L. GENITOURINARY CONDITIONS (do not code hydrocele or phimosis)

NONE ☐

1. UNDESCENDED TESTICLE
   a. Unilateral
   b. Bilateral
2. HYPOSPADIAS
3. CHORDEE
4. OTHER ABNORMALITY OF THE EXTERNAL GENITALIA (include pseudohermaphroditism), SPECIFY
5. BLADDER OUTFLOW OR URETHRAL OBSTRUCTION, SPECIFY
6. UPPER TRACT OBSTRUCTION, HYDRONEPHROSIS OR HYDRO-URETER (megaloureter), SPECIFY
7. CYSTIC KIDNEY
8. OTHER NON-INFECTIOUS, SPECIFY

M. NEOPLASTIC DISEASE AND/OR OTHER TUMORS (code hemangioma and lymphangioma under cat. O.)

NONE ☐

1. SPECIFY TYPE AND ORGAN
   a.
   b.
   c.
   d.

N. HEMATOLOGIC CONDITIONS

NONE ☐

1. HEMOGLOBINOPATHY, SPECIFY TYPE
2. HEMOLYTIC DISEASE
   a. Congenital
   b. Acquired
3. COAGULATION DEFECT, SPECIFY
4. MAJOR HEMORRHAGE, SPECIFY SITE (code intracranial hemorrhage under B.)
5. ANEMIA
   a. Less than 5 gm. %
      (1) IRON DEFICIENCY
      (2) OTHER, SPECIFY
   b. 5 to (but not including) 8 gm. %
      (1) IRON DEFICIENCY
      (2) OTHER, SPECIFY
6. OTHER, SPECIFY

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PED-12

1. PATIENT IDENTIFICATION

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SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

O. SKIN CONDITIONS AND MALFORMATIONS

NONE ☐

1. PORT WINE HEMANGIOMA
2. STRAWBERRY HEMANGIOMA
3. CAVERNOUS HEMANGIOMA
4. HAIRY PIGMENTED NEVUS
5. PIGMENTED NEVUS (6 or more that are ... or are larger than 3 cm.)
6. LYMPHANGIOMA
7. CAFÉ AU LAIT SPOTS (6 or more or one larger than 3 cm.)
8. ECZEMA
9. OTHER NON-INFECTIOUS, SPECIFY

P. SYNDROMES

NONE ☐

1. MONGOLISM (Down's syndrome)
2. GONADAL DYSGENESIS
3. ADRENOGENITAL
4. MARFAN'S
5. PIERRE ROBIN
6. SPASMUS NUTANS
7. HURLER'S (Gargoylism)
8. FAILURE TO THRIVE
9. OTHER, SPECIFY

Q. OTHER ENDOCRINE AND METABOLIC DISEASE

NONE ☐

1. HYPOTHYROIDISM, SPECIFY
2. FIBROCYSTIC DISEASE OF PANCREAS
3. INBORN ERRORS OF METABOLISM, SPECIFY
4. OTHER, SPECIFY

R. INFECTION AND INFLAMMATION (specify condition and agent)

NONE ☐

1. SEPTICEMIA

Agent

2. CENTRAL NERVOUS SYSTEM

a. Bacterial meningitis

Agent

b. Non-bacterial meningitis

Agent

c. Encephalitis

Agent

d. Other CNS, specify

Agent

3. RESPIRATORY (include upper and lower, mouth, retropharyngeal abscess and herpetic stomatitis. exclude, in general, common cold, pharyngitis, tonsillitis)

a. Pneumonia

Agent

b. Severe croup

Agent

c. Bronchiolitis

Agent

d. Other respiratory, specify

Agent

4. GENITOURINARY TRACT

Agent

5. BONE AND JOINT

Agent

6. HEART

Agent

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PED-12

1. PATIENT IDENTIFICATION

PED-12 SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

R. INFECTION AND INFLAMMATION (Continued)

7. GASTROINTESTINAL

a. Diarrhea requiring hospitalization

Agent

b. Other GI, specify

Agent

8. LIVER

a.

Agent

9. EYE (exclude uncomplicated simple conjunctivitis)

a.

Agent

10. EAR (exclude external otitis and uncomplicated non-draining otitis media)

a.

Agent

11. SKIN (exclude impetigo, [illegible], [illegible], and diaper rashes)

a.

Agent

12. SPECIFIC CHILDHOOD DISEASES

a. Roseola

b. German measles

c. Measles

d. Mumps

e. Chickenpox

f. Whooping cough

g. Other, specify

13. UNUSUALLY RECURRENT OR CHRONIC INFECTIONS, SPECIFY

14. OTHER, SPECIFY

a.

Agent

S. TRAUMA, PHYSICAL AGENTS, AND INTOXICATION

NONE

1. HEAD TRAUMA

a. Unconsciousness

b. Fractured skull

c. Bloody spinal fluid

d. Vomiting x3

e. Subdural hematoma

2. FRACTURES, OTHER, SPECIFY

3. BURNS LEADING TO HOSPITALIZATION (including fire and specify the location and agent)

a.

Agent

4. SYMPTOMATIC INTOXICATION

a. Salicylate

b. Hydrocarbon

(1) KEROSENE

(2) OTHER HYDROCARBON SPECIFY

c. Lead

d. Other, specify

T. DISTURBANCES IN HOMEOSTASIS

NONE

1. SHOCK REQUIRING HOSPITALIZATION

2. DEHYDRATION REQUIRING PARENTERAL FLUID THERAPY

3. ELECTROLYTE IMBALANCE, SPECIFY

a.

b.

4. HYPERTHERMIA (106°F or over)

5. HYPOTHERMIA (Below 96°F)

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PATIENT IDENTIFICATION

PED-12

SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8

T. DISTURBANCES IN HOMEOSTASIS (Continued)

6. EPISODE OF "HYPOXIA"

a. With unconsciousness ____

Specify cause

b. Without unconsciousness ____

Specify cause

7. OTHER, SPECIFY ____

U. OTHER CONDITIONS ____

NONE

Specify

1.

2.

3.

4.

V. PROCEDURES

NONE

1. BLOOD TRANSFUSIONS ____
2. PARENTERAL FLUID ____
3. SPINAL PUNCTURE ____
4. SUBDURAL PUNCTURE ____
5. VENTRICULAR PUNCTURE ____
6. GENERAL ANESTHESIA ____
7. SURGERY (exclude minor office surgery; specify) ____
8. CHROMOSOME STUDIES ____
9. E.E.G. ____
10. OTHER, SPECIFY ____

W. SOCIAL AND ENVIRONMENTAL CONDITIONS

NONE

INFORMATION INADEQUATE

1. LOSS OF ONE OR BOTH PARENTS OR PARENT SURROGATE ____
2. FOSTER HOME ____
3. UNFAVORABLE EMOTIONAL ENVIRONMENT ____
4. PROLONGED OR RECURRENT HOSPITALIZATION (totalling approximately 30 days) ____
5. OTHER, SPECIFY ____

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PED-12

Form Item Numbers Linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	5692....VAR		468	468	Behavior, atypical: maladaptive responses, failure to form rhythmic patterns
	6277....B-6		54	56	Brachial plexus: palsy (1 yr, interim, 7 yr)
	6274....B-6		60	62	Cerebral palsy, mixed (1 yr, interim, 7 yr)
	6280....B-6		70	70	Cerebral palsy, other, 1 yr
	6278....B-6		68	68	Cerebral palsy, progressive disease, any spec
	6268....B-6		42	44	Cerebral palsy: ataxia (1 yr, interim, 7 yr)
	6269....B-6		45	47	Cerebral palsy: diplegia, atonic (1 yr, interim, 7 yr)
	6270....B-6		48	50	Cerebral palsy: dyskinesia (1 yr, interim, 7 yr)
	6275....B-6		63	65	Cerebral palsy: hypotonic (1 yr, interim, 7 yr)
	6273....B-6		57	59	Cerebral palsy: [illegible] (1 yr, interim, 7 yr)
	6265....B-6		33	35	Cerebral palsy: paraparesis (1 yr, interim, 7 yr)
	6259....B-6		15	17	Cerebral palsy: paresis, hemi, left (1 yr, interim, 7 yr)
	6260....B-6		18	20	Cerebral palsy: paresis, hemi, right (1 yr, interim, 7 yr)
	6261....B-6		21	23	Cerebral palsy: paresis, mono, arm, left (1 yr, interim, 7 yr)
	6262....B-6		24	26	Cerebral palsy: paresis, mono, arm, right (1 yr, interim, 7 yr)
	6263....B-6		27	29	Cerebral palsy: paresis, mono, leg, left (1 yr, interim, 7 yr)
	6264....B-6		30	32	Cerebral palsy: paresis, mono, leg, right (1 yr, interim, 7 yr)
	6267....B-6		39	41	Cerebral palsy: quadriplegia, other (1 yr, interim, 7 yr)
	6266....B-6		36	38	Cerebral palsy: quadriplegia: diplegia (1 yr, interim, 7 yr)
	6271....B-6		51	53	Facial: palsy (1 yr, interim, 7 yr)
	5089....VAR		184	184	Gonorrhea, culture positive
	5090....VAR		185	185	Gonorrhea, smear positive
	5846....VAR		1022	1022	Infection and inflammation: skin
	6247....B-5		11	11	Malformations: congenital, nth, 1 year, source of information, PED-12
	4630,PED-12	1412	41	46	Medical conditions, specific, nth (where max n = 45)
	4633,PED-12	2412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 10 - 18
	4634,PED-12	3412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 19 - 27
	4635,PED-12	4412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 28 - 36
	4636,PED-12	5412	1	80	Medical conditions, specific, repeat of card 1412 for possible conditions 37 - 45
	4631,PED-12	1412	47	78	Medical conditions, specific, repeat of card 4121 col 43-46 for conditions 2 through 9
	6276....B-6		66	66	Spasmus nutans, 1 yr
A.1.a	5641....VAR		417	417	Paresis, hemi, left: cerebral spastic
A.1.a	4630,PED-12	1412	41	46	Paresis, hemi, left: cerebral spastic, codes: 003, 004
A.1.a	5640....VAR		416	416	Paresis, hemi, right: cerebral spastic
A.1.a	4630,PED-12	1412	41	46	Paresis, hemi, right: cerebral spastic, codes: 001, 002

Form Item Numbers Linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
A.1.b	5642....VAR		018	018	Paresis, tetra: cerebral spastic
A.1.b	4630.PED-12	1412	41	46	Paresis, tetra: cerebral spastic, codes: 005, 006
A.1.c	5643....VAR		019	019	Paresis, para: cerebral spastic
A.1.c	4630.PED-12	1412	41	46	Paresis, para: cerebral spastic, codes: 007, 008
A.1.d	4630.PED-12	1412	41	46	Equinovalgus, code: 014
A.1.d	4630.PED-12	1412	41	46	Paresis, monoplegia spastic, code: 011
A.1.d	5644....VAR		020	020	Paresis, other: cerebral spastic
A.1.d	4630.PED-12	1412	41	46	Paresis, other: cerebral spastic, codes: 009, 010
A.1.d	4630.PED-12	1412	41	46	Paresis, upper extremities spastic, code: 012
A.1.d	4630.PED-12	1412	41	46	Streeter's dysplasia, code: 013
A.2.a	4630.PED-12	1412	41	46	Hypotonia with deep tendon reflexes, codes: 015, 016
A.2.b	5646....VAR		022	022	Hypotonia without deep tendon reflexes
A.2.b	4630.PED-12	1412	41	46	Hypotonia without deep tendon reflexes, codes: 017, 018
A.3	5647....VAR		023	023	Dyskinesia
A.3	4630.PED-12	1412	41	46	Dyskinesia, codes: 019, 020
A.4	5648....VAR		024	024	Ataxia
A.4	4630.PED-12	1412	41	46	Ataxia, codes: 021, 022
A.5	4630.PED-12	1412	41	46	Motor disorders, atonic and flaccid monoplegia, code: 025
A.5	4630.PED-12	1412	41	46	Motor disorders, flaccid paralysis from wrist down, code: 026
A.5	5649....VAR		025	025	Motor disorders, other
A.5	4630.PED-12	1412	41	46	Motor disorders, other, codes: 023, 024
A.6.a	4630.PED-12	1412	41	46	Development, delayed motor, codes: 031, 032
A.6.a	5650....VAR		026	026	Developmental, delayed motor
A.6.b	4630.PED-12	1412	41	46	Development, delayed mental, codes: 033, 034
A.6.b	5651....VAR		027	027	Developmental, delayed mental
A.7	5652....VAR		028	028	Motor activity, regression
A.7	4630.PED-12	1412	41	46	Motor activity, regression, codes: 035, 036
A.8.a	5653....VAR		029	029	Spinal cord disease, spastic
A.8.a	4630.PED-12	1412	41	46	Spinal cord disease, spastic, codes: 037, 038
A.8.b	5654....VAR		030	030	Spinal cord disease, flaccid
A.8.b	4630.PED-12	1412	41	46	Spinal cord disease, flaccid, codes: 039, 040
A.9.a(1)(a)	5655....VAR		031	031	Visual impairment, total bilateral ocular
A.9.a(1)(a)	4630.PED-12	1412	41	46	Visual impairment, total bilateral ocular, codes: 041, 042
A.9.a(1)(b)	5656....VAR		032	032	Visual impairment, total bilateral nonocular
A.9.a(1)(b)	4630.PED-12	1412	41	46	Visual impairment, total bilateral nonocular, codes: 043, 044
A.9.a(2)(a)	5657....VAR		033	033	Visual impairment, total unilateral ocular
A.9.a(2)(a)	4630.PED-12	1412	41	46	Visual impairment, total unilateral ocular, codes: 045, 046
A.9.a(2)(b)	5658....VAR		034	034	Visual impairment, total unilateral nonocular
A.9.a(2)(b)	4630.PED-12	1412	41	46	Visual impairment, total unilateral nonocular, codes: 047, 048
A.9.b(1)(a)	5659....VAR		035	035	Visual impairment, partial bilateral ocular
A.9.b(1)(a)	4630.PED-12	1412	41	46	Visual impairment, partial bilateral ocular, codes: 049, 050
A.9.b(1)(b)	5660....VAR		036	036	Visual impairment, partial bilateral nonocular
A.9.b(1)(b)	4630.PED-12	1412	41	46	Visual impairment, partial bilateral nonocular, codes: 051, 052

Form Item Numbers linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
A.9.h(2)(a)	5661....VAR		837	837	Visual impairment, partial unilateral ocular
A.9.h(2)(a)	4630.PED-12	1412	43	46	Visual impairment, partial unilateral ocular, codes: 053, 054
A.9.h(2)(b)	5662....VAR		838	838	Visual impairment, partial unilateral monocular
A.9.h(2)(b)	4630.PED-12	1412	43	46	Visual impairment, partial unilateral monocular, codes: 055, 056
A.10.a(1)	5663....VAR		839	839	Esotropia, unilateral
A.10.a(1)	4630.PED-12	1412	43	46	Esotropia, unilateral, codes: 057, 058
A.10.a(2)	5664....VAR		840	840	Esotropia, bilateral
A.10.a(2)	4630.PED-12	1412	43	46	Esotropia, bilateral, codes: 059, 060
A.10.b	5665....VAR		841	841	Strabismus, alternating internal
A.10.b	4630.PED-12	1412	43	46	Strabismus, alternating internal, codes: 061 062
A.10.c(1)	5666....VAR		842	842	Exotropia, unilateral
A.10.c(1)	4630.PED-12	1412	43	46	Exotropia, unilateral, codes: 063, 064
A.10.c(2)	5667....VAR		843	843	Exotropia, bilateral
A.10.c(2)	4630.PED-12	1412	43	46	Exotropia, bilateral, codes: 065, 066
A.10.d	5668....VAR		844	844	Strabismus, alternating external
A.10.d	4630.PED-12	1412	43	46	Strabismus, alternating external, codes: 067, 068
A.10.e	5669....VAR		845	845	Extra ocular movement disorders, other
A.10.e	4630.PED-12	1412	43	46	Extra ocular movement disorders, other, codes: 069, 070
A.11.a(1)	5670....VAR		846	846	Nystagmus, involvement unilateral
A.11.a(1)	4630.PED-12	1412	43	46	Nystagmus, involvement unilateral, codes: 077, 078
A.11.a(2)	5671....VAR		847	847	Nystagmus, involvement unilateral with gaze only
A.11.a(2)	4630.PED-12	1412	43	46	Nystagmus, involvement unilateral with gaze only, codes: 079, 080
A.11.a(3)	5673....VAR		849	849	Nystagmus, involvement bilateral with gaze only
A.11.a(3)	4630.PED-12	1412	43	46	Nystagmus, involvement bilateral with gaze only, codes: 083, 084
A.11.b(1)	5674....VAR		850	850	Nystagmus, character pendular
A.11.b(1)	4630.PED-12	1412	43	46	Nystagmus, character pendular, codes: 085, 086
A.11.b(1)	5672....VAR		848	848	Nystagmus, involvement bilateral
A.11.b(1)	4630.PED-12	1412	43	46	Nystagmus, involvement bilateral, codes: 081, 082
A.11.b(2)	5675....VAR		851	851	Nystagmus, character jerky
A.11.b(2)	4630.PED-12	1412	43	46	Nystagmus, character jerky, codes: 087, 088
A.11.c(1)	5676....VAR		852	852	Nystagmus, direction horizontal
A.11.c(1)	4630.PED-12	1412	43	46	Nystagmus, direction horizontal, codes: 089, 090
A.11.c(2)	5677....VAR		853	853	Nystagmus, direction vertical
A.11.c(2)	4630.PED-12	1412	43	46	Nystagmus, direction vertical, codes: 091, 092
A.11.c(3)	5678....VAR		854	854	Nystagmus, direction rotatory
A.11.c(3)	4630.PED-12	1412	43	46	Nystagmus, direction rotatory, codes: 093, 094
A.11.d	4630.PED-12	1412	43	46	Nystagmus, bilateral roving or wandering, code: 097
A.11.d	4630.PED-12	1412	43	46	Nystagmus, central, code: 099
A.11.d	5679....VAR		855	855	Nystagmus, other
A.11.d	4630.PED-12	1412	43	46	Nystagmus, other, codes: 095, 096
A.11.d	4630.PED-12	1412	43	46	Nystagmus, type unspecified, code: 098
A.12.a	4630.PED-12	1412	43	46	Cranial nerve abnormality, facial, codes: 101, 102
A.12.a	5680....VAR		856	856	Cranial nerve abnormality, facial

Form Item Numbers linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
A.12.b	4630,PED-12	1412	43	46	Cranial nerve abnormality, other, codes: 103, 104
A.12.b	5681....VAR		857	857	Cranial: nerve abnormality, other
A.13	5682....VAR		858	858	Hearing impairment
A.13	4630,PED-12	1412	43	46	Hearing impairment, codes: 113, 114
A.14.a	4630,PED-12	1412	43	46	Peripheral nerve abnormality, brachial plexus, codes: 115, 116
A.14.a	5683....VAR		859	859	Peripheral: nerve abnormality, brachial plexus
A.14.b	4630,PED-12	1412	43	46	Abnormal: fingers, thumbs or toes, code: 120
A.14.b	4630,PED-12	1412	43	46	Congenital contractures hamstrings, code: 122
A.14.b	4630,PED-12	1412	43	46	Constrictive bands above: ankle, code: 125
A.14.b	4630,PED-12	1412	43	46	Contractures: toes, finger, fingers, or thumb, code: 124
A.14.b	4630,PED-12	1412	43	46	Coxa valga, code: 126
A.14.b	4630,PED-12	1412	43	46	Coxa vara, code: 127
A.14.b	4630,PED-12	1412	43	46	Peripheral nerve abnormality, foot drop, code: 119
A.14.b	4630,PED-12	1412	43	46	Peripheral nerve abnormality, other, codes: 117, 118
A.14.b	5684....VAR		860	860	Peripheral: nerve abnormality, other
A.15.a(1)	5685....VAR		861	861	Seizure states, generalized (grand mal) only with fever and less than 15 minute duration
A.15.a(1)	4630,PED-12	1412	43	46	Seizure states, generalized (grand mal) only with fever and less than 15 minute duration, codes: 129, 130
A.15.a(2)	5686....VAR		862	862	Seizure states, generalized (grand mal), other
A.15.a(2)	4630,PED-12	1412	43	46	Seizure states, generalized (grand mal), other, codes: 131, 132
A.15.b	5687....VAR		863	863	Seizure states, focal motor, total number
A.15.b	4630,PED-12	1412	43	46	Seizure states, focal motor, total number, codes: 133, 134
A.15.c	5688....VAR		864	864	Seizure states, infantile myoclonic
A.15.c	4630,PED-12	1412	43	46	Seizure states, infantile myoclonic, codes: 135, 136
A.15.d	5689....VAR		865	865	Seizure states, other
A.15.d	4630,PED-12	1412	43	46	Seizure states, other, codes: 137, 138
A.16.a	5690....VAR		866	866	Behavior disorder, maladaptive responses
A.16.a	4630,PED-12	1412	43	46	Behavior, atypical: maladaptive responses, codes: 149, 150
A.16.b	4630,PED-12	1412	43	46	Behavior, atypical: failure to develop appropriate social responses, codes: 151, 152
A.16.b	5691....VAR		867	867	Behavior, atypical: maladaptive responses, failure to develop appropriate social responses
A.16.c	4630,PED-12	1412	43	46	Behavior, atypical: failure to form rhythmic patterns, codes: 153, 154
A.16.d	4630,PED-12	1412	43	46	Behavior, atypical: disruption of rhythmic patterns, codes: 155, 156
A.16.d	5693....VAR		869	869	Behavior, atypical: maladaptive responses, disruption of rhythmic patterns
A.16.e	5694....VAR		870	870	Behavior, atypical: maladaptive responses, regression in behavior
A.16.e	4630,PED-12	1412	43	46	Behavior, atypical: regression in behavior, codes: 157, 158
A.16.f	5695....VAR		871	871	Behavior, atypical: maladaptive responses, stereotyped behavior
A.16.f	4630,PED-12	1412	43	46	Behavior, atypical: stereotyped behavior, codes: 159, 160

Form Item Numbers Linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
A.16.g	4630.PED-12	1412	43	46	Behavior, atypical: abnormalities of behavior control, codes: 165, 167
A.16.g	5696....VAR		872	872	Behavior, atypical: maladaptive responses, abnormalities of behavior control
A.16.h(1)	4630.PED-12	1412	43	46	Behavior, atypical: breath holding with unconciousness, codes: 173, 174
A.16.h(1)	5697....VAR		873	873	Behavior, atypical: maladaptive responses, breath holding with unconciousness
A.16.h(2)	4630.PED-12	1412	43	46	Behavior, atypical: breath holding without unconciousness, codes: 175, 176
A.16.h(2)	5698....VAR		874	874	Behavior, atypical: maladaptive responses, breath holding without unconciousness
A.16.i	4630.PED-12	1412	43	46	Behavior, atypical: hyperactivity to sensory stimuli, codes: 177, 178
A.16.i	5699....VAR		875	875	Behavior, atypical: maladaptive responses, hyperactivity to sensory stimuli
A.16.j	4630.PED-12	1412	43	46	Behavior, atypical: apathy, codes: 179, 180
A.16.j	5700....VAR		876	876	Behavior, atypical: maladaptive responses, apathy
A.16.k	5701....VAR		877	877	Behavior, atypical: maladaptive responses, phobia
A.16.k	4630.PED-12	1412	43	46	Behavior, atypical: phobia, codes: 181, 182
A.16.l(1)	5702....VAR		878	878	Behavior, atypical: maladaptive responses, pica, painter plaster
A.16.l(1)	4630.PED-12	1412	43	46	Behavior, atypical: pica, paint or plaster, codes: 183, 184
A.16.l(2)	5703....VAR		879	879	Behavior, atypical: maladaptive responses, pica, other
A.16.l(2)	4630.PED-12	1412	43	46	Behavior, atypical: pica, other, codes: 185, 186
A.16.m	4630.PED-12	1412	43	46	Behavior, atypical, other, codes: 195, 196
A.16.m	5704....VAR		880	880	Behavior, atypical: maladaptive responses, other
A.17	5705....VAR		881	881	Coma
A.17	4630.PED-12	1412	43	46	Coma, codes: 205, 206
A.18	5706....VAR		882	882	Neurologic abnormality, other
A.18	4630.PED-12	1412	43	46	Neurologic abnormality, other, codes: 215, 216
A.18	4630.PED-12	1412	43	46	Neurologic abnormality: anoxic brain damage, code: 217
A.18	4630.PED-12	1412	43	46	Neurologic abnormality: cerebral thrombosis, code: 222
A.18	4630.PED-12	1412	43	46	Neurologic abnormality: cranium bifidum, code: 218
A.18	4630.PED-12	1412	43	46	Neurologic abnormality: episode apnea with cyanosis, code: 219
A.18	4630.PED-12	1412	43	46	Neurologic abnormality: glycogenesis of neurons pons, medulla, horn cells ant., code: 223
A.18	4630.PED-12	1412	43	46	Neurologic abnormality: pseudo-tumor cerebri, code: 221
A.18	4630.PED-12	1412	43	46	Neurologic abnormality: severe CNS damage, etiology unknown, code: 223
B.1	5707....VAR		883	883	Macrocephaly
B.1	4630.PED-12	1412	43	46	Macrocephaly, codes: 225, 226
B.2	5708....VAR		884	884	Microcephaly
B.2	4630.PED-12	1412	43	46	Microcephaly, codes: 227, 228

Form Item Numbers linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
B.3	5709....VAR		885	885	Hydranencephaly
B.3	4630.PED-12	1412	41	46	Hydranencephaly, codes: 229, 230
B.4	5710....VAR		886	886	Hydrocephaly
B.4	4630.PED-12	1412	41	46	Hydrocephaly, codes: 231, 232
B.5	5711....VAR		887	887	Craniosynostosis
B.5	4630.PED-12	1412	41	46	Craniosynostosis, codes: 243, 244
B.6	5712....VAR		888	888	Skull, other abnormal shape
B.6	4630.PED-12	1412	41	46	Skull, other abnormal shape, codes: 249, 250
B.7	5713....VAR		889	889	Porencephaly
B.7	4630.PED-12	1412	41	46	Porencephaly, codes: 255, 256
B.8	4630.PED-12	1412	41	46	Encephalocele, codes: 257, 258
B.8	5714....VAR		890	890	Encephalocele
B.9	5715....VAR		891	891	Meningomyelocele; meningocele
B.9	4630.PED-12	1412	41	46	Meningomyelocele; meningocele, codes: 259, 260
B.10	5716....VAR		892	892	Pilonidal sinus
B.10	4630.PED-12	1412	41	46	Pilonidal sinus, codes: 261, 262
B.11	5717....VAR		893	893	Sinuses, midline, other
B.11	4630.PED-12	1412	41	46	Sinuses, midline, other, codes: 263, 264
B.12	5718....VAR		894	894	Subdural hematoma or effusion
B.12	4630.PED-12	1412	41	46	Subdural hematoma or effusion, codes: 269, 270
B.13	5719....VAR		895	895	Hemorrhage, intracranial, other
B.13	4630.PED-12	1412	41	46	Hemorrhage, intracranial, other, codes: 271, 272
B.14	4630.PED-12	1412	41	46	Absence or hypoplasia of: fibula, code: 285
B.14	4630.PED-12	1412	41	46	Absence or hypoplasia of: forearm, code: 286
B.14	4630.PED-12	1412	41	46	Absence or hypoplasia of: humerus, code: 287
B.14	4630.PED-12	1412	41	46	Absence or hypoplasia of: radius, code: 288
B.14	4630.PED-12	1412	41	46	Absence or hypoplasia of: rib or ribs, code: 290
B.14	4630.PED-12	1412	41	46	Absence or hypoplasia of: tibia, code: 284
B.14	4630.PED-12	1412	41	46	Absence or hypoplasia of: ulna, code: 289
B.14	5720....VAR		896	896	CNS malformations and related skeletal conditions, other
B.14	4630.PED-12	1412	41	46	CNS malformations and related skeletal conditions, other, codes: 279, 280
B.14	4630.PED-12	1412	41	46	CNS malformations and related skeletal conditions: cerebral sinus thrombosis, code: 282
B.14	4630.PED-12	1412	41	46	CNS malformations and related skeletal conditions: platybasia, code: 283
B.14	4630.PED-12	1412	41	46	CNS malformations and related skeletal conditions: skull, bony defect, code: 281
C.1	5721....VAR		897	897	Vertebral abnormality
C.1	4630.PED-12	1412	41	46	Vertebral: abnormality, codes: 291, 292
C.2	5722....VAR		898	898	Talipes equinovarus
C.2	4630.PED-12	1412	41	46	Talipes equinovarus, codes: 293, 294
C.3	5723....VAR		899	899	Metatarsus adductus

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ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
C.3	4630.PED-12	1412	43	46	Metatarsus adductus, codes: 295, 296
C.4	5724....VAR		900	900	Talipes calcaneovalgus
C.4	4630.PED-12	1412	43	46	Talipes calcaneovalgus, codes: 297, 298
C.5	5725....VAR		901	901	Hip dislocation or dysplasia, congenital
C.5	4630.PED-12	1412	43	46	Hip: dislocation or dysplasia, congenital, codes: 299, 300
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: femur, code: 311
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: finger or fingers, code: 305
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: foot, code: 306
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: hand, code: 304
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: lower extremity, code: 308
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: mandible, code: 123
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: pectoralis major, code: 303
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: ribs or spine, code: 319
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: talus, code: 124
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: toe or toes, code: 307
C.6	4630.PED-12	1412	43	46	Absence or hypoplasia of: upper extremity, code: 309
C.6	4630.PED-12	1412	43	46	Extremity or part: absence or hypoplasia of, codes: 301, 302
C.6	5726....VAR		902	902	Extremity: hypoplasia or absence
C.6	4630.PED-12	1412	43	46	Hemimelia, code: 321
C.6	4630.PED-12	1412	43	46	Hemivertebrae, code: 322
C.6	4630.PED-12	1412	43	46	Phocomelia, code: 320
C.7	5727....VAR		903	903	Polydactyly
C.7	4630.PED-12	1412	43	46	Polydactyly, code: 310
C.8	5728....VAR		904	904	Syndactyly
C.8	4630.PED-12	1412	43	46	Syndactyly, code: 312
C.9	5729....VAR		905	905	Torticollis
C.9	4630.PED-12	1412	43	46	Torticollis, codes: 313, 314
C.10	5730....VAR		906	906	Arthrogryposis multiplex
C.10	4630.PED-12	1412	43	46	Arthrogryposis multiplex, codes: 315, 316
C.11	4630.PED-12	1412	43	46	Abduction feet; or forefoot, code: 234
C.11	4630.PED-12	1412	43	46	Abduction with contracture: hip, code: 235
C.11	4630.PED-12	1412	43	46	Abnormal shape and implantation: toes, code: 236
C.11	4630.PED-12	1412	43	46	Adduction, contracture, or tightness: hip, code: 237
C.11	4630.PED-12	1412	43	46	Adduction: heel, code: 239
C.11	4630.PED-12	1412	43	46	Calcaneous varus, code: 241
C.11	4630.PED-12	1412	43	46	Cavus deformity feet, talipes cavus, code: 452
C.11	4630.PED-12	1412	43	46	Clinodactyly, code: 233
C.11	4630.PED-12	1412	43	46	Congenital adduction: wrists and abnormal thumbs, code: 240
C.11	4630.PED-12	1412	43	46	Congenital ankylosis elbow with dislocation head radius and abnormal hand, code: 242
C.11	4630.PED-12	1412	43	46	Contractures elbows or knees or extremity, code: 317
C.11	4630.PED-12	1412	43	46	Extremity, hypertrophy, code: 652
C.11	4630.PED-12	1412	43	46	Hemihypertrophy, code: 318

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ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
C.11	5731....VAR		907	907	Musculoskeletal abnormality, other noninfectious
C.11	4630.PED-12	1412	43	46	Musculoskeletal abnormality, other noninfectious, codes: 317, 318
C.11	4630.PED-12	1412	43	46	Scoliosis, lordosis, kyphosis, code: 326
C.11	4630.PED-12	1412	43	46	Tali, bilateral vertical, code: 239
C.11	4630.PED-12	1412	43	46	Talipes valgus, code: 881
C.11	4630.PED-12	1412	43	46	Talipes varus, code: 880
C.11	4630.PED-12	1412	43	46	Thumb, bilateral cine, code: 245
C.11	4630.PED-12	1412	43	46	Webbed neck, code: 882
D.1	5732....VAR		908	908	Chorioretinitis
D.1	4630.PED-12	1412	43	46	Chorioretinitis, codes: 329, 330
D.2	5733....VAR		909	909	Retrolental fibroplasia
D.2	4630.PED-12	1412	43	46	Retrolental fibroplasia, codes: 331, 332
D.3	5734....VAR		910	910	Cataract
D.3	4630.PED-12	1412	43	46	Cataract, codes: 333, 334
D.4	5735....VAR		911	911	Corneal opacity
D.4	4630.PED-12	1412	43	46	Corneal opacity, codes: 335, 336
D.5	5736....VAR		912	912	Microphthalmia
D.5	4630.PED-12	1412	43	46	Microphthalmia, codes: 337, 338
D.6	4630.PED-12	1412	43	46	Aniridia, code: 363
D.6	4630.PED-12	1412	43	46	Anisocoria, code: 343
D.6	4630.PED-12	1412	43	46	Coloboma, code: 346
D.6	4630.PED-12	1412	43	46	Detached retina, code: 348
D.6	4630.PED-12	1412	43	46	Exophthalmos, proptosis, code: 207
D.6	5737....VAR		913	913	Eye conditions, other noninfectious
D.6	4630.PED-12	1412	43	46	Eye conditions, other noninfectious, codes: 339, 340
D.6	4630.PED-12	1412	43	46	Glaucoma, code: 347
D.6	4630.PED-12	1412	43	46	Iris cysts, medullated nerve fibers, pupillary membrane, code: 197
D.6	4630.PED-12	1412	43	46	Megalocornea, code: 198
D.6	4630.PED-12	1412	43	46	Nasolacrimal duct stenosis, code: 345
D.6	4630.PED-12	1412	43	46	Optic atrophy, code: 199
D.6	4630.PED-12	1412	43	46	Ptosis, code: 344
D.6	4630.PED-12	1412	43	46	Pupil, fixed dilated, code: 202
D.6	4630.PED-12	1412	43	46	Removal of eye, surgical, code: 341
D.6	4630.PED-12	1412	43	46	Retinal hemorrhage, code: 200
D.6	4630.PED-12	1412	43	46	Synechia, code: 342
D.6	4630.PED-12	1412	43	46	Wedge defect-superior palpebra, code: 201
F.1	5738....VAR		914	914	Ears low set
F.1	4630.PED-12	1412	43	46	Ears low set, codes: 349, 350
F.2	5739....VAR		915	915	Ear pinna deformed
F.2	4630.PED-12	1412	43	46	Ear pinna deformed, codes: 351, 352
F.3	5740....VAR		916	916	Branchial cleft anomaly
F.3	4630.PED-12	1412	43	46	Branchial cleft anomaly, codes: 353, 354
F.4	5741....VAR		917	917	Ear drum (tympanic membrane) perforated

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ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
F.4	4630.PED-12	1412	43	46	Ear drum: (tympanic membrane) perforated, codes: 355, 356
F.5	4630.PED-12	1412	43	46	Accessory auricle, code: 360
F.5	4630.PED-12	1412	43	46	Auditory canal, external: abnormal, deformed or absent, code: 359
F.5	5742....VAR		918	918	Ear conditions, other noninfectious
F.5	4630.PED-12	1412	43	46	Ear conditions, other noninfectious, codes: 357, 358
F.5	4630.PED-12	1412	43	46	External ear absent-trauma, code: 362
F.5	4630.PED-12	1412	43	46	Preauricular skin tag, code: 361
F.1	5743....VAR		919	919	Cleft palate
F.1	4630.PED-12	1412	43	46	Cleft palate, code: 368
F.2	5744....VAR		920	920	Cleft uvula
F.2	4630.PED-12	1412	43	46	Cleft uvula, code: 370
F.3	5745....VAR		921	921	Cleft lip
F.3	4630.PED-12	1412	43	46	Cleft lip, code: 372
F.4	5746....VAR		922	922	Cleft gum
F.4	4630.PED-12	1412	43	46	Cleft gum, code: 374
F.5	5747....VAR		923	923	Micrognathia
F.5	4630.PED-12	1412	43	46	Micrognathia, codes: 375, 376
F.6	4630.PED-12	1412	43	46	Epiglottis malformation: angulated epiglottis, code: 379
F.6	4630.PED-12	1412	43	46	Epiglottis malformation: laryngeal stridor, code: 380
F.6	4630.PED-12	1412	43	46	Epiglottis malformation: laryngomalacia, code: 382
F.6	5748....VAR		924	924	Epiglottis malformation: larynx malformation
F.6	4630.PED-12	1412	43	46	Epiglottis malformation: larynx malformation, codes: 377, 378
F.6	4630.PED-12	1412	43	46	Epiglottis malformation: tracheomalacia, code: 383
F.7	4630.PED-12	1412	43	46	Delayed, edentulous, no dentition, retarded eruption, code: 387
F.7	5749....VAR		925	925	Teeth, abnormal
F.7	4630.PED-12	1412	43	46	Teeth, abnormal, codes: 385, 386
F.7	4630.PED-12	1412	43	46	Teeth, anomalous shape, malformed, code: 388
F.7	4630.PED-12	1412	43	46	Teeth, extra supernumerary, code: 389
F.7	4630.PED-12	1412	43	46	Teeth, fused, code: 390
F.7	4630.PED-12	1412	43	46	Teeth, hypoplasia of enamel, pitting, code: 391
F.7	4630.PED-12	1412	43	46	Teeth, notched, code: 392
F.8	4630.PED-12	1412	43	46	Abnormality: nasal cartilage, bone, including septum, code: 395
F.8	4630.PED-12	1412	43	46	Choanal atresia, code: 396
F.8	4630.PED-12	1412	43	46	Choanal stenosis, code: 397
F.8	4630.PED-12	1412	43	46	Macroglossia, code: 398
F.8	4630.PED-12	1412	43	46	Respiratory tract, upper and mouth conditions, other, codes: 393, 394
F.8	5750....VAR		926	926	Respiratory tract, upper: mouth conditions, other
F.8	4630.PED-12	1412	43	46	Saddle nose, code: 399
F.8	4630.PED-12	1412	43	46	Thyroglossal duct cyst, code: 400
F.8	4630.PED-12	1412	43	46	Tracheo-esophageal fistulae, code: 401
G.1	5751....VAR		927	927	Diaphragm anomaly
G.1	4630.PED-12	1412	43	46	Diaphragm anomaly, codes: 405, 406

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ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
G.1	4630.PED-12	1412	43	46	Diaphragm, eventration, code: 408
G.1	4630.PED-12	1412	43	46	Diaphragmatic hernia, epigastric hiatus, code: 407
G.1	4630.PED-12	1412	43	46	Hiatal hernia, code: 409
G.2	5752....VAR		928	928	Rib anomaly
G.2	4630.PED-12	1412	43	46	Rib anomaly, codes: 413, 414
G.2	4630.PED-12	1412	43	46	Rib congenital malformation, number or form, code: 415
G.3	5753....VAR		929	929	Pectus excavatum
G.3	4630.PED-12	1412	43	46	Pectus excavatum, codes: 417, 418
G.4	5754....VAR		930	930	Pigeon breast
G.4	4630.PED-12	1412	43	45	Pigeon breast, codes: 419, 420
G.4	4630.PED-12	1412	43	46	Rickets, code: 640
G.4	4630.PED-12	1412	43	46	Salt losing nephropathy, code: 641
G.4	4630.PED-12	1412	43	46	Thelarche, premature, code: 639
G.5	4630.PED-12	1412	43	46	Breast hyperthrophy, code: 473
G.5	5755....VAR		931	931	Thoracic conditions, other
G.5	4630.PED-12	1412	43	46	Thoracic conditions, other, codes: 421, 422
H.1	5756....VAR		932	932	Asthma
H.1	4630.PED-12	1412	43	46	Asthma, codes: 431, 432
H.2	5757....VAR		933	933	Emphysema
H.2	4630.PED-12	1412	43	46	Emphysema, codes: 433, 434
H.3	5758....VAR		934	934	Pneumothorax
H.3	4630.PED-12	1412	43	46	Pneumothorax, codes: 435, 436
H.4	5759....VAR		935	935	Lung anomaly
H.4	4630.PED-12	1412	43	46	Lung anomaly, codes: 437, 438
H.4	4630.PED-12	1412	43	46	Lung, bilobed right, code: 439
H.4	4630.PED-12	1412	43	46	Lung, fusion lobes, code: 440
H.4	4630.PED-12	1412	43	46	Pneumatocele, code: 441
H.4	4630.PED-12	1412	43	46	Pulmonary cyst, code: 442
H.4	4630.PED-12	1412	43	46	Vena cava: thrombosis inferior, code: 444
H.5	4630.PED-12	1412	43	46	Atelectasis, code: 447
H.5	4630.PED-12	1412	43	46	Hydrothorax, code: 450
H.5	4630.PED-12	1412	43	46	Lung: collapsed lobe, code: 448
H.5	4630.PED-12	1412	43	46	Lung: herniation, code: 449
H.5	4630.PED-12	1412	43	46	Pneumomediastinum, code: 451
H.5	5760....VAR		936	936	Respiratory tract abnormality, lower, other noninfectious
H.5	4630.PED-12	1412	43	46	Respiratory tract abnormality, lower, other noninfectious, codes: 445, 446
I.1	5761....VAR		937	937	Cardiovascular disease: congenital: acyanotic
I.1	4630.PED-12	1412	43	46	Cardiovascular disease: congenital: acyanotic, codes: 457, 458
I.2	5762....VAR		938	938	Cardiovascular disease: congenital: cyanotic
I.2	4630.PED-12	1412	43	46	Cardiovascular disease: congenital: cyanotic, codes: 459, 460
I.3	5763....VAR		939	939	Fibroelastosis
I.3	4630.PED-12	1412	43	46	Fibroelastosis, codes: 461, 462

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ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
I.4	5764....VAR		940	940	Cardiac rhythm disorder
I.4	4630.PED-12	1412	43	46	Cardiac rhythm disorder, codes: 461, 464
I.5	5765....VAR		941	941	Cardiac rate disorder
I.5	4630.PED-12	1412	43	46	Cardiac rate disorder, codes: 465, 466
I.6	5766....VAR		942	942	Cardiac enlargement
I.6	4630.PED-12	1412	43	46	Cardiac enlargement, codes: 467, 468
I.7	5767....VAR		943	943	Cardiac decompensation
I.7	4630.PED-12	1412	43	46	Cardiac decompensation, codes: 469, 470
I.8	5768....VAR		944	944	Cardiovascular disease: cyanotic episodes, severe
I.8	4630.PED-12	1412	43	46	Cardiovascular disease: cyanotic episodes, severe, codes: 471, 472
I.9	4630.PED-12	1412	43	46	A-V canal, code: 478
I.9	4630.PED-12	1412	43	46	Aberrant: pulmonary artery, right, code: 428
I.9	4630.PED-12	1412	43	46	Aorta: dextroposition, code: 404
I.9	4630.PED-12	1412	43	46	Aortic arch, double, code: 204
I.9	4630.PED-12	1412	43	46	Aortic arch, right, code: 488
I.9	4630.PED-12	1412	43	46	Aortic stenosis, code: 477
I.9	4630.PED-12	1412	43	46	Aortic valve, bi-valvular, code: 364
I.9	4630.PED-12	1412	43	46	Atrial septal defect, code: 456
I.9	4630.PED-12	1412	43	46	Cardiac arrest, code: 479
I.9	5769....VAR		945	945	Cardiovascular diagnosis, specific
I.9	4630.PED-12	1412	43	46	Cardiovascular diagnosis, specific, code: 474
I.9	4630.PED-12	1412	43	46	Cardiovascular disease: congenital: anomalous origin right subclavian from aortic arch, code: 473
I.9	4630.PED-12	1412	43	46	Cardiovascular diseases and conditions, corrected transposition, code: 485
I.9	4630.PED-12	1412	43	46	Coarctation: aorta, code: 480
I.9	4630.PED-12	1412	43	46	Coarctation: pulmonary artery, right, code: 429
I.9	4630.PED-12	1412	43	46	Common ventricle (tri-loculare biatriatum), code: 486
I.9	4630.PED-12	1412	43	46	Cor biloculare, code: 481
I.9	4630.PED-12	1412	43	46	Dextro cardia, situs inversus, levorotation, code: 489
I.9	4630.PED-12	1412	43	46	Endocardial cushion defect, code: 490
I.9	4630.PED-12	1412	43	46	Hypoplastic: ventricle, right, code: 427
I.9	4630.PED-12	1412	43	46	Mitral valve, congenital blood cysts, code: 430
I.9	4630.PED-12	1412	43	46	Patent ductus, code: 483
I.9	4630.PED-12	1412	43	46	Pulmonary atresia, code: 203
I.9	4630.PED-12	1412	43	46	Pulmonary drainage, anomalous, code: 476
I.9	4630.PED-12	1412	43	46	Pulmonary hypertension, code: 491
I.9	4630.PED-12	1412	43	46	Pulmonary stenosis, code: 487
I.9	4630.PED-12	1412	43	46	Subaortic stenosis, code: 492
I.9	4630.PED-12	1412	43	46	Subtricuspid atresia, code: 365
I.9	4630.PED-12	1412	43	46	Tetralogy of Fallot, code: 412
I.9	4630.PED-12	1412	43	46	Transposition of great vessels, code: 366
I.9	4630.PED-12	1412	43	46	Tricuspid atresia, code: 426

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ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
I.9	4630.PED-12	1412	43	46	Vascular ring, code: 367
I.9	4630.PED-12	1412	43	46	Ventricular hypertrophy, right, code: 41:
I.9	4630.PED-12	1412	43	46	Ventricular septal defect, code: 475
I.10	5770....VAR		946	946	Cardiovascular diseases and conditions, other
I.10	4630.PED-12	1412	43	46	Cardiovascular diseases and conditions, other, codes: 483, 484
J.1	5771....VAR		947	947	Hernia
J.1	4630.PED-12	1412	43	46	Hernia, codes: 491, [illegible]
J.1	4630.PED-12	1412	43	46	Inguinal hernia, code: 495
J.1	4630.PED-12	1412	43	46	Umbilical hernia, code: 496
J.2	5772....VAR		948	948	Volvulus
J.2	4630.PED-12	1412	43	46	Volvulus, codes: 501, 502
J.3	5773....VAR		949	949	Intussusception
J.3	4630.PED-12	1412	43	46	Intussusception, codes: 503, 504
J.4	5774....VAR		950	950	Vomiting, persistent
J.4	4630.PED-12	1412	43	46	Vomiting, persistent, codes: 505, 506
J.5	5775....VAR		951	951	Megacolon
J.5	4630.PED-12	1412	43	46	Megacolon, codes: 507, 508
J.6	5776....VAR		952	952	Pyloric stenosis
J.6	4630.PED-12	1412	43	46	Pyloric stenosis, codes: 509, 510
J.7	5777....VAR		953	953	Visceral perforation
J.7	4630.PED-12	1412	43	46	Visceral perforation, codes: 511, 512
J.8	5778....VAR		954	954	Malrotation
J.8	4630.PED-12	1412	43	46	Malrotation, codes: 513, 514
J.9	5779....VAR		955	955	Intestinal obstruction
J.9	4630.PED-12	1412	43	46	Intestinal obstruction, codes: 515, 516
J.10	5780....VAR		956	956	Chalasia
J.10	4630.PED-12	1412	43	46	Chalasia, codes: 517, 518
J.11	5781....VAR		957	957	Alimentary tract conditions, other noninfectious
J.11	4630.PED-12	1412	43	46	Alimentary tract conditions, other noninfectious, codes: 519, 520
J.11	4630.PED-12	1412	43	46	Cecum, duplication, code: 527
J.11	4630.PED-12	1412	43	46	Colostomy, ileostomy, code: 523
J.11	4630.PED-12	1412	43	46	Duodenal atresia, code: 525
J.11	4630.PED-12	1412	43	46	Duodenal bands: congenital, code: 524
J.11	4630.PED-12	1412	43	46	Duodenal ulcer, code: 526
J.11	4630.PED-12	1412	43	46	Esophageal atresia, code: 529
J.11	4630.PED-12	1412	43	46	Esophageal varices, code: 530
J.11	4630.PED-12	1412	43	46	Gastric perforation, traumatic, code: 545
J.11	4630.PED-12	1412	43	46	Imperforate anus, code: 498
J.11	4630.PED-12	1412	43	46	Meckel's diverticulum, code: 499
J.11	4630.PED-12	1412	43	46	Mesenteric cysts, code: 500
J.11	4630.PED-12	1412	43	46	Necrosis: ilium, or colon, code: 403
J.11	4630.PED-12	1412	43	46	Pancreas, annular, code: 522
J.11	4630.PED-12	1412	43	46	Pancreas, ectopic jejunal, code: 528

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ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
J.11	4630,PED-12	1412	43	46	Pancreatic duct stenosis, code: 548
J.11	4630,PED-12	1412	43	46	Pancreatitis, acute, code: 521
J.11	4630,PED-12	1412	43	46	Rectal fistula, code: 547
J.11	4630,PED-12	1412	43	46	Rectal prolapse, code: 497
J.11	4630,PED-12	1412	43	46	Situs inversus-abdomen, code: 545
K.1	5782....VAR		958	958	Biliary atresia
K.1	4630,PED-12	1412	43	46	Biliary atresia, codes: 531, 532
K.2.a	5783....VAR		959	959	Jaundice acquired, persistent beyond nursery period
K.2.a	4630,PED-12	1412	43	46	Jaundice, persistent beyond nursery period, codes: 533, 534
K.2.b	5784....VAR		960	960	Jaundice acquired after nursery period
K.2.b	4630,PED-12	1412	43	46	Jaundice, acquired after nursery period, codes: 535, 536
K.3	4630,PED-12	1412	43	46	Biliary cirrhosis, code: 540
K.3	4630,PED-12	1412	43	46	Choledochal cyst, code: 541
K.3	5785....VAR		961	961	Liver abnormality; bile duct abnormality; spleen abnormality
K.3	4630,PED-12	1412	43	46	Liver abnormality; bile duct abnormality; spleen abnormality, codes: 537, 538
K.3	4630,PED-12	1412	43	46	Spleen, accessory, code: 539
L.1.a	5786....VAR		962	962	Testicle, undescended unilateral
L.1.a	4630,PED-12	1412	43	46	Testicle, undescended unilateral, codes: 549, 550
L.1.b	5787....VAR		963	963	Testicle, undescended bilateral
L.1.b	4630,PED-12	1412	43	46	Testicle, undescended bilateral, codes: 551, 552
L.2	5788....VAR		964	964	Hypospadias
L.2	4630,PED-12	1412	43	46	Hypospadias, code: 554
L.3	5789....VAR		965	965	Chordee
L.3	4630,PED-12	1412	43	46	Chordee, codes: 555, 556
L.4	4630,PED-12	1412	43	46	Clitoris, enlarged, code: 561
L.4	4630,PED-12	1412	43	46	Epispadias, code: 567
L.4	5790....VAR		966	966	Genitalia, external abnormality, other
L.4	4630,PED-12	1412	43	46	Genitalia, external abnormality, other, codes: 557, 558
L.4	4630,PED-12	1412	43	46	Hydrocolpos, code: 584
L.4	4630,PED-12	1412	43	46	Hymen; imperforate, code: 580
L.4	4630,PED-12	1412	43	46	Labia, fusion or adhesions, code: 571
L.4	4630,PED-12	1412	43	46	Meatal stenosis; urethral meatus stenosis, code: 583
L.4	4630,PED-12	1412	43	46	Penis; hypoplasia, code: 568
L.4	4630,PED-12	1412	43	46	Pseudohermaphroditism, code: 582
L.4	4630,PED-12	1412	43	46	Recto-labial fistula, code: 410
L.4	4630,PED-12	1412	43	46	Scrotum, bifid, code: 559
L.4	4630,PED-12	1412	43	46	Scrotum; hypoplasia, code: 587
L.4	4630,PED-12	1412	43	46	Testicle, infarction and/or gangrene, code: 572
L.4	4630,PED-12	1412	43	46	Testicle; hypoplasia or atrophy, code: 585
L.4	4630,PED-12	1412	43	46	Testicular torsion; epididymus torsion, code: 581
L.4	4630,PED-12	1412	43	46	Testis, constrictive band, right, code: 371
L.4	4630,PED-12	1412	43	46	Urethral meatus, double, code: 560

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L.4	4630.PED-12	1412	43	46	Urogenital sinus, code: 580
L.5	4630.PED-12	1412	43	46	Bladder neck obstruction, code: 565
L.5	5791....VAR		967	967	Bladder outflow/urethral obstruction
L.5	4630.PED-12	1412	43	46	Bladder outflow/urethral obstruction, codes: 563, 564
L.6	4630.PED-12	1412	43	46	Hydronephrosis, code: 574
L.6	4630.PED-12	1412	43	46	Hydroureter, megaloureter, code: 573
L.6	4630.PED-12	1412	43	46	Kidney, surgical removal, code: 587
L.6	4630.PED-12	1412	43	46	Kidney; crossed ectopia, code: 424
L.6	5792....VAR		968	968	Urinary tract obstruction, upper; hydronephrosis; hydroureter
L.6	4630.PED-12	1412	43	46	Urinary tract obstruction, upper; hydronephrosis; hydroureter, codes: 569, 570
L.7	5793....VAR		969	969	Cystic; kidney
L.7	4630.PED-12	1412	43	46	Cystic; kidney, codes: 575, 576
L.8	4630.PED-12	1412	43	46	Absence or hypoplasia of; kidney, code: 171
L.8	4630.PED-12	1412	43	46	Atonic; bladder, code: 169
L.8	4630.PED-12	1412	43	46	Feipinecele, code: 165
L.8	5794....VAR		970	970	Genitourinary conditions, other noninfectious
L.8	4630.PED-12	1412	43	46	Genitourinary conditions, other noninfectious, codes: 577, 578
L.8	4630.PED-12	1412	43	46	Horseshoe; kidney, code: 166
L.8	4630.PED-12	1412	43	46	Kidney, non-functioning upper pole right, ectopic ureter, code: 173
L.8	4630.PED-12	1412	43	46	Ovary or ovaries, cystic, code: 543
L.8	4630.PED-12	1412	43	46	Ovary, fallopian tube, incarcerated, code: 167
L.8	4630.PED-12	1412	43	46	Recto-vaginal fistula, code: 541
L.8	4630.PED-12	1412	43	46	Renal vein, bilateral thrombosis, code: 579
L.8	4630.PED-12	1412	43	46	Renal vein, bilateral; thrombosis, code: 170
L.8	4630.PED-12	1412	43	46	Retention cyst; kidney, code: 168
L.8	4630.PED-12	1412	43	46	Ureter, double, code: 163
L.8	4630.PED-12	1412	43	46	Vagina and uterus, double, code: 164
M.1	4630.PED-12	1412	43	46	Astrocytoma, code: 192
M.1	4630.PED-12	1412	43	46	Bone cyst, code: 193
M.1	4630.PED-12	1412	43	46	Eosinophilic granuloma, code: 599
M.1	4630.PED-12	1412	43	46	Ganglion, code: 194
M.1	4630.PED-12	1412	43	46	Glioma brain, code: 600
M.1	4630.PED-12	1412	43	46	Hemangioma beneath periosteum-forehead, code: 597
M.1	4630.PED-12	1412	43	46	Hemangioma-orbit, code: 598
M.1	4630.PED-12	1412	43	46	Juvenile xanthogranuloma, code: 187
M.1	4630.PED-12	1412	43	46	Leukemia, code: 596
M.1	4630.PED-12	1412	43	46	Lipoma, code: 188
M.1	4630.PED-12	1412	43	46	Liposarcoma, code: 189
M.1	4630.PED-12	1412	43	46	Mediastinal neuroblastoma, code: 190
M.1	4630.PED-12	1412	43	46	Myoepithelial hamartoma ileum, code: 594
M.1	5795....VAR		971	971	Neoplastic disease; tumors, specified

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M.1	4630.PED-12	1412	41	46	Neoplastic disease: tumors, specified, codes: 580, 590
M.1	4630.PED-12	1412	41	46	Retinoblastoma, code: 591
M.1	4630.PED-12	1412	41	46	Subepidermal fibroma, code: 592
M.1	4630.PED-12	1412	41	46	Tumor overlying right upper dental ridge and adjacent palate, codes: 593
M.1	4630.PED-12	1412	41	46	Wilms' tumor, code: 595
M.1	5796....VAR		972	972	Hemoglobinopathy
M.1	4630.PED-12	1412	41	46	Hemoglobinopathy, codes: 601, 602
M.1	4630.PED-12	1412	41	46	Hemoglobinopathy: A-C, code: 603
M.1	4630.PED-12	1412	41	46	Hemoglobinopathy: A-S, code: 604
M.1	4630.PED-12	1412	41	46	Hemoglobinopathy: S-S, code: 605
M.1	4630.PED-12	1412	41	46	Hemoglobinopathy: sickle cell anemia, code: 607
M.1	4630.PED-12	1412	41	46	Hemoglobinopathy: sickle cell disease, code: 608
M.2.a	5797....VAR		973	973	Hemolytic disease: congenital
M.2.a	4630.PED-12	1412	41	46	Hemolytic disease: congenital, codes: 609, 610
M.2.b	5798....VAR		974	974	Hemolytic disease: acquired
M.2.b	4630.PED-12	1412	41	46	Hemolytic disease: acquired, codes: 611, 612
M.3	5799....VAR		975	975	Coagulation defect
M.3	4630.PED-12	1412	41	46	Coagulation defect, codes: 613, 614
M.3	4630.PED-12	1412	41	46	Hemoglobinopathy: sickle cell trait or positive prep, code: 618
M.3	4630.PED-12	1412	41	46	Hemophilia, code: 615
M.3	4630.PED-12	1412	41	46	Hypoprothrombinemia, code: 617
M.3	4630.PED-12	1412	41	46	Thrombocytopenia, code: 616
M.4	5800....VAR		976	976	Hemorrhage, major, specified site
M.4	4630.PED-12	1412	41	46	Hemorrhage, major, specified site, codes: 619, 620
M.5.a(1)	5801....VAR		977	977	Anemia, iron deficiency, hemoglobin less than 5 gm percent
M.5.a(1)	4630.PED-12	1412	41	46	Anemia, iron deficiency, hemoglobin less than 5 gm percent, codes: 627, 628
M.5.a(2)	5802....VAR		978	978	Anemia, other, hemoglobin less than 5 gm percent
M.5.a(2)	4630.PED-12	1412	41	46	Anemia, other, hemoglobin less than 5 gm percent, codes: 629, 630
M.5.b(1)	4630.PED-12	1412	41	46	Anemia, iron deficiency, hemoglobin 5 to 8 gm percent, codes: 635, 636
M.5.b(1)	5803....VAR		979	979	Anemia, iron deficiency, hemoglobin 5 up to 8 gm percent
M.5.b(2)	4630.PED-12	1412	41	46	Anemia, other, hemoglobin 5 to 8 gm percent, codes: 637, 638
M.5.b(2)	5804....VAR		980	980	Anemia, other, hemoglobin 5 up to 8 gm percent
M.6	4630.PED-12	1412	41	46	Granulocytopenia, code: 648
M.6	5805....VAR		981	981	Hematologic conditions, other
M.6	4630.PED-12	1412	41	46	Hematologic conditions, other, codes: 645, 646
M.6	4630.PED-12	1412	41	46	Henoch Schoenlein purpura, code: 647
M.6	4630.PED-12	1412	41	46	Hypogammaglobulinemia, code: 649
M.6	4630.PED-12	1412	41	46	Methemoglobinemia, code: 650
N	5822....VAR		998	998	Failure to thrive
N.1	5806....VAR		982	982	Hemangioma: portwine

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O.1	4630.PED-12	1412	43	46	Hemangioma: portwine, codes: 657, 658
O.2	5807....VAR		983	983	Hemangioma: strawberry
O.2	4630.PED-12	1412	43	46	Hemangioma: strawberry, codes: 659, 660
O.3	5808....VAR		984	984	Hemangioma: cavernous
O.3	4630.PED-12	1412	43	46	Hemangioma: cavernous, codes: 661, 662
O.4	5809....VAR		985	985	Nevus, hairy pigmented
O.4	4630.PED-12	1412	43	46	Nevus, hairy pigmented, codes: 663, 664
O.5	5810....VAR		986	986	Nevus, pigmented
O.5	4630.PED-12	1412	43	46	Nevus, pigmented, codes: 665, 666
O.6	5811....VAR		987	987	Lymphangioma
O.6	4630.PED-12	1412	43	46	Lymphangioma, codes: 667, 668
O.7	5812....VAR		988	988	Cafe au lait spots
O.7	4630.PED-12	1412	43	46	Cafe au lait spots, codes: 669, 670
O.8	5813....VAR		989	989	Eczema
O.8	4630.PED-12	1412	43	46	Eczema, codes: 671, 672
O.9	5814....VAR		990	990	Skin conditions and malformations, other noninfectious
O.9	4630.PED-12	1412	43	46	Skin conditions and malformations, other noninfectious, codes: 673, 674
P.1	5815....VAR		991	991	Mongolism (Down syndrome)
P.1	4630.PED-12	1412	43	46	Mongolism (Down syndrome), codes: 685, 686
P.2	5816....VAR		992	992	Gonadal dysgenesis
P.2	4630.PED-12	1412	43	46	Gonadal dysgenesis, codes: 687, 688
P.3	5817....VAR		993	993	Adrenogenital syndrome
P.3	4630.PED-12	1412	43	46	Adrenogenital syndrome, codes: 689, 690
P.4	5818....VAR		994	994	Marfan syndrome
P.4	4630.PED-12	1412	43	46	Marfan's syndrome, codes: 691, 692
P.5	5819....VAR		995	995	Pierre Robin syndrome
P.5	4630.PED-12	1412	43	46	Pierre Robin syndrome, codes: 693, 694
P.6	5820....VAR		996	996	Spasmus nutans
P.6	4630.PED-12	1412	43	46	Spasmus nutans, codes: 695, 696
P.7	5821....VAR		997	997	Hurler syndrome
P.7	4630.PED-12	1412	43	46	Hurler's syndrome, codes: 697, 698
P.8	4630.PED-12	1412	43	46	Failure to thrive, codes: 699, 700
P.9	4630.PED-12	1412	43	46	Achondroplasia, code: 704
P.9	4630.PED-12	1412	43	46	Battered child-baby, code: 705
P.9	4630.PED-12	1412	43	46	Cleidocranial dysostosis, code: 708
P.9	4630.PED-12	1412	43	46	Congenital rubella [illegible], code: 710
P.9	4630.PED-12	1412	43	46	Cranial facial dyst[illegible], code: 121
P.9	4630.PED-12	1412	43	46	Crib death, code: 7[illegible]
P.9	4630.PED-12	1412	43	46	Familial dysautonomia, code: 711
P.9	4630.PED-12	1412	43	46	Infantile cortical hyperostosis (Caffey's disease), code: 706
P.9	4630.PED-12	1412	43	46	Klinefelter's syndrome, code: 653
P.9	4630.PED-12	1412	43	46	Klippel-Feil syndrome, code: 654

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P.9	4630.PED-12	1417	43	46	Letterer-Siwe disease, code: 655
P.9	4630.PED-12	1417	43	46	Lowe's syndrome, code: 656
P.9	4630.PED-12	1417	43	46	Nail patella syndrome, code: 631
P.9	4630.PED-12	1417	43	46	Neurofibromatosis, code: 632
P.9	4630.PED-12	1417	43	46	Osteogenesis imperfecta, code: 712
P.9	5021....VAR		999	999	Syndromes, other
P.9	4630.PED-12	1417	43	46	Syndromes, other, codes: 701, 713
P.9	4630.PED-12	1417	43	46	Treacher-Collins syndrome, code: 633
P.9	4630.PED-12	1417	43	46	Trisomy 18, code: 707
P.9	4630.PED-12	1417	43	46	Waterhouse-Friderichsen syndrome, code: 634
P.9	4630.PED-12	1417	43	46	Werdnig-Hoffmann syndrome, code: 642
P.9	4630.PED-12	1417	43	46	Wolff-Parkinson-White syndrome, code: 703
P.9	4630.PED-12	1417	43	46	Arachnodactyly, code: 714
Q.1	4630.PED-12	1417	43	46	Cretinism, code: 715
Q.1	5024....VAR		1000	1000	Hypothyroidism
Q.1	4630.PED-12	1417	43	46	Hypothyroidism, codes: 713, 716
Q.2	5025....VAR		1001	1001	Fibrocystic disease of pancreas (cystic fibrosis)
Q.2	4630.PED-12	1417	43	46	Fibrocystic disease of pancreas (cystic fibrosis), codes: 719, 720
Q.3	4630.PED-12	1417	43	46	Albinism, code: 721
Q.3	4630.PED-12	1417	43	46	Cataracts, acidosis, abnormal renal functions, mental retardation, code: 722
Q.3	4630.PED-12	1417	43	46	G6 - P.D. deficiency (glucose 6 phosphate dehydrogenase), code: 724
Q.3	4630.PED-12	1417	43	46	Galactosemia, code: 726
Q.3	4630.PED-12	1417	43	46	Glycogen storage disease, code: 725
Q.3	5026....VAR		1002	1002	Inborn errors of metabolism
Q.3	4630.PED-12	1417	43	46	Inborn errors of metabolism, codes: 721, 727
Q.4	4630.PED-12	1417	43	46	Adrenal hypoplasia, code: 735
Q.4	4630.PED-12	1417	43	46	Diabetes, code: 731
Q.4	5027....VAR		1003	1003	Endocrine diseases, other; metabolic diseases, other
Q.4	4630.PED-12	1417	43	46	Endocrine diseases, other; metabolic diseases, other, codes: 729, 730
Q.4	4630.PED-12	1417	43	46	Hypocalcemia, code: 730
Q.4	4630.PED-12	1417	43	46	Hypocalcemia-hypophosphatemia, code: 732
Q.4	4630.PED-12	1417	43	46	Hypocalcemic tetany, code: 733
Q.4	4630.PED-12	1417	43	46	Metabolic acidosis cause unknown, code: 736
Q.4	4630.PED-12	1417	43	46	Osteoporosis, code: 738
R.1	5028....VAR		1004	1004	Infection and inflammation; septicemia
R.1	4630.PED-12	1417	43	46	Infection and inflammation; septicemia, codes: 739, 740
R.2	5029....VAR		1005	1005	Infection and inflammation; CNS
R.2	4630.PED-12	1417	43	46	Infection and inflammation; CNS, codes: 741, 742
R.3.a	5030....VAR		1006	1006	Infection and inflammation; meningitis, bacterial

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8.2.a	6630.PED-12	1412	41	46	Infection and inflammation: meningitis, bacterial, codes: 743, 744
8.2.b	5831....VAR		1007	1007	Infection and inflammation: meningitis, nonbacterial
8.2.b	6630.PED-12	1412	41	46	Infection and inflammation: meningitis, nonbacterial, codes: 745, 746
8.2.c	5832....VAR		1008	1008	Infection and inflammation: encephalitis
8.2.c	6630.PED-12	1412	41	46	Infection and inflammation: encephalitis, codes: 747, 748
8.2.d	5833....VAR		1009	1009	Infection and inflammation: CNS, other
8.2.d	6630.PED-12	1412	41	46	Infection and inflammation: CNS, other, codes: 749, 750
8.3.a	5834....VAR		1010	1010	Infection and inflammation: pneumonia
8.3.a	6630.PED-12	1412	41	46	Infection and inflammation: pneumonia, codes: 761, 762
8.3.b	5835....VAR		1011	1011	Infection and inflammation: croup, severe
8.3.b	6630.PED-12	1412	41	46	Infection and inflammation: croup, severe, codes: 763, 764
8.3.c	5836....VAR		1012	1012	Infection and inflammation: bronchiolitis
8.3.c	6630.PED-12	1412	41	46	Infection and inflammation: bronchiolitis, codes: 765, 766
8.3.d	5837....VAR		1013	1013	Infection and inflammation: respiratory, other
8.3.d	6630.PED-12	1412	41	46	Infection and inflammation: respiratory, other, codes: 767, 768
8.4	5838....VAR		1014	1014	Infection and inflammation: genitourinary tract
8.4	6630.PED-12	1412	41	46	Infection and inflammation: genitourinary tract, codes: 779, 780
8.5	5839....VAR		1015	1015	Infection and inflammation: bone and joint
8.5	6630.PED-12	1412	41	46	Infection and inflammation: bone and joint, codes: 781, 782
8.6	5840....VAR		1016	1016	Infection and inflammation: heart
8.6	6630.PED-12	1412	41	46	Infection and inflammation: heart, codes: 783, 784
8.7.a	5841....VAR		1017	1017	Infection and inflammation: gastrointestinal, diarrhea requiring hospitalization
8.7.a	6630.PED-12	1412	41	46	Infection and inflammation: gastrointestinal, diarrhea requiring hospitalization, codes: 785, 786
8.7.b	5842....VAR		1018	1018	Infection and inflammation: gastrointestinal, other
8.7.b	6630.PED-12	1412	41	46	Infection and inflammation: gastrointestinal, other, codes: 787, 788
8.8	5843....VAR		1019	1019	Infection and inflammation: liver
8.8	6630.PED-12	1412	41	46	Infection and inflammation: liver, codes: 799, 800
8.9	5844....VAR		1020	1020	Infection and inflammation: eye
8.9	6630.PED-12	1412	41	46	Infection and inflammation: eye, codes: 801, 802
8.10	5845....VAR		1021	1021	Infection and inflammation: ear
8.10	6630.PED-12	1412	41	46	Infection and inflammation: ear, codes: 803, 804
8.11	6630.PED-12	1412	41	46	Infection and inflammation: skin, codes: 805, 806
8.12.a	5847....VAR		1023	1023	Roseola
8.12.a	6630.PED-12	1412	41	46	Roseola, codes: 807, 808
8.12.b	6630.PED-12	1412	41	46	Rubella: German measles, codes: 809, 810
8.12.b	5848....VAR		1024	1024	Rubella: German measles
8.12.c	5849....VAR		1025	1025	Measles
8.12.c	6630.PED-12	1412	41	46	Measles, codes: 811, 812
8.12.d	5850....VAR		1026	1026	Mumps

Form Item Numbers Linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
P.12.d	4630.PED-12	1412	43	46	Measles, codes: 013, 014
P.12.e	5851....VAR		1027	1027	Chickenpox
P.12.e	4630.PED-12	1412	43	46	Chickenpox, codes: 015, 016
P.12.f	5852....VAR		1028	1028	Pertussis: whooping cough
P.12.f	4630.PED-12	1412	43	46	Pertussis: whooping cough, codes: 017, 018
P.12.g	5853....VAR		1029	1029	Childhood diseases, other
P.12.g	4630.PED-12	1412	43	46	Childhood diseases, other, codes: 019, 020
P.13	4630.PED-12	1412	43	46	Infection, unusually recurrent or chronic, codes: 031, 032
P.13	5854....VAR		1030	1030	Infection: unusually recurrent or chronic
P.14	4630.PED-12	1412	43	46	Congenital lues, code: 039
P.14	4630.PED-12	1412	43	46	Cytomegalic inclusion disease, code: 040
P.14	5855....VAR		1031	1031	Infection/inflammation, other
P.14	4630.PED-12	1412	43	46	Infection/inflammation, other, codes: 037, 038
P.14	4630.PED-12	1412	43	46	Liver, laceration, code: 048
P.14	4630.PED-12	1412	43	46	Toxoplasmosis, code: 041
S.1.a	5856....VAR		1032	1032	Head trauma, with unconsciousness
S.1.a	4630.PED-12	1412	43	46	Head trauma, with unconsciousness, codes: 049, 050
S.1.b	5857....VAR		1033	1033	Head trauma: fractured skull
S.1.b	4630.PED-12	1412	43	46	Head trauma: fractured skull, codes: 051, 052
S.1.c	5858....VAR		1034	1034	Head trauma, bloody spinal fluid
S.1.c	4630.PED-12	1412	43	46	Head trauma, bloody spinal fluid, codes: 053, 054
S.1.d	5859....VAR		1035	1035	Head trauma, vomiting three times
S.1.d	4630.PED-12	1412	43	46	Head trauma, vomiting three times, codes: 055, 056
S.1.e	5860....VAR		1036	1036	Head trauma, subgaleal hematoma
S.1.e	4630.PED-12	1412	43	46	Head trauma, subgaleal hematoma, codes: 057, 058
S.2	4630.PED-12	1412	43	46	Sprained: knee, code: 031
S.2	4630.PED-12	1412	43	46	Dislocated: knee, code: 121
S.2	4630.PED-12	1412	43	46	Fractures: vertebra, code: 062
S.2	5861....VAR		1037	1037	Fractures, other
S.2	4630.PED-12	1412	43	46	Fractures, other, codes: 059, 060
S.2	4630.PED-12	1412	43	46	Fractures: clavicle, code: 064
S.2	4630.PED-12	1412	43	46	Fractures: dislocation: elbow, code: 065
S.2	4630.PED-12	1412	43	46	Fractures: dislocation: hip, code: 066
S.2	4630.PED-12	1412	43	46	Fractures: dislocation: shoulder, code: 067
S.2	4630.PED-12	1412	43	46	Fractures: finger, code: 062
S.2	4630.PED-12	1412	43	46	Fractures: humerus, radius, ulna, arm, code: 061
S.2	4630.PED-12	1412	43	46	Fractures: leg, femur, tibia, fibula, code: 063
S.2	4630.PED-12	1412	43	46	Fractures: pelvis, code: 068
S.2	4630.PED-12	1412	43	46	Fractures: rib or ribs, code: 069
S.2	4630.PED-12	1412	43	46	Fractures: torn cartilage: left elbow, code: 070
S.2	4630.PED-12	1412	43	46	Subluxation-thumb, code: 028
S.3	5867....VAR		1038	1038	Burns, infant hospitalized
S.3	4630.PED-12	1412	43	46	Burns, infant hospitalized, codes: 011, 012

Form Item Numbers linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
S.4.a	5863....VAR		1039	1039	Symptomatic intoxication: salicylate
S.4.a	4630,PED-12	1412	43	46	Symptomatic intoxication: salicylate, codes: 883, 884
S.4.b.(1)	5864....VAR		1040	1040	Symptomatic intoxication: hydrocarbon, kerosene
S.4.b.(1)	4630,PED-12	1412	43	46	Symptomatic intoxication: hydrocarbon, kerosene, codes: 885, 886
S.4.b(2)	4630,PED-12	1412	43	46	Symptomatic intoxication: hydrocarbon, camphor oil, code: 891
S.4.b(2)	4630,PED-12	1412	43	46	Symptomatic intoxication: hydrocarbon, furniture polish, code: 890
S.4.b(2)	4630,PED-12	1412	43	46	Symptomatic intoxication: hydrocarbon, O'Cedar furniture polish, codes: 889
S.4.b(2)	5865....VAR		1041	1041	Symptomatic intoxication: hydrocarbon, other
S.4.b(2)	4630,PED-12	1412	43	46	Symptomatic intoxication: hydrocarbon, other, codes: 887, 888
S.4.c	5866....VAR		1042	1042	Symptomatic intoxication: lead, other
S.4.c	4630,PED-12	1412	43	46	Symptomatic intoxication: lead, other, codes: 893, 894
S.4.d	5867....VAR		1043	1043	Symptomatic intoxication, other
S.4.d	4630,PED-12	1412	43	46	Symptomatic intoxication, other, codes: 895, 896
S.4.d	4630,PED-12	1412	43	46	Symptomatic intoxication: carbon monoxide, code: 897
T.1	5868....VAR		1044	1044	Shock, requiring hospitalization
T.1	4630,PED-12	1412	43	46	Shock, requiring hospitalization, codes: 901, 902
T.2	5869....VAR		1045	1045	Dehydration, requiring parenteral fluid therapy
T.2	4630,PED-12	1412	43	46	Dehydration, requiring parenteral fluid therapy, codes: 903, 904
T.3	5870....VAR		1046	1046	Electrolyte imbalance
T.3	4630,PED-12	1412	43	46	Electrolyte imbalance, codes: 905, 906
T.4	5871....VAR		1047	1047	Hyperthermia, 106 F or over
T.4	4630,PED-12	1412	43	46	Hyperthermia, 106 F or over, codes: 911, 912
T.5	5872....VAR		1048	1048	Hypothermia, below 94 F
T.5	4630,PED-12	1412	43	46	Hypothermia, below 94 F, codes: 913, 914
T.6.a	5873....VAR		1049	1049	Hypoxia episode with unconsciousness
T.6.a	4630,PED-12	1412	43	46	Hypoxia episode with unconsciousness, codes: 915, 916
T.6.b	5874....VAR		1050	1050	Hypoxia episode without unconsciousness
T.6.b	4630,PED-12	1412	43	46	Hypoxia episode without unconsciousness, codes: 917, 918
T.7	4630,PED-12	1412	43	46	Drowning, code: 921
T.7	4630,PED-12	1412	43	46	Homeostasis, other disturbances, codes: 919, 920
T.7	4630,PED-12	1412	43	46	Intracranial pressure, increased, code: 922
T.7	4630,PED-12	1412	43	46	Respiratory arrest, code: 923
U.1-4	5876....VAR		1052	1052	Diseases and conditions, other specified
U.1-4	4630,PED-12	1412	43	46	Diseases and conditions, other specified, codes: 929, 930
V.1	5877....VAR		1053	1053	Blood transfusions
V.1	4630,PED-12	1412	43	46	Blood transfusions, codes: 941, 942
V.2	5878....VAR		1054	1054	Fluid administration: parenteral
V.2	4630,PED-12	1412	43	46	Fluid administration: parenteral, codes: 943, 944
V.3	5879....VAR		1055	1055	Spinal puncture
V.3	4630,PED-12	1412	43	46	Spinal puncture, codes: 945, 946
V.4	5880....VAR		1056	1056	Subdural puncture
V.4	4630,PED-12	1412	43	46	Subdural puncture, codes: 947, 948

Form Item Numbers Linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
V.5	5881....VAR		1057	1057	Ventricular puncture
V.5	4630.PED-12	1412	43	46	Ventricular puncture, codes: 949, 950
V.6	5882....VAR		1058	1058	Anesthesia, general
V.6	4630.PED-12	1412	43	46	Anesthesia, general, codes: 951, 952
V.7	5883....VAR		1059	1059	Surgery
V.7	4630.PED-12	1412	43	46	Surgery, codes: 953, 954
V.8	5884....VAR		1060	1060	Chromosome studies
V.8	4630.PED-12	1412	43	46	Chromosome studies, codes: 965, 966
V.9	5885....VAR		1061	1061	Electroencephalography (EEG)
V.9	4630.PED-12	1412	43	46	Electroencephalography (EEG), codes: 967, 968
V.10	5886....VAR		1062	1062	Procedures, other
V.10	4630.PED-12	1412	43	46	Procedures, other, codes: 969, 970
W.1	5887....VAR		1063	1063	Social/environmental conditions, loss of one or both parents or parent surrogate
W.1	4630.PED-12	1412	43	46	Social/environmental conditions: parents or parent surrogate, loss of one or both, codes: 981, 982
W.2	5888....VAR		1064	1064	Social/environmental conditions: foster home
W.2	4630.PED-12	1412	43	46	Social/environmental conditions: foster home, codes: 983, 984
W.3	5889....VAR		1065	1065	Social/environmental conditions unfavorable emotional environment
W.3	4630.PED-12	1412	43	46	Social/environmental conditions: emotional environment, unfavorable, codes: 985, 986
W.4	5890....VAR		1066	1066	Social/environmental conditions: hospitalization prolonged or recurrent
W.4	4630.PED-12	1412	43	46	Social/environmental conditions: hospitalization prolonged or recurrent, codes: 987, 988
W.5	5891....VAR		1067	1067	Social/environmental conditions, other
W.5	4630.PED-12	1412	43	46	Social/environmental conditions, other, codes: 989, 990
6	4604.PED-12	1412	15	16	Information source
9	4605.PED-12	1412	17	17	Behaviour information (A.16) or: social/environmental information (d), inadequate
11	4615.PED-12	1412	27	27	Alimentary tract conditions: summary, number
11	4614.PED-12	1412	26	26	Cardiovascular conditions: summary, number
11	4607.PED-12	1412	19	19	CNS condition: skeletal conditions: summary, number
11	4610.PED-12	1412	22	22	Ear conditions: summary, number
11	4622.PED-12	1412	34	34	Endocrine diseases; metabolic disease: summary, number
11	4609.PED-12	1412	21	21	Eye conditions: summary, number
11	4617.PED-12	1412	29	29	Genitourinary conditions: summary, number
11	4619.PED-12	1412	31	31	Hematologic conditions: summary, number
11	4625.PED-12	1412	37	37	Homeostasis disturbance: summary, number
11	4623.PED-12	1412	35	35	Infection; inflammation: summary, number
11	4616.PED-12	1412	28	28	Liver abnormality: bile duct abnormality; spleen abnormality: summary, number
11	4626.PED-12	1412	38	38	Medical conditions, other: summary, number

Form Item Numbers Linked to Data Items on PED-12, Summary of 1st Year of Life After Duration Summarized on PED-8

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
11	4611.PED-12	1412	23	23	Mouth conditions; Respiratory tract, upper, conditions; summary, number
11	4608.PED-12	1412	20	20	Musculoskeletal abnormality; summary, number
11	4618.PED-12	1412	30	30	Neoplastic diseases; tumors; summary, number
11	4606.PED-12	1412	18	18	Neurologic abnormality; summary, number
11	5639....VAR		915	915	PED-12: switch, data availability, any info in variable file locations 1068-1090, 1=no, 2=yes
11	4627.PED-12	1412	39	39	Procedures; summary, number
11	4613.PED-12	1412	25	25	Respiratory tract, lower, abnormality; summary, number
11	4620.PED-12	1412	32	32	Skin; malformations and conditions; summary, number
11	4628.PED-12	1412	40	40	Social conditions; environmental conditions, summary, number
11	4621.PED-12	1412	33	33	Syndromes; summary, number
11	4612.PED-12	1412	24	24	Thoracic conditions; summary, number
11	4624.PED-12	1412	36	36	Trauma; physical agents; toxicosis; summary, number
11.A	5892....VAR		1068	1068	Neurologic abnormality, number of, PED-12 sect A
11.B	5893....VAR		1069	1069	Central nervous system conditions; skeletal conditions, number of, PED-12 sect B
11.C	5894....VAR		1070	1070	Musculoskeletal abnormality, number of, PED-12 sect C
11.D	5895....VAR		1071	1071	Eye conditions, number of, PED-12 sect D
11.E	5896....VAR		1072	1072	Ear conditions, number of, PED-12 sect E
11.F	5897....VAR		1073	1073	Oral conditions; respiratory tract, upper, conditions, number of, PED-12 sect F
11.G	5898....VAR		1074	1074	Thoracic conditions, number of, PED-12 sect G
11.H	5899....VAR		1075	1075	Respiratory tract abnormality, lower, number of, PED-12 sect H
11.I	5900....VAR		1076	1076	Cardiovascular conditions, number of, PED-12 sect I
11.J	5901....VAR		1077	1077	Alimentary tract conditions, number of, PED-12 sect J
11.K	5902....VAR		1078	1078	Liver abnormality; bile duct abnormality; spleen abnormality, number of, PED-12 sect K
11.L	5903....VAR		1079	1079	Genitourinary conditions, number of, PED-12 sect L
11.M	5904....VAR		1080	1080	Neoplastic diseases; tumors, number of, PED-12 sect M
11.N	5905....VAR		1081	1081	Hematologic conditions, number of, PED-12 sect N
11.O	5906....VAR		1082	1082	Skin conditions and malformations, number of, PED-12 sect O
11.P	5907....VAR		1083	1083	Syndromes, number of, PED-12 sect P
11.Q	5908....VAR		1084	1084	Endocrine diseases; metabolic diseases, number of, PED-12 sect Q
11.R	5909....VAR		1085	1085	Infection; inflammation, number of, PED-12 sect R
11.S	5910....VAR		1086	1086	Trauma; physical agents; toxicoses, number of, PED-12 sect S
11.T	5911....VAR		1087	1087	Homeostasis, disturbances, number of, PED-12 sect T
11.U	5912....VAR		1088	1088	Diseases and conditions, other, number of, PED-12 sect U
11.V	5913....VAR		1089	1089	Procedures, number of, PED-12 sect V
11.W	5914....VAR		1090	1090	Social/environmental conditions, number of, PED-12 sect W

DEFINITION OF CODES
SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE
DURATION SUMMARIZED ON THE PED-8
FORM PED-12 CARD 14120

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 412	2-4
3.	Revision Number Code: 0 - Form Dated: 6/63	5
4.	NINDB Number Nine-digit number for Patient Identification Code: As given	6-14
5.	Information Sources Item 6 Two-digit code for: Source: PED-10, PED-11 (col. 15) Code: 0 - Neither PED-10 nor PED-11 1 - PED-10 only 2 - PED-11 only 3 - Combination of codes 1 and 2 Source: PS-3, PED-20, PED-29 (col. 16) Code: 0 - Neither PS-3, PED-20 nor PED-29 1 - PS-3 only 2 - PED-20 only 3 - PED-29 only 4 - Combination of codes 1 and 2 5 - Combination of codes 1 and 3 6 - Combination of codes 2 and 3 7 - Combination of codes 1, 2 and 3	15-16
6.	Information Inadequate on Categories A-16 and/or W Item 9 Code: 0 - Information adequate for both 1 - A-16 (A-typical behavior) only 2 - W (Social and environmental conditions) only 3 - Combination of codes 1 and 2	17

FIELD		CARD COLUMN
7.	Summary Data: Number of Conditions Reported Item 11	18-42

Twenty-five digit code for:

Neurologic Abnormality	(col. 18)
Related CNS and Skeletal Conditions	(col. 19)
Musculoskeletal Abnormality	(col. 20)
Eye Conditions	(col. 21)
Ear Conditions	(col. 22)
Upper Respiratory Tract and Mouth Conditions	(col. 23)
Thoracic Conditions	(col. 24)
Lower Respiratory Tract Abnormality	(col. 25)
Cardiovascular Conditions	(col. 26)
Alimentary Tract Conditions	(col. 27)
Abnormality of Liver, Bile Ducts and/or Spleen	(col. 28)
Genitourinary Conditions	(col. 29)
Neoplastic Disease and/or other Tumors	(col. 30)
Hematologic Conditions	(col. 31)
Skin Conditions and Malformations	(col. 32)
Syndromes	(col. 33)
Other Endocrine and Metabolic Disease	(col. 34)
Infection and Inflammation	(col. 35)
Trauma, Physical Agents and Intoxication	(col. 36)
Disturbances in Homeostasis	(col. 37)
Other Conditions	(col. 38)
Procedures	(col. 39)
Social and Environmental Conditions	(col. 40)

Code for each column:
- 0 - None
- 1-8 - As given
- 9 - 9 or more

Total Number of Conditions Reported (cols. 41-42)

Code: 00 - None
01-97 - As given
98 - 98 or more

Note: 0's in entire field = no conditions reported*

FIELD		CARD COLUMN
8.	First Condition	43-46

Four-digit code for:

Condition (cols. 43-45)
Code: See attachment "Conditions"

Source (col. 46)
Code: 1 - PED-11 only
2 - Prior exam or PED-29
3 - Combination of codes 1 and 2
4 - History only

* Card ends in col. 42

FIELD		CARD COLUMN
9.	Second Through Ninth Condition Code: Same as in Field 3 if needed	47-78

Note: Card 2 required if 10-18 diagnoses reported. Codes same as card 1 except card col. 1 is "2".

Card 3 required if 19-27 diagnoses reported. Codes same as card 1 except card col. 1 is "3".

Card 4 required if 28-36 diagnosis reported. Codes same as card 1 except card col. 1 is "4".

Card 5 required if 37-45 diagnosis reported. Codes same as card 1 except card col. 1 is "5".

CONDITIONS

CODE*	NAME
Neurologic Abnormality	
Cerebral Spastic Paresis	
001,002	Hemi-right
003,004	Hemi-left
005,006	Tetra
007,008	Para
009,010	Other
015,016	Hypotonia with deep tendon reflexes
017,018	Hypotonia without deep tendon reflexes
019,020	Dyskinesia
021,022	Ataxia
023,024	Other motor disorders
031,032	Delayed development - motor
033,034	Delayed development - mental
035,036	Regression in motor activity
037,038	Cord disease - spastic
039,040	Cord disease - flaccid
Visual Impairment	
041,042	Total, bilateral, ocular
043,044	Total, bilateral, non-ocular
045,046	Total, unilateral, ocular
047,048	Total, unilateral, non-ocular
049,050	Partial, bilateral, ocular
051,052	Partial, bilateral, non-ocular
053,054	Partial, unilateral, ocular
055,056	Partial, unilateral, non-ocular
Extra Ocular Movements	
057,058	Esotropia, unilateral
059,060	Esotropia, bilateral
061,062	Alternating internal strabismus
063,064	Exotropia, unilateral
065,066	Exotropia, bilateral
067,068	Alternating external strabismus
069,070	Other
Nystagmus	
077,078	Involvement, unilateral
079,080	Involvement, unilateral with gaze only
081,082	Involvement, bilateral
083,084	Involvement, bilateral with gaze only
085,086	Character, pendular
087,088	Character, jerky
089,090	Direction, horizontal
091,092	Direction, vertical
093,094	Direction, rotatory
095,096	Other
101,102	Cranial nerve abnormality - facial
103,104	Cranial nerve abnormality - other
113,114	Hearing impairment
115,116	Peripheral nerve abnormality - brachial plexus
117,118	Peripheral nerve abnormality - other
Seizure States	
129,130	Generalized - only with fever and less than 15 min. duration
131,132	Generalized, other
133,134	Focal motor
135,136	Infantile myoclonic seizures
137,138	Other
Atypical Behavior	
149,150	Maladaptive response
151,152	Failure to develop social response
153,154	Failure to form rhythmic patterns
155,156	Disruption of rhythmic pattern
157,158	Regression in behavior
159,160	Stereotyped behavior
161,162	Abnormalities of behavior control
173,174	Breath holding with unconsciousness
175,176	Breath holding without unconsciousness
177,178	Hyper-reactivity to sensory stimuli
179,180	Apathy
181,182	Phobia
183,184	Pica, paint or plaster
185,186	Pica, other

* Odd number codes indicate suspect condition; even number codes indicate definite condition

CONDITIONS (Continued)

CODE*	NAME
	Atypical Behavior (cont.)
195,196	Other atypical behavior
205,206	Coma
215,216	Other neurologic abnormality

Related Central Nervous System and Skeletal Conditions

CODE*	NAME
225,226	Macrocephaly
227,228	Microcephaly
229,230	Hydranencephaly
231,232	Hydrocephaly
243,244	Craniosynostosis
249,250	Other abnormal shape of skull
255,256	Porencephaly
257,258	Encephalocele
259,260	Meningomyelocele/Meningocele
261,262	Pilonidal sinus
263,264	Other midline sinuses
269,270	Subdural hematoma or effusion
~~271,272~~	~~Other intracranial hemorrhage~~
279,280	Other

Musculoskeletal Abnormality

CODE*	NAME
291,292	Vertebral abnormality
293,294	Talipes equinovarus
295,296	Metatarsus adductus
297,298	Talipes calcaneovalgus
299,300	Congenital dislocation or displasia of hip
301,302	Absence or hypoplasia of extremity or part
310	Polydactyly
312	Syndactyly
313,314	Torticollis
315,316	Arthrogryposis multiplex
317,318	Other, non-infectious

Eye Conditions

CODE*	NAME
329,330	Chorio-retinitis
331,332	Retrolental fibroplasia
333,334	Cataract
335,336	Corneal opacity
337,338	Microphthalmia
339,340	Other, non-infectious

Ear Conditions

CODE*	NAME
349,350	Low set ears
351,352	Deformed ear pinna
353,354	Branchial cleft anomaly
355,356	Perforated ear drum
357,358	Other, non-infectious

Upper Respiratory Tract and Mouth Conditions

CODE*	NAME
368	Cleft palate
370	Cleft uvula
372	Cleft lip
374	Cleft gum
375,376	Micrognathia
377,378	Malformation of the epiglottis and larynx
385,386	Abnormality of teeth
393,394	Other, non-infectious

Thoracic Conditions

CODE*	NAME
405,406	Anomaly of diaphragm
413,414	Anomaly of ribs
417,418	Pectus excavatum
419,420	Pigeon breast
421,422	Other

Lower Respiratory Tract Abnormality

CODE*	NAME
431,432	Asthma
433,434	Emphysema
435,436	Pneumothorax
437,438	Anomaly of lung
445,446	Other, non-infectious

Cardiovascular Conditions

CODE*	NAME
457,458	Acyanotic CHD
459,460	Cyanotic CHD
461,462	Fibroelastosis
463,464	Disorders of rhythm
465,466	Disorders of rate
467,468	Cardiac enlargement
469,470	Decompensation

* Odd number codes indicate suspect condition; even number codes indicate definite condition

CONDITIONS (Continued)

CODE*	NAME
	Cardiovascular Conditions (cont.)
471,472	Severe cyanotic episodes
474	Specific C-V diagnosis
483,484	Other
	Alimentary Tract Conditions
493,494	Hernia
501,502	Volvulus
503,504	Intussusception
505,506	Persistent vomiting
507,508	Megacolon
509,510	Pyloric stenosis
511,512	Visceral perforation
513,514	Malrotation
515,516	Intestinal obstruction
517,518	Chalasia
519,520	Other, non-infectious
	Abnormality of Liver, Bile Ducts, and/or Spleen
531,532	Biliary atresia
533,534	Jaundice, persistent beyond duration
535,536	Jaundice, acquired after duration
537,538	Other, non-infectious
	Genitourinary Conditions
549,550	Undescended testicle, unilateral
551,552	Undescended testicle, bilateral
554	Hypospadias
555,556	Chordee
557,558	Other abnormality of external genitalia
563,564	Bladder outflow or urethral obstruction
569,570	Upper tract obstruction, hydronephrosis or hydroureter
575,576	Cystic kidney
577,578	Other, non-infectious
	Neoplastic Disease and/or Other Tumors
589,590	Neoplastic disease and/or other tumors

CODE*	NAME
	Hematologic Conditions
601,602	Hemoglobinopathy
609,610	Hemolytic disease, congenital
611,612	Hemolytic disease, acquired
613,614	Coagulation defect
619,620	Major hemorrhage
	Anemia, less than 5 gm. %
627,628	Iron deficiency
629,630	Other
	Anemia, 5 to 8 gm. %
635,636	Iron deficiency
637,638	Other
645,646	Other hematologic conditions
	Skin Conditions and Malformations
657,658	Portwine hemangioma
659,660	Strawberry hemangioma
661,662	Cavernous hemangioma
663,664	Hairy pigmented nevus
665,666	Pigmented nevus
667,668	Lymphangioma
669,670	Café au lait spots
671,672	Eczema
673,674	Other, non-infectious
	Syndromes
685,686	Mongolism
687,688	Gonadal dysgenesis
689,690	Adrenogenital
691,692	Marfan's
693,694	Pierre Robin
695,696	Spasmus nutans
697,698	Hurler's
699,700	Failure to thrive
701,702	Other
	Other Endocrine and Metabolic Disease
713,714	Hypothyroidism
719,720	Fibrocystic disease of pancreas
721,722	Inborn errors of metabolism
729,730	Other

* Odd number codes indicate suspect condition: even number codes indicate definite condition

CONDITIONS (Continued)

CODES*	NAME
Infection and Inflammation	
739,740	Septicemia
741,742	Central nervous system
743,744	Bacterial meningitis
745,746	Non-bacterial meningitis
747,748	Encephalitis
749,750	Other CNS
Respiratory	
761,762	Pneumonia
763,764	Severe croup
765,766	Bronchiolitis
767,768	Other respiratory
779,780	Genitourinary tract
781,782	Bone and joint
783,784	Heart
785,786	Gastrointestinal, diarrhea requiring hospitalization
787,788	Other GI
799,800	Liver
801,802	Eye
803,804	Ear
805,806	Skin
Specific Childhood Diseases	
807,808	Roseola
809,810	German measles
811,812	Measles
813,814	Mumps
815,816	Chickenpox
817,818	Whooping cough
819,820	Other
831,832	Unusually recurrent or chronic infections
837,838	Other
Trauma, Physical Agents and Intoxication	
Head Trauma	
849,850	Unconsciousness
851,852	Fractured skull
853,854	Bloody spinal fluid
855,856	Vomiting - 3 times
857,858	Subgaleal hematoma

CODES*	NAME
859,860	Fractures, other
871,872	Burns leading to hospitalization
Symptomatic Intoxication	
883,884	Salicylate
885,886	Hydrocarbon, kerosene
887,888	Hydrocarbon, other
893,894	Lead
895,896	Other
Disturbances in Homeostasis	
901,902	Shock requiring hospitalization
903,904	Dehydration requiring parenteral fluid therapy
905,906	Electrolyte imbalance
911,912	Hyperthermia, 106°F or over
913,914	Hypothermia, below 94°F
915,916	Episode of "Hypoxia" with unconsciousness
917,918	Episode of "Hypoxia" without unconsciousness
919,920	Other
929,930	Other conditions
Procedures	
941,942	Blood transfusions
943,944	Parenteral fluid
945,946	Spinal puncture
947,948	Subdural puncture
949,950	Ventricular puncture
951,952	General anesthesia
953,954	Surgery
965,966	Chromosome studies
967,968	EEG
969,970	Other
Social and Environmental Conditions	
981,982	Loss of one or both parents or parent surrogate

* Odd number codes indicate suspect condition; even number codes indicate definite condition

CONDITIONS (Continued)

CODES*	NAME
Social and Environmental Conditions (cont.)	
983,984	Foster home
985,986	Unfavorable emotional environment
987,988	Prolonged or recurrent hospitalization
989,990	Other

* Odd number codes indicate suspect condition; even number codes indicate definite condition

CONDITIONS (continued)

Additional Codes for Other Specific Conditions

CODES*	NAME
	Neurologic Abnormality
	Cerebral Spastic Paresis
011	Monoplegia - spastic
012	Spastic upper extremities
	Other Motor Disorders
025	Atrophic and flaccid monoplegia
026	Flaccid paralysis from wrist down
	Nystagmus
097	Bilateral roving or wandering nystagmus
098	Nystagmus type unspecified
099	Central
	Peripheral Nerve Abnormality
119	Foot Drop
	Other
217	Anoxic brain damage
218	Cranium bifidum
219	Episode apnea c̄ cyanosis
220	Glycogenesis of neurons pons, medulla, horn cells ant.
221	Pseudo-tumor cerebri
222	Cerebral thrombosis
223	Severe CNS damage, etiology unknown
	Related Central Nervous System and Skeletal Conditions
281	Bony defect skull
282	Cerebral sinus thrombosis
283	Platybasia
	Musculoskeletal Abnormality
	Absence or hypoplasia of extremity or part
284	Tibia
285	Fibula
286	Forearm
287	Humerus
288	Radius
289	Ulna
290	Rib or ribs
303	Pectoralis major
304	Hand
305	Finger or fingers
306	Foot
307	Toe or toes
308	Lower extremity
309	Upper Extremity
311	Femur
319	Ribs and Spine
320	Phocomelia
321	Hemimelia
322	Hemivertebrae
323	Mandible
324	Talus
	Other non-infectious
013	Streeter's Dysplasia
014	Equinovalgus
120	Abnormal fingers or thumbs or toes
122	Congenital contracture hamstrings
124	Contracture of toes, or finger, or fingers, or thumb
125	Constrictive bands above ankle
126	Coxa valga
127	Coxa vara
233	Clinodactyly
234	Abduction feet or forefoot
235	Abduction hip c̄ contracture
236	Abnormal shape and implantation toes
237	Adduction, or contracture, or tightness hip
238	Adduction heel
239	Bilateral vertical tali
240	Congenital adduction wrists & abnormal thumbs
241	Calcaneous varus
242	Congenital ankylosis elbow c̄ dislocation head radius & abnormal hand
245	Bilateral claw thumb
326	Scoliosis, Lordosis, Kyphosis
452	Cavus deformity feet, TALIPES CAVUS
652	Hypertrophy extremity
727	Contractures elbows or knees or extremity
728	Hemihypertrophy
880	Talipes varus
881	Talipes valgus
882	Webbed neck
	Eye Conditions
197	Iris cysts, medullated nerve fibers, pupillary membrane

* All conditions are definite.

Additional Codes for Other Specific Conditions*

CODES*	NAME
Eye Conditions (Continued)	
198	Megalocornea
199	Optic atrophy
200	Retinal hemorrhage
201	Wedge defect - superior palpebra
202	Fixed dilated pupil
207	Exophthalmos, proptosis
341	Removal of eye, surgical
342	Synechia
343	Anisocoria
344	Ptosis
345	Nasolacrimal duct stenosis
346	Coloboma
347	Glaucoma
348	Detached retina
363	Aniridia
Ear Conditions	
359	Abnormal external auditory canal, deformed or absent
360	Accessory auricle
361	Preauricular skin tag
362	External ear absent - trauma
Upper Respiratory Tract and Mouth Conditions	
Abnormalities of Teeth	
387	Delayed, edentulous, no dentition, retarded eruption
388	Anomalous shape, malformed
389	Extra teeth, supernumerary
390	Fused
391	Hypoplasia of enamel, pitting
392	Notched
Other Non-infectious	
379	Angulated epiglottis
380	Laryngeal stridor
382	Laryngomalacia
383	Tracheomalacia
395	Abnormality nasal cartilage, bone, including septum
396	Choanal atresia
397	Choanal stenosis
398	Macroglossia
399	Saddle nose
400	Thyroglossal duct cyst
401	Tracheo-esophageal fistulae
Thoracic Conditions	
Anomaly of Diaphragm	
407	Diaphragmatic hernia, epigastric hiatus
408	Eventration diaphragm
409	Hiatal hernia

CODES*	NAME
Thoracic Conditions (Continued)	
Anomaly of Ribs	
415	Congenital malformation, rib number or form
Other	
422	Breast hyperthrophy
Lower Respiratory Tract Abnormality	
Anomaly of Lung	
439	Bilobed right lung
440	Fusion lobes
441	Pneumatocele
442	Pulmonary cyst
Other Non-infectious	
447	Atelectasis
448	Collapsed lobe
449	Herniation lung
450	Hydrothorax
451	Pneumomediastinum
Cardiovascular Conditions	
Specific C-V Diagnosis	
203	Pulmonary atresia
204	Double aortic arch
364	Bi-valvular aortic valve
365	Subtricuspid atresia
366	Transposition of great vessels
367	Vascular ring
404	Dextroposition aorta
411	Right ventricular hypertrophy
412	Tetralogy of Fallot
426	Tricuspid atresia
427	Hypoplastic right ventricle
428	Aberrant right pulmonary artery
429	Coarctation right pulmonary artery
430	Congenital blood custs of the mitral valve
444	Thrombosis inferior vena cava
456	Atrial septal defect
473	Anomalous origin right subclavian from aortic arch
475	Ventricular septal defect
476	Anomalous pulmonary drainage
477	Aortic stenosis
478	A - V canal
479	Cardiac arrest
480	Coarctation aorta

* All conditions are definite.

Additional Codes for Other Specific Conditions*

CODES*	NAME
	Cardiovascular Conditions (Continued)
	Specific C-V Diagnosis (Continued)
[illegible]	Cor biloculare
[illegible]	Patent ductus
[illegible]	Corrected transposition
[illegible]	Common Ventricle (tri-loculare biatriatum)
[illegible]	Pulmonary stenosis
[illegible]	Right Aortic Arch
[illegible]	Dextro cardia, situs inversus, levorotation
[illegible]	Endocardial cushion defect
[illegible]	Pulmonary hypertension
[illegible]	Subaortic stenosis
	Alimentary Tract Conditions
	Hernia
[illegible]	Inguinal
[illegible]	Umbilical
	Other Non-infectious
[illegible]	Necrosis of ilium, or colon
[illegible]	Rectal prolapse
[illegible]	Imperforate anus
[illegible]	Meckel's Diverticulum
520	Mesenteric cysts
521	Acute pancreatitis
522	Annular pancreas
523	Colostomy, ileostomy
524	Congenital duodenal bands
525	Duodenal Atresia
526	Duodenal ulcers
527	Duplication cecum
528	Ectopic jejunal pancrea.
529	Esophageal atresia
530	Esophageal varices
[illegible]	Traumatic gastric perforation
[illegible]	Situs inversus - abdomen
[illegible]	Rectal fistula
[illegible]	Pancreatic duct stenosis
	Abnormality of Liver, Bile Ducts, and/or Spleen
	Other Non-infectious
[illegible]	Accessory spleen
[illegible]	Biliary cirrhosis
[illegible]	Choledochal cyst
[illegible]	Laceration liver

CODES*	NAME
	Genitourinary Conditions
	Other Abnormality of External Genitalia
[illegible]	Constrictive band right testis
410	Recto-labial fistula
559	Bifid scrotum
560	Double urethral meatus
561	Enlarged clitoris
562	Epispadias
571	Fusion or adhesions-labia minora or majora
572	Infarction and/or gangrene testicle
580	Urogenital sinus
581	Testicular torsion or epididymis torsion
582	Pseudohermaphrodism
583	Meatal stenosis, urethral meatus stenosis
584	Hydrocolpos
585	Hypoplasia or atrophy testicle
586	Hypoplasia penis
587	Hypoplasia scrotum
588	Imperforate hymen
	Bladder Outflow or Urethral Obstruction
[illegible]	Bladder neck obstruction
	Upper Tract Obstruction, Hydronephrosis or Hydroureter
[illegible]	Non-functioning upper pole right kidney, ectopic ureter
573	Hydroureter, megaloureter
574	Hydronephrosis
	Other Non-infectious
[illegible]	Double ureter
164	Double vagina & uterus
165	Epiplocele
166	Horseshoe kidney
167	Incarcerated ovary, fallopian tube
168	Retention cyst kidney
169	Atonic bladder
170	Bilateral renal vein thrombosis
171	Absence kidney, hypoplastic kidney
[illegible]24	Crossed ectopia kidney
542	Surgical removal kidney
543	Cystic ovary or ovaries
544	Recto-vaginal fistula
[illegible]	Bilateral renal vein thrombosis

* All conditions are definite.

CONDITIONS (Continued)

Additional Codes for Other Specific Conditions*

CODES*	NAME
Neoplastic Disease and/or Other Tumors	
187	Juvenile xanthogranuloma
188	Lipoma
189	Lipomyxoma
190	Mediastinal neuroblastoma
191	Wilms' tumor
192	Astrocytoma
193	Bone cyst
194	Ganglion
591	Retinoblastoma
592	Subepidermal fibroma
593	Tumor replacing right upper dental ridge and adjacent palate
594	Myoepithelial hamartoma ileum
596	Leukemia
597	Hemangioma beneath periosteum - forehead
598	Hemangioma - orbit
599	Eosinophilic granuloma
600	Glioma brain
Hematologic Conditions	
Hemoglobinopathy	
603	A-C
604	A-S
606	S-S
607	Sickle cell anemia
608	Sickle cell disease
613	Sickle cell trait or positive prep
Coagulation Defect	
615	Hemophilia
616	Thrombocytopenia
617	Hypoprothrombinemia
Other	
647	Henoch Schoelein Purpura
648	Granulocytopenia
649	Hypogammaglobulinemia
650	Methemoglobinemia
Syndromes	
013	Streeter's dysplasia
121	Cranial facial dysostosis
328	Arachnodactyly
631	Nail patella syndrome
632	Neurofibromatosis
633	Treacher-Collins syndrome
634	Waterhouse-Friderichson syndrome

CODES*	NAME
Syndromes (Continued)	
642	Werdnig-Hoffmann syndrome
653	Klinefelter's syndrome
654	Klippel-Feil syndrome
655	Letterer-Siwe disease
656	Lowe's syndrome
703	Wolf-Parkinson-White syndrome
704	Achondroplasia
705	Battered child - baby
706	Infantile cortical hyperostosis (Caffey's disease)
707	Trisomy 18
708	Cleidocranial dysostosis
709	Crib death
710	Congenital rubella syndrome
711	Familial dysautonomia
712	Osteogenesis imperfecta
Other Endocrine and Metabolic Disease	
Hypothyroidism	
715	Cretinism
Inborn Errors of Metabolism	
723	Albinism
724	G-6 - P.D. deficiency (glucose 6 phosphate dehydrogenase)
725	Glycogen storage
726	Galactosemia
727	Cataracts, acidosis, abnormal renal functions, mental retardation
Other	
639	Premature thelarche
640	Rickets
641	Salt losing nephropathy
731	Diabetes
732	Hypocalcemia - Hyperphosphatemia
733	Hypocalcemic tetany
734	Hypoglycemia
735	Adrenal hypoplasia
736	Metabolic acidosis cause unknown
738	Osteoporosis
Infection and Inflammation	
839	Congenital lues
840	Cytomegalic inclusion disease
841	Toxoplasmosis

*All conditions are definite.

CONDITIONS (Continued)

Additional Codes for Other Specific Conditions*

CODES*	NAME
	Trauma, Physical Agents and Intoxication
	Fractures, Other
123	Dislocated knee
861	Humerus, radius, ulna, arm
862	Finger
863	Leg, femur, tibia, fibula
864	Clavicle
865	Dislocation - elbow
866	Dislocation - hip
867	Dislocation - shoulder
868	Pelvic
869	Rib or ribs
870	Torn cartilage - left elbow
928	Subluxation - thumbs
931	Broken toe
932	Fractured vertebra
	Symptomatic Intoxication
	Hydrocarbon, Other
889	O'Cedar furniture polish
890	Furniture polish
891	Camphor oil
	Other
297	Carbon monoxide
	Disturbances in Homeostasis
921	Drowning
922	Increased intracranial pressure
923	Respiratory arrest

* All conditions are definite.

SUMMARY OF THE FIRST YEAR OF LIFE AFTER THE DURATION SUMMARIZED ON THE PED-8
FROM PED-12

ITEM # ON FORM *	1	6	11		
CARD # 1442 87	UUDDB **		SUMMARY DATA: NUMBER REPORTED	SPECIFIC CONDITIONS	BLANK
				I | II | III | IV | V | VI | VII | VIII | IX	

* Item numbers refer to form dated: 6/63
** Additional card(s) required for more than 9 conditions

PED-12 - . .

MANUAL FOR THE PED-12 FORM
SUMMARY OF THE FIRST YEAR OF LIFE
AFTER THE DURATION SUMMARIZED ON THE PED-8

I. General Instructions:

1. The PED-12 is a summary of the diagnoses and major events of the first year of life *after* the duration summarized on the Newborn Diagnostic Summary (PED-8).

2. PED-12 is to be completed on:

   A. *All* Study cases following a PED-11 (One-Year Neurological Examination.)

   B. Other Study cases when a PED-11 has not been done, if there is some information available beyond that summarized on PED-8 (Newborn Diagnostic Summary). In such instances, the PED-12 should be completed when the age limit of 60 weeks for the PED-11 examination has been exceeded.

3. Items on PED-12 are followed by a set of five boxes. The first box is for coding the item as suspect, the second box for coding the item as definite. In general, all clear-cut unquestionable diagnoses, conditions, states or events should be coded as definite. Where there is doubt regarding the presence of the condition or its existence in significant degree, the coder will check suspect.

   In cases where a finding reported on PED-12 is suspect or definite on the PED-11 and absent on a prior exam, or vice versa, no apparent coding conflict exists. However, in some cases a finding may be reported on PED-10 (Four-Month Pediatric Examination) as definite and on PED-11 (One-Year Neurological Examination) as suspect. In cases of conflict between suspect and definite, code the finding as reflected on the PED-11.

   The remaining three boxes are to be used to qualify the suspect or definite by indicating the *source of the information.* Each applicable box would be checked.

   The third box, "PED-11," would be checked if the diagnosis, state or condition was noted on the One-Year Neurological Examination (PED-11). Included in this third box would be findings of a referral clinic or diagnostic procedure that directly followed or were primarily indicated from a PED-11 examination.

   The fourth box, "Prior Exam or PED-39," would be checked if the diagnosis was based on some *medical* documentation *prior* to the PED-11 and after the duration summarized on PED-8. This would include the PED-10 (Four-Month Pediatric Examination), PS-3 (Eight-Month Psychological), and reports on PED-39 (Summary of Medical Records of Illness or Hospitalization) that reflect a medical examination.

   The fifth box, "History Only," would qualify diagnoses, states, conditions or events that are based *only* on historical information *without medical documentation* as recorded on PED-20.

   In some instances, a congenital anomaly might be repaired by the time the PED-11 examination is completed. If the anomaly had been noted on some examination after the duration summarized on PED-8 and prior to the PED-11 examination, the fourth box would be checked. The surgical repair would be listed under category Procedures, V-7.

4. The duration summarized on PED-8 is not to be included on the PED-12. However, items coded on PED-8 that continue to be findings at subsequent examinations during the first year of life are to be coded on PED-12.

5. Completion of the PED-12 form is the responsibility of a senior Study physician.

II. Specific Instructions for completing items at the top of Page 1:

Items 1 to 4: No explanation necessary.

Item 5: Checking the box following "PED-4" indicates that the infant has died during the interval summarized on PED-12. If an autopsy was done, check the box following "autopsy." Information available from the autopsy should be used in completing PED-12. If the final autopsy diagnosis changes the original PED-12 submitted to the PRB, forward a totally revised PED-12 to the PRB clearly identifying the PED-12 as *revised.*

Item 6: Information sources: Check the boxes that reflect Study protocols reviewed in completing PED-12.

Item 7: Date of PED-11 examination: If the PED-11 exam is not done, write "N.A." in this space.

Item 8: Age of child at PED-11 examination: If the PED-11 exam is not done, write "N.A." in this space.

Item 9: Information inadequate on categories A-16 and/or W: If the coder finds the information available concerning categories A-16 and/or W to be inadequate, check the appropriate box or boxes.

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Item 10: Check this box if no items are coded in categories A thru W. In cases with no items coded in categories A thru W and this "none" box checked, only *Page 1 of PED-12 need be submitted to the PRB.* "None" boxes in each category are optional, if the "none" box in item 10 has been checked.

A. NEUROLOGIC ABNORMALITY:

Patients with multiple neurologic abnormalities should be coded wherever applicable. In cases with both spasticity and ataxia, each would be coded in the appropriate area. For practical purposes, some neurophysiologic over-simplifications have been made within this section in order to facilitate classification.

1. CEREBRAL SPASTIC PARESIS: This refers to upper motor neuron paresis of presumed cerebral origin with hyperreflexia but not necessarily hypertonus at one year of age.

Item 1-a: Cerebral spastic hemiparesis

Code here any unilateral cerebral paresis of the type usually associated with involvement of the corticospinal tract. It is to be recognized that some cases will not yet be obviously spastic even at the age of one year and may be manifest only by asymmetry of function and of automatisms, plus less obvious degrees of hyperreflexia, stretch reflexes on passive movement, etc.

Item 1-b: Cerebral spastic tetraparesis:

Distinction is not made as to whether the upper extremities or the lower are most severely involved. The category would include such terms as spastic quadriplegia, tetraplegia, double hemiplegia, as well as diplegia.

Item 1-c: Cerebral spastic paraparesis

This category is intended to be limited to cases with involvement of the lower extremities *only*, without even such signs as hyperreflexia in the upper extremities.

Item 1-d: Other, specify:

Code here other spastic paresis, such as monoparesis, not covered by the above items.

2. HYPOTONIA:

This unavoidably heterogeneous category includes some patients who will later show athetosis or other types of unwanted movement as well as a few who will later become spastic, together with persistent hypotonic types and others who later may be more properly classifiable as ataxic. It seems useful to separate the patients on the basis of the presence or absence of deep tendon reflexes but not possible to attempt to break them down into other sub-categories at the age of one year. If a specific diagnosis is known, such as Mongolism or Werdnig-Hoffmann disease, *code* also under Syndromes, P.

3. DYSKINESIA: (Includes "extrapyramidal" rigidity)

Include here any patients who show athetosis, chorea, ballismus, or dystonia, but do not code here the patient who is considered to be a probable "future athetoid" without demonstrable adventitious movement at one year.

Cases of rigidity should also be coded here if of the extrapyramidal rather than spastic type. A "lead pipe" rather than the "jack-knife" type of hypertonus is the principal differentiating point, together with the possible presence of decerebrate postural reflexes and the relative absence of hyperreflexia.

4. ATAXIA:

This includes both truncal ataxia and ataxia of the extremities but should be limited to that of presumed cerebellar origin. Failure to acquire sitting or standing balance, without true ataxia, should not be coded here.

5. OTHER MOTOR DISORDERS, SPECIFY:

Most cases will probably not be otherwise classified at one year of age. Tremor would be coded here, as well as presumed cerebral palsy not classified above.

6. DELAYED DEVELOPMENT:

Delayed development, motor and/or mental. The coding of one does not necessitate the coding of the other.

Item 6-a: Motor:

This category should be used to code the child with delayed milestones of motor development whether or not a "cerebral palsy" has been coded above.

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A. **NEUROLOGIC ABNORMALITY: (Continued)**

6. **DELAYED DEVELOPMENT: (Continued)**

Item 6-b: Mental:

This category should be used to code the child with evidence of delayed mental development. This category would generally be coded as suspect at this age.

7. **REGRESSION IN MOTOR ACTIVITY:**

Code here regression of previously achieved developmental milestones of motor activity.

8. **CORD DISEASE:**

Code here the resulting spastic or flaccid findings of primary cord disease, such as meningomyelocele, myelodysplasia, diastematomyelia, Werdnig-Hoffmann or any other lesion or disease of the spinal cord. Distinction should be made as to whether the lower extremities are spastic or flaccid (i.e. hypertonic or hypotonic).

9. **VISUAL IMPAIRMENT:**

If there is any reasonable doubt regarding total visual impairment, either unilateral or bilateral should be checked as suspicious. Only *visual impairment*, regardless of underlying cause, should be checked here. Anatomical and pathological factors will be coded under category D and/or R.

"Ocular" means that the cause of the blindness is visible to the examiner of the eyes including appearance of the fundi and discs. If the child has visual impairment and the eye examination (including fundi) is normal, code "non-ocular."

10. **EXTRA OCULAR MOVEMENTS:**

Items in this group are self-explanatory. If the coder is not also the examiner and does not have adequate information, he should code Item A-10-e, and specify either what data he has or write type undetermined. The wandering eye movements of the blind child are not a nystagmus and should be coded here under Item A-10-e, *not* under nystagmus, Item A-11.

11. **NYSTAGMUS**

Provided adequate data are recorded on PED-11 or available from another source, code all nystagmus items separately including a, b, *and* c. The wandering, roving eye movements of the blind child are coded under Item A-10-e.

If nystagmus is present, but adequate detail not available, code under Item A-11-d and write type undetermined.

12. **CRANIAL NERVE ABNORMALITY: (Other than II, III, IV, VI, VIII)**

Item 12-a: Facial:

No explanation necessary.

Item 12-b: Other, Specify:

This item is for the presumably very rare occurrences of involvement of the trigeminal (motor and sensory), glossopharyngeal, vagus, accessory and hypoglossal nerves. If Item A-12-b is checked, it is mandatory to list the nerve(s) involved.

13. **HEARING IMPAIRMENT:**

Considering the age group coded on PED-12, ~~hearing impairment will usually be coded under~~ suspicious rather than definite. Specific causes should not be listed here. They will be coded under category E and/or R. It is not considered feasible to differentiate otologic from neurologic hearing impairment at the age of one year.

14. **PERIPHERAL NERVE ABNORMALITY: (Other than cranial nerve)**

Item 14-a: Brachial Plexus:

No explanation necessary.

Item 14-b: Other, Specify:

Include all other lesions of the peripheral nervous system. Specify the nerve(s) involved: e.g., left sciatic neuropathy, right radial nerve palsy, etc. Code cranial nerve abnormality under A-12, and primary spinal cord abnormality under A-8.

15. **SEIZURE STATES:**

All seizures occurring after the period covered by PED-8 shall be coded. Most seizures will not be witnessed by the examining physician and thus should be coded as "history only." From the available information, the coder must decide whether the seizures are suspect or definite.

A. NEUROLOGIC ABNORMALITY: (Continued)

15. SEIZURE STATES: (Continued)

Item 15-a: Generalized (grand mal):

The total number of generalized seizures that have occurred are to be listed. *Also* code under Item A-15-b those seizures that have a focal component. More than ten seizures will usually be only estimates and may be listed in round numbers (i.e., 15, 30, 50, 100 plus, etc.). This number includes those with and without fever.

(1) Only With Fever and Less Than 15 Minutes Duration:

This category should include all simple febrile seizures. Fever of at least 102° should accompany them. The duration must be less than 15 minutes for coding here.

(2) Other, Specify:

Code here generalized seizures occurring with less than 102° fever, regardless of duration, and febrile seizures lasting longer than fifteen minutes.

Item 15-b: Focal motor:

All focal motor seizures, including generalized seizures coded in A-15-a having any clear local features, should be listed here with an estimate of the total number (as mentioned in Item A-15-a).

Item 15-c: Infantile Myoclonic seizures:

This group should include all episodes of brief, usually single, motor jerks and brief losses of muscle tone, such as (1) "Infantile Spasms" (massive myoclonic jerks) or (2) "Akinetic" attacks and so-called other minor motor seizures.

Item 15-d: Other, Specify:

All seizure states not classified above are listed here, with as clear a descriptive title as possible. Petit mal (with classic EEG pattern) and psychomotor (or temporal lobe) seizures will rarely, if ever, be seen at this age, but should be coded with this group. If generalized seizures (previously coded in Item A-15-a) are continuous for 2 hours or more, code here and specify "status."

16. ATYPICAL BEHAVIOR:

Any behavior coded here should reflect a clear deviation as atypical. In general, if atypical behavior is noted only once, it would usually be coded as suspect. If noted repeatedly, it would be coded as definite. Consideration should be made for the child who may be hungry, sleepy, tired, too quickly approached or carrying a recently needled buttock.

Item 16-a: Maladaptive responses:

Code here maladaptive response to change in environmental stimuli, such as, if a child cannot tolerate any changes in routine, i.e., introduction of solids or other change of food; or if he cannot tolerate any change in the environment, such as change of room, presence of strangers, etc.

Item 16-b: Failure to develop social responses or inappropriate social behavior for age:

Code (1) if social behavior is below or has only reached a previous special age level, i.e., fourth month at eight months, etc. (2) if a child fails to respond positively to a positive approach; (3) if a child's behavior becomes completely disorganized by any social approach; (4) if at one year there is failure to distinguish between people, i.e., mother and strangers; (5) or if unable to transfer interest to toys so that there is constant demand for being picked up.

Item 16-c: Failure to form rhythmic patterns:

Code if a child after the age of 4 months has failed to develop a definite pattern of sleeping, eating, elimination, etc. Do not code if the pattern is rhythmic but the schedule is shifted to suit the living pattern of the family; i.e., "Put to bed at midnight, sleeps until 10 or 11 in the morning every day. Father comes home late at night, likes to

A. NEUROLOGIC ABNORMALITY: (Continued)

16. ATYPICAL BEHAVIOR: (Continued)

play with the baby"; or if mother has made no attempt to provide routines.

Item 16-d: Disruption of rhythmic patterns:

Code if an established rhythmic pattern of sleeping, eating, elimination, etc. is broken.

Item 16-e: Regression in behavior:

Code if regression of previously achieved developmental milestones in areas of speech, self care, sleeping, eating, elimination, etc. is precipitated by sickness, temporary maternal separation, arrival of new sibling, change of caretaker or any other frustrating experience.

Item 16-f: Stereotyped behavior:

Code if there is a history of persistent purposeless behavior; i.e., head banging, rhythmic movements, etc.

Item 16-g: Abnormalities of behavior control, specify:

Code (1) if there is undercontrol in relation to generalized stimuli, leading to overactivity, directionless behavior in a stimulating situation or if frustration repeatedly leads to temper tantrums, hitting, biting, etc.; (2) if there is overcontrol resulting in lack of environmental exploration despite the presence of obvious interest, i.e., excessive shyness. Breathholding is to be coded under A-16-h.

Item 16-h: Breath Holding:

(1) With unconsciousness:

Episodes of unconsciousness clearly associated with a precipitating factor; i.e., pain, fright, anger, etc., and usually preceded by crying, then apnea, should be coded here. If convulsive movements occur with the unconsciousness, they should also be coded under Item 15. If neither a precipitating factor nor crying occur, convulsive movements would generally be classified only under Item 15.

(2) Without unconsciousness:

Code here breath-holding episodes without unconsciousness.

Item 16-i: Hyper-reactivity to sensory stimuli:

Code for unusual sudden startle response to ordinary stimuli of a visual, tactile or auditory nature.

Item 16-j: Apathy:

Code (1) if there is failure to respond to pleasant or unpleasant environmental stimuli; (2) if there is no emotional expression or response to social stimuli by mother or caretaker. This must be distinguished from failure to respond in one specific modality, i.e. hearing.

Item 16-k: Phobia:

Code here if there is a repetitive reaction of fear to particular noises, persons, animals or objects. This must be distinguished from a strangeness reaction to new situations or people.

Item 16-l: Pica:

No explanation necessary.

Item 16-m: Other, Specify:

No explanation necessary.

17. COMA, Specify Cause:

Code here coma and specify the cause, such as metabolic imbalance, intoxication, head trauma, etc.

18. OTHER, SPECIFY:

Code here autonomic dysfunction, harlequin color changes, etc.

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B. RELATED CENTRAL NERVOUS SYSTEM AND SKELETAL CONDITIONS:

1. MACROCEPHALY:

Code here primary macrocephaly with head size ordinarly above 50 cms. at 48-60 weeks or by the examiner's judgment *and* associated with evidence of subnormal mental development. Do not code here macrocephaly secondary to hydrocephaly, subdural hematoma, intracranial tumor, etc. Head measurements are coded directly from PED-10 and PED-11.

2. MICROCEPHALY:

Code here microcephaly associated with head size ordinarily 42.5 cms. or below at 48-60 weeks or by the examiner's judgment *and* with abnormal neurological findings or subnormal mental development. Head measurements are coded directly from PED-10 and PED-11.

3. HYDRANENCEPHALY:

This is difficult to separate from severe hydrocephaly. Enter under definite only after direct visualization at the operating table or at autopsy.

4. HYDROCEPHALY:

Specify cause and anatomic lesion.

5. CRANIOSYNOSTOSIS:

Code suspect on clinical grounds, definite with radiologic support. Specify involved sutures.

6. OTHER ABNORMAL SHAPE OF SKULL, SPECIFY:

Code hypertelorism here. Specify shape.

7. PORENCEPHALY:

Code here a cavity of the brain that opens into the ventricles or the subarachnoid space. Documentation by pneumoencephalogram or direct viewing should be available for coding definite. Non-communicating cysts are coded under B-14, Other, Specify.

8. ENCEPHALOCELE:

No explanation necessary.

9. MENINGOMYELOCELE/MENINGOCELE:

Knowledge of neural tissue involvement is not needed for coding definite.

10. PILONIDAL SINUS (Not Dimple):

Only an actual opening or tract should be coded: i.e., dimples are disregarded.

11. OTHER MIDLINE SINUSES, SPECIFY:

Congenital dermal sinuses (lumbar and above) should be coded here. Specify site.

12. SUBDURAL HEMATOMA OR EFFUSION:

For coding definite, there should be additional information beyond the clinical impression, such as positive subdural taps, craniotomy, autopsy, etc.

13. OTHER INTRACRANIAL HEMORRHAGE, SPECIFY SITE:

Usually coded suspect, but definite may be coded on the basis of findings of autopsy, craniotomy, subdural, ventricular or lumbar puncture, etc.

14. OTHER, SPECIFY (Do not code spina bifida occulta or craniotabes):

Code here a cavity of the brain that does not communicate with ventricles or the subarachnoid space. Rare CNS malformation would be coded here.

C. MUSCULOSKELETAL ABNORMALITY:

1. VERTEBRAL ABNORMALITY:

In general, code definite *only* with radiologic documentation or autopsy. Do not code spina bifida occulta.

2. TALIPES EQUINOVARUS:

Code here talipes equinovarus where the forefoot is adducted, the entire foot is inverted (varus), and the entire foot is plantar flexed (equinus).

3. METATARSUS ADDUCTUS (Varus):

A metatarsus adductus deformity is one in which the forefoot is adducted and no other deformity is present.

4. TALIPES CALCANEOVALGUS:

Code here deformities with forefoot abducted, entire foot everted (valgus) and in a position of marked dorsiflexion (calcaneous).

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C. MUSCULOSKELETAL ABNORMALITY: (Cont'd.)

5. CONGENITAL DISLOCATION OR DYSPLASIA OF THE HIP:

Radiologic documentation should be obtained for coding definite.

6. ABSENCE OR HYPOPLASIA OF EXTREMITY OR PART, SPECIFY:

Include here digits. Describe the anatomical part, and degree, i.e., absence or hypoplasia. Do not code merely decreased subcutaneous fat. Code hypoplastic mandible under F-5.

7. POLYDACTYLY:

Code extra or rudimentary digits even if no bone is demonstrated, as in postminimi.

8. SYNDACTYLY:

Code here fusions, including soft tissue fusions, of digits or parts of more than one digit.

9. TORTICOLLIS:

Code torticollis from any cause, with or without sternocleidomastoid muscle abnormality.

10. ARTHROGRYPOSIS MULTIPLEX (amyoplasia Congenita): No explanation necessary.

11. OTHER, NON-INFECTIOUS, SPECIFY:

Code here musculoskeletal deformities or diseases that do not relate directly to the nervous system. For example, aplasia of abdominal muscles, hyperplasia of an extremity, muscle group or skeletal part, abnormality of sternocleidomastoid muscle without torticollis, etc. Skeletal malformations of the skull, mandible, vertebrae, and thorax are not coded here. Do not code diastasis recti.

D. EYE CONDITIONS:

1. CHORIO-RETINITIS:

If process is active, code also under R-9.

2 thru 5. No explanation necessary.

6. OTHER NON-INFECTIOUS, SPECIFY

List here other abnormalities of the globe and eyelids, such as glaucoma and enophthalmos. Infections are coded under R-9. Abnormality of orbit (hypertelorism, proptosis, etc.) are coded under B-6.

E. EAR CONDITIONS:

1 and 2. No explanation necessary.

3. BRANCHIAL CLEFT ANOMALY:

Pre-auricular sinuses and sinuses in other positions in relation to the ear should be coded here. Branchial cleft anomalies in other positions are also coded here.

4. No explanation necessary.

5. OTHER, NON-INFECTIOUS, SPECIFY:

List here absence of external ear, imperforate ear canal, malformed middle ear or drum, and papillary masses (persistent hillocks), which occur anterior to the tragus or on the cheeks. Code infectious under R-10.

F. UPPER RESPIRATORY TRACT AND MOUTH CONDITIONS:

1. CLEFT PALATE:

Any cleft of the hard or soft palate, excluding cleft uvula, should be coded here.

2. CLEFT UVULA:

Code here isolated cleft (bifid) uvula not associated with cleft palate.

3. CLEFT LIP:

No explanation necessary.

4. CLEFT GUM:

Code here isolated cleft gum not associated with cleft lip or palate.

5. MICROGNATHIA:

If this condition is associated with palate abnormality, then also code "Pierre Robin" under P-5.

6. MALFORMATION OF THE EPIGLOTTIS AND LARYNX, SPECIFY:

Code here congenital laryngeal stenosis, laryngeal web, etc. Specify abnormality.

7. ABNORMALITY OF TEETH, SPECIFY:

Code here markedly retarded eruption, hypoplastic enamel, malformations, severe malocclusion, etc.

F. UPPER RESPIRATORY TRACT AND MOUTH CONDITIONS: (Continued)

8. OTHER NON-INFECTIOUS, SPECIFY:

Code here benign "congenital laryngeal stridor" without demonstrable malformation, abnormality of the trachea, etc. Code here high arched palate if considered significant. Do not list tongue-tie unless *extreme*.

G. THORACIC CONDITIONS (Except Neoplastic and Cardiovascular Conditions):

1 to 4. No explanation necessary.

5. OTHER, SPECIFY:

Do not list neoplastic and cardiovascular conditions here.

H. LOWER RESPIRATORY TRACT ABNORMALITY:

In general, this category is coded for non-infectious abnormalities of the lower tract. In some instances, these abnormalities will be associated with infection, and in such cases the infection will *also* be coded in the appropriate area under category R, Infection and Inflammation.

I. CARDIOVASCULAR CONDITIONS:

1. ACYANOTIC CHD:

2. CYANOTIC CHD:

The division of congenital heart disease on the basis of cyanosis asks the physician, at times, to make an arbitrary decision. In general, code as cyanotic those with cyanosis at rest. If there is cardiac enlargement, code *also* under I-6. If a specific diagnosis can be made, code *also* under I-9. Do not list murmurs, code etiology if indicated.

3. FIBROELASTOSIS:

Code suspect on clinical basis, with definite coded on direct viewing at the operating table or at autopsy.

4. DISORDERS OF RHYTHM:

Code here changes from regular rhythm. Do not code simple sinus arrhythmia associated with respiration. If a specific diagnosis is known, code *also* under I-9.

5. DISORDERS OF RATE:

Code here rates over 180 or under 90. If specific diagnosis is known, code *also* under I-9.

6. CARDIAC ENLARGEMENT:

Code definite with autopsy or radiographic documentation. If a specific diagnosis is known, code *also* under I-9.

7. DECOMPENSATION

No explanation needed.

8. SEVERE CYANOTIC EPISODES

Code here severe cyanotic episodes occurring in infants with congenital heart disease previously coded in I-1 or I-2.

9. SPECIFIC C-V DIAGNOSIS.

Coding here should have documentation beyond clinical impression. E.K.G., catheterization, radiography (including angiocardiography and aortography), etc., may establish the specific diagnosis. Code here patent ductus arteriosus, arteriovenous fistula, and coarctation of the aorta. Cases of congenital heart disease are also coded under I-1 or I-2. Code hemangiomata and telangiectasia under O.

10. OTHER, SPECIFY

Code acquired heart disease here. Myocarditis and pericarditis would be coded here as well as under R-4. Metabolic disease with myocardial involvement would be coded here as well as under U.

J. ALIMENTARY TRACT CONDITIONS

In general, many of the diagnoses to be coded here will require radiographic confirmation, surgical exploration, biopsy or autopsy to warrant coding definite.

1. HERNIA

Specify the type. Code diaphragmatic hernia under G-1. Code here complicated umbilical hernia that causes symptoms and requires treatment. This is meant to exclude umbilical hernia of minor degree so often observed in some racial groups.

2 to 10. No explanation necessary.

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J ALIMENTARY TRACT CONDITIONS (Continued)

11 OTHER NON-INFECTIOUS, SPECIFY

List here esophageal stenosis without fistula, short esophagus, situs inversus abdominalis, Meckel's diverticulum, annular pancreas, rectal fistula, etc.

K ABNORMALITY OF LIVER, BILE DUCTS, AND/OR SPLEEN

1 BILIARY ATRESIA

No explanation necessary.

2 JAUNDICE

Code jaundice as (a) if persistent beyond duration summarized on PED-8 or (b) if acquired after the duration summarized on PED-8.

3 OTHER NON-INFECTIOUS, SPECIFY

Code here clinically significant primary hepatomegaly and/or splenomegaly of unknown etiology. Code hepatitis under B-[illegible].

L GENITOURINARY CONDITIONS

1 thru 4 No explanation necessary.

5 CYSTIC KIDNEY

Code here both polycystic and [illegible] kidney.

6 OTHER NON-INFECTIOUS, SPECIFY

List here [illegible] kidney, [illegible] kidney, agenesis of kidney, bladder [illegible], etc.

M NEOPLASTIC DISEASE AND/OR OTHER TUMORS

Specify type and origin. If [illegible] [illegible] [illegible] [illegible] PED-12, [illegible] [illegible] [illegible] [illegible] summarized on the PED-8. Code [illegible] here [illegible] [illegible] [illegible].

N HEMATOLOGIC CONDITIONS

1 HEMOGLOBINOPATHY, SPECIFY TYPE

[illegible]

2 HEMOLYTIC DISEASE

Code congenital hemolytic disease on the basis of constitutional factors. Code acquired hemolytic disease on the basis of extrinsic or unknown factors which would include hemolytic disease associated with isohemolysins or iso-agglutinins. However, erythroblastosis fetalis summarized on PED-8 would not be coded on PED-12.

3 COAGULATION DEFECT, SPECIFY

Code here thrombocytopenia, hemophilia, afibrinogenemia, etc.

4 MAJOR HEMORRHAGE, SPECIFY SITE

Code subdural and intracranial hemorrhages under category B.

5 ANEMIA

The hemoglobin values in classifying anemia have been arbitrarily set as less than 8 gm.% and from 8 to (but not including) 9 gm.% [illegible] [illegible] 9 gm.% or more is not to be recorded on PED-12. Mention the etiology of the anemia as iron deficiency or other, specify.

6 OTHER, SPECIFY

Code here hematologic conditions not covered in the above category. [illegible] splenomegaly would be coded under K, and leukemia coded under M.

O SKIN CONDITIONS AND MALFORMATIONS

1 PIGMENTED HEMANGIOMA

[illegible] are to be considered [illegible] [illegible]. [illegible] here would be [illegible].

2 to 8 No explanation necessary.

9 OTHER, SPECIFY

[illegible]

P SYNDROMES

[illegible]

P. SYNDROMES: (Continued)

1. MONGOLISM (Down's Syndrome):

Definite clinical diagnosis of mongolism should be independently made by two examiners. Suspect mongolism may be made by a single experienced examiner's observation. Record chromosome studies, if done, under V-8.

2. GONADAL DYSGENESIS:

Code definite only after chromosome count or laparotomy.

3. ADRENOGENITAL:

Chemical documentation is desirable.

4 and 5. No explanation necessary.

6. SPASMUS NUTANS:

This syndrome is meant to include infants showing rhythmic nodding or twisting of the head and intermittent nystagmus.

7. HURLER'S (Gargoylism)

No explanation necessary.

8. FAILURE TO THRIVE:

Code here failure to thrive as the result of inborn errors of metabolism, fibrocystic disease of the pancreas, congenital myopathies, nutritional deficiencies, and also that due to neglect, maternal anxiety, improper emotional environment, etc.

9. OTHER, SPECIFY

No explanation necessary.

Q. OTHER ENDOCRINE AND METABOLIC DISEASE:

In general, coding definite should be confirmed by special studies. When applicable, code procedure used under Section V. The specific results of these studies should be recorded on a CP-6 with local normal values for infants of the specific study included, if this data has not been previously submitted to the P.R.B.

1. HYPOTHYROIDISM, SPECIFY

For coding definite, laboratory confirmation is desirable. This code should not be used to list just funny or unusual looking infants.

2. FIBROCYSTIC DISEASE OF PANCREAS

Code definite only if documented by chemical changes in sweat, or other acceptable tests.

3 and 4. No explanation necessary.

R. INFECTION AND INFLAMMATION:

In general, for each diagnosis coded, the associated agent should also be specified. If the agent is unknown, write "unknown" following agent.

1 and 2. No explanation necessary.

3. RESPIRATORY:

Code here infection and inflammation of both the upper and lower respiratory tract, including the mouth, retropharyngeal abscess, herpetic stomatitis, etc. It is the intent not to code minor uncomplicated respiratory infections, such as, common cold, pharyngitis and tonsillitis. However, if these infections are severe enough to require hospitalization, they should be coded here.

4 thru 11. No explanation necessary.

12. SPECIFIC CHILDHOOD DISEASES:

Coding here will generally be done on a historical basis and the associated agent is not recorded.

13. UNUSUALLY RECURRENT OR CHRONIC INFECTIONS, SPECIFY:

Code here unusually recurrent or chronic infections and specify the organ involved. Code also under the specific organ involved. As an example, recurrent genitourinary tract infections would be coded under R-4, as well as here.

14. OTHER, SPECIFY:

Code here peritonitis and other infections and inflammations not covered by the above items.

S. TRAUMA, PHYSICAL AGENTS, AND INTOXICATION:

1. HEAD TRAUMA:

Coding here is done by checking the appropriate boxes that qualify the extent of head trauma.

2. FRACTURES, OTHER, SPECIFY

Fractured skull is coded under S-1, Head Trauma. In general, fractures should be coded definite only when radiologically proven. Specify bone involved.

S TRAUMA, PHYSICAL AGENTS, AND INTOXICATION: (Continued)

3. BURNS LEADING TO HOSPITALIZATION:
Code here burns (including thermal, chemical, electric, solar, radioactive, etc.) that require hospitalization for therapy. Specify under (a) the general location and degree. Record the agent responsible for the burns in the space provided.

4. SYMPTOMATIC INTOXICATION:

The coder will make a reasonable decision concerning the agent causing the symptomatic intoxication depending on history, symptoms, and available laboratory confirmation. If symptomatic intoxication is definite, but the etiology unknown, code as definite under S-4-d and write agent unknown. In some instances, there will be laboratory evidence of lead or other heavy metal intoxication without symptomatic intoxication. Such instances should be coded here.

T. DISTURBANCES IN HOMEOSTASIS.

1 and 2. No explanation necessary.

3. ELECTROLYTE IMBALANCE, SPECIFY:

Code here the major components of the electrolyte imbalance. Include such imbalances as hypo- and hyper-natremia, hypo- and hyper-kalemia, etc. In general, coding definite should be confirmed by electrolyte studies. The specific results of these studies should be recorded on a CP-5 with local normal values for infants of the specific study included, if this data has not been previously submitted to the P.R.B.

4 and 5. No explanation necessary.

6. EPISODE OF "HYPOXIA"

Code here all episodes of "hypoxia" as (a) with unconsciousness, or (b) without unconsciousness. In both instances, specify the cause. Include aspiration of a foreign body, drowning, carbon monoxide, etc.

7. OTHER, SPECIFY

List here other major disturbances in homeostasis.

U. OTHER CONDITIONS, SPECIFY

Code here significant conditions that are not logically coded elsewhere on PED-12.

V. PROCEDURES:

1. BLOOD TRANSFUSIONS:

Code here any blood administered regardless of amount or number of times.

2. PARENTERAL FLUIDS:

Code here parenteral fluid administered to maintain and/or correct hydration and/or electrolyte balance.

3. SPINAL PUNCTURE:

Code attempts. Do not record the number of times the procedure is done but note untoward or severe reactions under the appropriate area on PED-12.

4. SUBDURAL PUNCTURE.

As Item V-3.

5. VENTRICULAR PUNCTURE

As Item V-3.

6. GENERAL ANESTHESIA:

Complications, such as shock, should be coded under category T

7. SURGERY (EXCLUDE MINOR OFFICE SURGERY, SPECIFY):

Do not code circumcisions and simple vein cutdowns, simple digit or skin tag ligations. List each surgical procedure separately. Do not list laparotomy, unless it was the only surgery done. Biopsy and bone marrow punctures may be recorded under this item.

8. CHROMOSOME STUDIES:

Complete report (including method) to be reported on CP-5, if this data has not been previously submitted to the P.R.B.

9. E. E. G.

No explanation necessary.

10. OTHER SPECIFY

Code here other procedures of significance in terms of risk to the child or special studies that are of interest in the evaluation of the child.

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W. SOCIAL AND ENVIRONMENTAL CONDITIONS:

The coder is given an opportunity to record here the social and environmental deficiencies that he may consider significant in their effect on the general development of the child.

1. LOSS OF ONE OR BOTH PARENTS OR PARENT SURROGATE:

No explanation necessary.

2. FOSTER HOME:

No explanation necessary.

3. UNFAVORABLE EMOTIONAL ENVIRONMENT:

This would be indicated if there were mental disorder or institutionalization in parents, divorce, separation, lack of interest in child, broken home, frequent moves (more than 3 in a year), intemperance, narcotic addiction, excessive concern or sibling closer than 15 months.

4. PROLONGED OR RECURRENT HOSPITALIZATION (Totalling approximately 30 days):

No explanation necessary.

5. OTHER, SPECIFY:

No explanation necessary.

PED-14 Physical Growth Measurements

Form PED-14 provided for the orderly standardized collection of growth measurements of the child at different ages; uniformity of procedure and type of equipment used for the measurements was emphasized. First implemented into the study in February 1964, the form was never revised. Data may be found on card 1414 of the master file (Table PED-14.1).

TABLE PED-14.1 Cards and Data Records by Revision for Form PED-14

Card Name	Card Number	Rev. No.	Number Records
PED-14: Weight, Length, Head and Chest Circumference Measurements	1414	0	103,068
	total for form		103,068

Data Items Referencing Form PED-14, Physical Growth Measurements

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4637........		1414	1	5	Card number (sequence, form type, form number, revision number)
4638........		1414	6	14	NINDB case number
4639.PED-14	1	1414	15	16	Birth date (mo)
4640.PED-14	1	1414	17	18	Birth date (day)
4641.PED-14	1	1414	19	20	Birth date (yr)
4642.PED-14	4	1414	21	22	Form PED-14 date (mo)
4643.PED-14	4	1414	23	24	Form PED-14 date (day)
4644.PED-14	4	1414	25	26	Form PED-14 date (yr)
4645.PED-14	5	1414	27	29	Age (mon)
4646.PED-14	6	1414	30	32	Weight (lbs)
4647.PED-14	6	1414	33	34	Weight (oz)
4648.PED-14	6	1414	35	35	Weight, condition
4649.PED	7	1414	36	38	Length: body (cm)
4650.PED-14	7	1414	39	40	Length: body (in)
4651.PED-14	7	1414	41	41	Length, condition
4652.PED-14	8	1414	42	43	Head circumference (cm)
4653.PED-14	8	1414	44	44	Head circumference, condition
4654.PED-14	9	1414	45	47	Length: crown rump (cm)
4655.PED-14	9	1414	48	49	Length: crown rump (in)
4656.PED-14	9	1414	50	50	Length: crown rump, condition
4657.PED-14	10	1414	51	52	Chest circumference (cm)
4658.PED-14	10	1414	53	53	Chest circumference, condition
4659.PED-14	11	1414	54	54	Physical measurements, other
4660........		1414	55	80	Blank
5965....VAR	8		1165	1166	Head circumference, 8 mo (cms)
5966....VAR	8		1167	1168	Head circumference, 3 yrs (cms)
5967....VAR	8		1169	1170	Head circumference, 4 yrs (cms)
5971....VAR	6		1181	1184	Weight, 8 mo (lbs/oz)
5973....VAR	6		1188	1190	Weight, 3 yr (kgs)
5974....VAR	6		1191	1193	Weight, 4 yr (kgs)
5979....VAR	7		1202	1203	Length: body, 8 mo (cms)
5982....VAR	7		1208	1210	Length: body, 3 yr (cms)
5983....VAR	7		1211	1213	Length: body, 4 yr (cms)

PHYSICAL GROWTH MEASUREMENTS

2. OBTAINED BY

3. TITLE OR POSITION

4. DATE MEASURE TAKEN: MO. | DAY | YEAR

5. AGE (Insert one only)

NOTE: OPTIMAL CONDITIONS INCLUDE THE FOLLOWING
A. Cooperation satisfactory
B. Child undressed
C. Measuring equipment according to protocol
If any of the above conditions (A thru C) do not obtain, check box under the "other" column.

CONDITIONS (check appropriate box)

Measurement	OPTIMAL	OTHER
6. WEIGHT ____ KILOGRAMS ____ LBS. ____ OZS.	☐	☐
7. LENGTH ____ CENTIMETERS ____ INCHES	☐	☐
8. HEAD CIRCUMFERENCE ____ CENTIMETERS	☐	☐

OPTIONAL:

Measurement	OPTIMAL	OTHER
9. CROWN-RUMP ____ CENTIMETERS ____ INCHES	☐	☐
10. CHEST CIRCUMFERENCE ____ CENTIMETERS	☐	☐
11. ADDITIONAL (Specify) ____	☐	☐
____	☐	☐

12. COMMENTS

13. MEDICAL EDITOR'S COMMENTS (Insert one only)

NONE ☐

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MD.

PED-14

Form Item Numbers linked to Data Items on PED-14, Physical Growth Measurements

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
1	4640.PED-14	1414	17	18	Birth date (day)
1	4639.PED-14	1414	15	16	Birth date (mo)
1	4641.PED-14	1414	19	20	Birth date (yr)
4	4643.PED-14	1414	23	24	Form PED-14 date (day)
4	4642.PED-14	1414	21	22	Form PED-14 date (mo)
4	4644.PED-14	1414	25	26	Form PED-14 date (yr)
5	4645.PED-14	1414	27	29	Age (mon)
6	4646.PED-14	1414	30	32	Weight (lbs)
6	4647.PED-14	1414	33	34	Weight (oz)
6	6179....VAR		14[illegible]	1491	Weight 8 mo (gms)
6	5973....VAR		1188	1190	Weight, 3 yr (kgs)
6	5974....VAR		1191	1193	Weight, 4 yr (kgs)
6	5971....VAR		1181	1184	Weight, 8 mo (lbs/oz)
6	4648.PED-14	1414	35	35	Weight, condition
7	4651.PED-14	1414	41	41	Length, condition
7	4649.PED-14	1414	36	38	Length: body (cm)
7	4650.PED-14	1414	39	40	Length: body (in)
7	5982....VAR		1208	1210	Length: body, 3 yr (cms)
7	5983....VAR		1211	1213	Length: body, 4 yr (cms)
7	5979....VAR		1202	1203	Length: body, 8 mo (cms)
8	4652.PED-14	1414	42	43	Head circumference (cm)
8	5966....VAR		1167	1168	Head circumference, 3 yrs (cms)
8	5967....VAR		1169	1170	Head circumference, 4 yrs (cms)
8	5965....VAR		1165	1166	Head circumference, 8 mo (cms)
8	4653.PED-14	1414	44	44	Head circumference, condition
9	4654.PED-14	1414	45	47	Length: crown rump (cm)
9	4655.PED-14	1414	48	49	Length: crown rump (in)
9	4656.PED-14	1414	50	50	Length: crown rump, condition
10	4657.PED-14	1414	51	52	Chest circumference (cm)
10	4658.PED-14	1414	53	53	Chest circumference, condition
11	4659.PED-14	1414	54	54	Physical measurements, other

DEFINITION OF CODES
PHYSICAL GROWTH MEASUREMENTS
FORM PED-14 CARD 1414

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 414	2-4
3.	Revision Number Code: 0 - Form dated: 2/64	5
4.	NINDB Number Item 1 Nine-digit number for Patient Identification Code: As given	6-14
5.	Date of Birth Item 1 Six-digit code for: Month (cols. 15-16) Day (cols. 17-18) Year (cols. 19-20) Code: As given 99 - Month, day and/or year unknown	15-20
6.	Date Measure Taken Item 4 Six-digit code for: Month (cols. 21-22) Day (cols. 23-24) Year (cols. 25-26) Code: As given	21-26
7.	Age Item 5 Code: As given in months 999 - Unknown	27-29
8.	Weight Item 6 Six-digit code for: Weight (cols. 30-34) Code: As given in pounds and ounces 99999 - Unknown Condition (col. 35) Code: 0 - Optimal 8 - Other 9 - Unknown	30-35

FORM PED-14
Card 1414

FIELD		CARD COLUMN
9.	Length Item 7 Six-digit code for: Cms (cols. 36-38) Code: As given 000 - Measurement in inches only 999 - Unknown Inches (cols. 39-40) Code: As given 00 - Measurement in cms. only 99 - Unknown Condition (col. 41) Code: Same as in Field 8 col. 35	36-41
10.	Head Circumference Item 8 Three-digit code for: Circumference (cols. 42-43) Code: As given in cms. 99 - Unknown Condition (col. 44) Code: Same as in Field 8 col. 35	42-44
11.	Crown-Rump Length Item 9 Code: Same as in Field 9	45-50
12.	Chest Circumference Item 10 Code: Same as in Field 10	51-53
13.	Additional Measurements Item 11 Code: 0 - No 1 - Yes	54

Note: A card is punched for each examination with columns 1-54 same as above.

Physical Growth Measurements
Form PED-14

ITEM # ON FORM		1	1	4	5	6	7	8	9	10	11	
CARD # 1414		NINDB #	BIRTHDATE (MO. DAY YR.)	DATE MEASURE TAKEN (MO. DAY YR.)	AGE	WEIGHT: POUNDS, OUNCES, CONDITION	LENGTH: IN CENTIMETERS, IN INCHES, CONDITION	HEAD CIRCUMFERENCE: MEASUREMENT, CONDITION	CROWN RUMP: IN CENTIMETERS, IN INCHES, CONDITION	CHEST CIRCUMFERENCE: MEASUREMENT, CONDITION	CONDITION OF MEASUREMENTS	BLANK

PED-14 - 1

MANUAL FOR THE COLLECTION OF PHYSICAL GROWTH MEASUREMENTS BEYOND THE NEWBORN PERIOD

and

INSTRUCTIONS IN THE USE OF THE PED-14 FORM

PART A. GENERAL INFORMATION

I. INTRODUCTION

This manual was developed because the Collaborative Study involves many institutions that have researchers with varied interests and abilities and because care and attention is needed in taking accurate measurement data. Uniformity of procedure and type of equipment used is emphasized.

II. GENERAL INSTRUCTIONS

The PED-14 form and explicit instructions in this manual provide for the orderly standardized collection of growth measurement data at specified intervals throughout the time the child is in the Collaborative Study. The PED-14 form is designed specifically for recording physical measurements at times other than at the newborn, four-month, and one-year examinations. The four-month and one-year measurements should be taken in accord with recommendations outlined in this manual. However the measures are to be recorded on the PED-10 and PED-11 forms respectively in areas already provided for this purpose. Regardless of which form is used, if the measurements are not taken under the optimal conditions recommended in Part B, III, items 6-11, an explanation should be recorded in the "comment column."

III. SPECIFIC INSTRUCTIONS

A. The Study child is to be weighed and measured at 4, 8 and 12 months, and thereafter whenever the child is seen for a regularly scheduled Study examination and at other times at the discretion of the local institution. The results of these measurements are to be incorporated into the Study record on the appropriate form.

B. The following physical measurements are to be considered the minimum essentials:

(1) Body weight
(2) Head circumference
(3) Body length (or height)

and the following physical measurements are placed in the optional category:

(4) Crown-rump (sitting height after 20 months)
(5) Chest circumference (because of inaccuracy)
(6) Lower segment length (because of inaccuracy)
(7) Additional measurements of local interest

C. The techniques of obtaining the measurements are as follows

(1) Weight. Infants should be weighed nude (without diapers) through 20 months — after which light underpants and socks may be worn. Scales should be calibrated at least semi-annually

(2) Head circumference. A narrow flexible steel or non-stretchable tape should be used and the measurement recorded in centimeters.

(3) Body length (crown-heel). An approved standardized measuring board is to be used. (see F. Falkner's article in the [illegible] Practice and Procedures issue of the Pediatric Clinics of North America, Feb. [illegible], pp. [illegible])

Children are to be measured in supine position through age 20 months. Thereafter, the child should be measured erect wherever possible.

Measurements are to be recorded in centimeters.

D. Accuracy of measurements.

(1) Weight. If in pounds, to the nearest oz. through 20 months, thereafter, to the nearest quarter of a pound. If in grams, to the nearest 30 grams through 20 months, then to the nearest 100 grams.

(2) Head circumference. To the nearest 0.5 cm.

(3) Length. To the nearest 0.5 cm.

If the reading falls at the exact midpoint, take the lower value. Examples: 62.7 becomes 62.5, 62.75 becomes 62.5, and 62.8 becomes 63.0.

E. Personnel obtaining measurements may be non-medical but should be properly trained and supervised

F. Recording of measurements is to be done where appropriate on already existing forms. Where no protocol record exists for this purpose, the PED-14 form should be used.

February 1964

PART II. INSTRUCTIONS FOR COMPLETING THE PED-14 FORM

I. INTRODUCTION

The PED-14 form provides space for recording physical measurements on those occasions where existing forms make no provision for such recordings. Longitudinal measurement data collected carefully and recorded under standardized conditions provides growth increment information which is a further means of evaluating the Study child.

II. GENERAL INSTRUCTIONS

Accuracy of data collection is the most important point to keep in mind. Uniformity of procedure and standardization of equipment used is emphasized. It is also desirable that there be some indication of whether optimal conditions were met while the measurements were being obtained. Such conditions would include the state of the child as well as whether he was cooperative or irritable and fighting. Boxes are provided for indicating conditions optimal or otherwise. If the box "other" is checked, an explanation must be written opposite the item in the comment column (Item 12). Clearly indicate to which item the explanation refers.

A. The Measurer

It is important that the individual taking the measurements be alerted to the importance of this function through adequate supervision and training — particularly since nonmedical personnel may be measurers. In many instances, the individual completing the interval pediatric history form will also carry out the measurement activity. This is acceptable providing the data is collected under close supervision or the individual has received specific training for this purpose (current and by Study personnel).

B. Timing

The PED-14 form shall be completed at the following examination times:

(1) Eight-Month Psychological Examination
(2) Three-Year Speech and Hearing Examination
(3) Four-Year Psychological Examination
(4) Other regularly scheduled Core Study examinations beyond the One-Year Neurological Examination.

II. GENERAL INSTRUCTIONS (Continued)

In general, when measurements are taken in conjunction with other examinations such as psychological or speech and hearing, it is recommended that the measuring be done *after* the scheduled Study examination is completed in order to avoid possible distraction during the testing procedures.

The completed form should be transmitted to PRB as soon as possible (i.e., after each examination) rather than as a cumulative record.

III. SPECIFIC INSTRUCTIONS

Item 1. *Patient Identification*. The patient's name plate should be stamped here.

Items 2-4. No explanation necessary.

Item 5. This item is for local use only as birth date and date of measurement will be used in calculating age for study purposes.

Items 6-11. *Conditions*. For data recorded in items 6 through 11, check boxes are provided for the measurer to indicate whether the particular measurement was obtained under optimal conditions. These conditions may vary for the particular measure taken but in general they will include the conditions set forth in "NOTE" printed under patient identification box on the PED-14 form. They are to be interpreted as follows:

A. Cooperation satisfactory: applies to all items.

B. Child undressed means child suitably undressed for the measure being taken — i.e., without shoes for body length, or totally for weight through 20 months or with light underpants and socks for weight after 20 months.

C. Measuring equipment according to protocol: This includes using measuring scales calibrated at least semi-annually and the use of a standardized measuring board for body length measurements. [illegible]

Item 6. *Weight*. It is desirable that weight be recorded in metric units. Record to the nearest 10 grams through 20 months, thereafter to the nearest 100 grams. However, if an English scale is used, record in pounds to the nearest oz. through 20 months, thereafter to the nearest quarter of a pound.

February 1964

III SPECIFIC INSTRUCTIONS (Continued)

Comments The child should be nude (or in diapers) through 20 months of age and thereafter in light underpants and socks for optimal conditions. If socks, panties and/or other garments are not removed check "Other" box and record explanation under "Comments."

Item 7 Length (crown-heel, recumbent through 20 months). A standardized measuring board is used and the child is measured in supine position if 20 months of age or less. There should be two individuals taking the measure — one to hold the head steady and the second to manipulate the foot board of the measuring board while holding the child's legs firmly against the board. The length should be recorded in centimeters.

Beyond 20 months of age the child stands erect, with heel, buttocks, and shoulders against the backboard. The head is positioned so that eyes look straight ahead with the axis of vision horizontal. The head block is brought to rest on the crown of the head and the length recorded to the nearest 0.5 centimeter.

Should the measurement reading fall at the exact midpoint, record the lower value.

Comments Whenever it is not possible to use the standardized measuring board for the body length measurement, the best measure possible should be taken, the condition box "other" checked and an explanation recorded under "comments."

If the child is in a cast, or if for some other reason he must be recumbent when the body length measurement is taken after 20 months of age, the condition box "Other" should be checked and an explanation written in the comment column.

III SPECIFIC INSTRUCTIONS (Continued)

Item 8 Head circumference (at largest point). The crown is measured with a narrow flexible steel or non-stretchable tape. Special care should be taken to obtain the head circumference at the largest point. The measure should be recorded in centimeters.

Comments Braided hair or bandages when not removed would mean the measure was not optimal. Thus the condition box "Other" should be checked and reason, clearly identified, recorded under "Comments."

Items 9, 10 and 11 are optional.

Even though these items are not required, standard methods of obtaining and recording them should be followed when they are obtained. If taken, the following techniques should be observed:

Crown-rump measure is obtained while child is in supine position on the measuring board by raising the legs and pressing the foot-board firmly against the buttocks.

Chest circumference is measured at the level of the nipples in a plane at right angles to the vertebral column, using a non-stretchable tape. The measure should be taken at expiration.

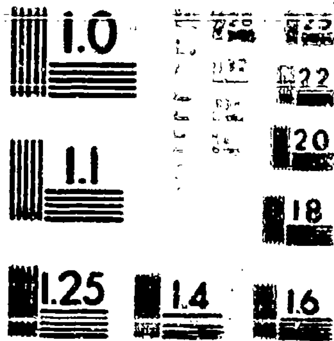
Lower segment should be measured with a flexible non-stretchable measuring tape from the heel to the upper portion of the symphysis pubis.

Measurements should be recorded to the nearest 0.5 centimeter (or 1/4 inch).

Item 12. Comments. If conditions other than optimal exist (such conditions are noted above the item 12 column) then "Other" box should be checked and a clear description should be recorded here.

Item 13. Medical Editor's Comments (local use only). No comment necessary.

February 1964



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PED-20 Interval Medical History

Form PED-20 was used in obtaining information that would help in identifying children in whom a postnatal medical event resulted in brain damage. On the basis of the information obtained, the reviewing physician decided whether the medical information obtained should be verified and whether the child should by recalled for further study. The first version of the form implemented into the study was undated: the form was revised in April 1960 and again in February 1962. Revision resulted in substantial alteration of the form. Data from PED-20 are available on microfilm and on work file number 6.

Data Items Referencing Form PED-20, Interval Medical History

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
6259....W-6			15	17	Cerebral palsy: paresis, hemi, left (1 yr, interim, 7 yr)
6260....W-6			18	20	Cerebral palsy: paresis, hemi, right (1 yr, interim, 7 yr)
6261....W-6			21	23	Cerebral palsy: paresis, mono, arm, left (1 yr, interim, 7 yr)
6262....W-6			24	26	Cerebral palsy: paresis, mono, arm, right (1 yr, interim, 7 yr)
6263....W-6			27	29	Cerebral palsy: paresis, mono, leg, left (1 yr, interim, 7 yr)
6264....W-6			30	32	Cerebral palsy: paresis, mono, leg, right (1 yr, interim, 7 yr)
6265....W-6			33	35	Cerebral palsy: paraparesis (1 yr, interim, 7 yr)
6266....W-6			36	38	Cerebral palsy: quadriplegia: diplegia (1 yr, interim, 7 yr)
6267....W-6			39	41	Cerebral palsy: quadriplegia, other (1 yr, interim, 7 yr)
6268....W-6			42	44	Cerebral palsy: ataxia (1 yr, interim, 7 yr)
6269....W-6			45	47	Cerebral palsy: diplegia, atonic (1 yr, interim, 7 yr)
6270....W-6			48	50	Cerebral palsy: dyskinesia (1 yr, interim, 7 yr)
6271....W-6			51	53	Facial: palsy (1 yr, interim, 7 yr)
6272....W-6			54	56	Brachial plexus: palsy (1 yr, interim, 7 yr)
6273....W-6			57	59	Cerebral palsy: maladroit (1 yr, interim, 7 yr)
6274....W-6			60	62	Cerebral palsy, mixed (1 yr, interim, 7 yr)
6275....W-6			63	65	Cerebral palsy: hypotonic (1 yr, interim, 7 yr)
6277....W-6			67	67	Cerebellitis, acute, interim
6278....W-6			68	68	Cerebral palsy, progressive disease, any epoc

[illegible]
REV. [illegible]

1. PATIENT IDENTIFICATION

INTERVAL MEDICAL HISTORY

2. HISTORY AT AGE

- 6 MONTHS
- 9 MONTHS
- 12 MONTHS
- 18 MONTHS
- 24 MONTHS
- 30 MONTHS
- 36 MONTHS
- 48 MONTHS
- ___ MONTHS

3. HISTORY OBTAINED

- AT CLINIC VISIT
- AT HOME VISIT
- BY PHONE
- BY MAIL
- OTHER (Specify) ____________

4. DATE OF HISTORY Month Day Year

5. INTERVIEWER'S NAME

6. TITLE OR POSITION

7. INFORMANT

- MOTHER
- OTHER (Specify) ____________

NAME (Optional) ____________

8. CURRENT RESIDENCE OF PATIENT

ADDRESS ____________

TELEPHONE ____________

NAME OF INSTITUTION ____________

9. ROUTINE HEALTH CARE

- NO
- YES (Describe)

DATE OF LAST VISIT ____________

10. INPATIENT HOSPITAL CARE

- NO
- YES (Describe on page 2)

11. OTHER MEDICAL CARE

- NO
- YES (Describe on page 2)

12. INJURY NOT TREATED BY PHYSICIAN

- NO
- YES
  - WITH LOSS OF CONSCIOUSNESS
  - WITHOUT LOSS OF CONSCIOUSNESS
  - OTHER

13. CONVULSION NOT TREATED BY PHYSICIAN

- NO
- YES (Describe)

14. OTHER MEDICAL EVENT NOT TREATED BY PHYSICIAN

- NO
- YES (Describe)

15. COMMENTS

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MD

PED-20
REV. [illegible]
PAGE 1 [illegible]

COLLABORATIVE
REV. 3-66

INTERVAL MEDICAL HISTORY
REPORT OF MEDICAL CARE

16. PATIENT IDENTIFICATION

17. HISTORY AT AGE

- ☐ 4 MONTHS
- ☐ 8 MONTHS
- ☐ 12 MONTHS
- ☐ 18 MONTHS
- ☐ 24 MONTHS
- ☐ 36 MONTHS
- ☐ 48 MONTHS
- ☐ 60 MONTHS
- ☐ ___ MONTHS

20. DATE HOSPITALIZED OR SEEN BY PHYSICIAN — Month / Day / Year

18. LOCATION OF MEDICAL RECORDS

- ☐ STUDY FACILITY
- ☐ OTHER HOSPITAL
- ☐ PRIVATE PHYSICIAN
- ☐ OTHER (Specify)

21. AGE OF CHILD AT ONSET OF EVENT

22. DURATION OF EVENT

23. DIAGNOSIS

DO NOT WRITE IN THIS SPACE

19. NAME AND ADDRESS OF FACILITY (If other than Study facility)

24. SUMMARY OF INFORMANT'S ACCOUNT OF MEDICAL CARE RECEIVED

IF NECESSARY, CONTINUE ON FORM CP-6 CONTINUATION SHEET

REVIEW BY STUDY PHYSICIAN: NAME ______________________ M.D.

25. VERIFICATION (Form PED-20)

- ☐ NOT INDICATED
- ☐ INDICATED

26. EXAMINATION

- ☐ NOT INDICATED
- ☐ INDICATED

27. REFERRED TO

- ☐ STUDY FACILITY
- ☐ PRIVATE PHYSICIAN
- ☐ OTHER (Specify)

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MD.

PED-20
REV. 3-66

Form Item Numbers Linked to Data Items on PED-20, Interval Medical History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	6272.....-6		54	56	Brachial plexus palsy (1 yr, interim, 7 yr)
	6277.....-6		67	67	Cerebellitis, acute, interim
	6274.....-6		60	62	Cerebral palsy, mixed (1 yr, interim, 7 yr)
	6278.....-6		68	68	Cerebral palsy, progressive disease, any age
	6268.....-6		42	44	Cerebral palsy; ataxia (1 yr, interim, 7 yr)
	6269.....-6		45	47	Cerebral palsy; diplegia, atonic (1 yr, interim, 7 yr)
	6270.....-6		48	50	Cerebral palsy; dyskinesia (1 yr, interim, 7 yr)
	6275.....-6		63	65	Cerebral palsy; hypotonic (1 yr, interim, 7 yr)
	6273.....-6		57	59	Cerebral palsy; [illegible] (1 yr, interim, 7 yr)
	6265.....-6		33	35	Cerebral palsy; paraparesis (1 yr, interim, 7 yr)
	6259.....-6		15	17	Cerebral palsy; paresis, hemi, left (1 yr, interim, 7 yr)
	6260.....-6		18	20	Cerebral palsy; paresis, hemi, right (1 yr, interim, 7 yr)
	6261.....-6		21	23	Cerebral palsy; paresis, mono, arm, left (1 yr, interim, 7 yr)
	6262.....-6		24	26	Cerebral palsy; paresis, mono, arm, right (1 yr, interim, 7 yr)
	6263.....-6		27	29	Cerebral palsy; paresis, mono, leg, left (1 yr, interim, 7 yr)
	6264.....-6		30	32	Cerebral palsy; paresis, mono, leg, right (1 yr, interim, 7 yr)
	6267.....-6		39	41	Cerebral palsy; quadriplegia, other (1 yr, interim, 7 yr)
	6266.....-6		36	38	Cerebral palsy; quadriplegia; diplegia (1 yr, interim, 7 yr)
	6271.....-6		51	53	Facial palsy (1 yr, interim, 7 yr)

PEDIATRIC MANUAL
INTERVAL MEDICAL HISTORY
(For Form PED-20, Rev. 2-62)

I. Introduction

This manual is a guide for the interviewer in obtaining and recording the information requested in the items listed on Form PED-20.

The purpose of Form PED-20 is to obtain information which will help identify children in whom a postnatal medical event resulted in brain damage. On the basis of the information obtained, the reviewing physician will decide whether the medical information obtained should be verified and whether the child should be recalled for further study.

II. General Instructions

A. Age Schedule. An interval history is to be obtained at ages 4, 8, 12, 18, and 24 months and annually thereafter.

B. Time-Span of History. The interval history is to cover the period from the time the child was last seen by the Study to the time of the current interview.

C. The Interviewer. The information is to be obtained and recorded by an appropriately trained lay interviewer, nurse, or social worker.

D. Informant. The information is to be obtained whenever possible from the person who has primary responsibility for the care of the child. In most cases this will be the biological mother, but in some cases this will be a mother surrogate (a person who is the functional mother).

E. Reporting. The history is for the purpose of obtaining what the informant reports and **what the informant reports** is to be recorded under each item. If no information is obtainable about a particular item, do not leave the item blank but write "Unk." in that space.

III. SPECIFIC INSTRUCTIONS

Item 1, Patient Identification. This item is to be completed using the child's identification stamp. The latter shall include the patient's name, NINDB number, date of birth, time of birth, sex, race, and birth weight.

Item 2, History At Age. The age-span covered by each age-level box is shown in the accompanying table.

History Age-Level	Age-Span Covered
4 months	Under 26 weeks
8 months	26-43 weeks
12 months	44-64 weeks
18 months	15-20 months
24 months	21-29 months
36 months	30-41 months

The 4 months box will be checked for infants interviewed at ages under 26 weeks. The 8 months box will be checked for infants interviewed at any age from 26 weeks through 43 weeks, etc.

Item 3, History Obtained . . . Check the appropriate box to show whether the history was obtained at a clinic or home visit, by phone or mail query, or by some other method.

Item 4, Date Of History. Record here the calendar date on which the history is obtained.

Item 5, Interviewer's Name. Record here the surname and, if necessary for positive identification, the initials of the interviewer.

Item 6, Title or Position. Use initials or abbreviations to indicate the professional training status of the interviewer (Interviewer, Nurse, Social Worker, etc.).

Item 7, Informant. If the history is obtained from the biological mother, check the box "Mother." If the history is obtained from a person other than the biological mother, check the box "Other" and specify the relationship of the informant to the child (Grandmother, Father,

Aunt, etc.). Write in the name of the informant if this information is desired by the Study institution.

Item 8, Current Address of Patient. Insert here the current address and telephone number of the patient's abode, if this information is desired by the Study institution. If child is institutionalized, give name of institution.

Item 9, Routine Health Care. Check "Yes" when the child has visited a physician or a related health practitioner for routine health supervision. Give the date of the last visit so made. Describe the nature of the visit in the "Comment" section.

Item 10, Inpatient Hospital Care. Inpatient hospital care means confinement in a hospital for a period of 24 hours or more. A "Yes" response to this item requires completion of page 2 of the form and does not otherwise require a written comment.

Item 11, Other Medical Care. Check "Yes" when the child has not been hospitalized but has been seen by a physician or a related health practitioner in an emergency room, clinic, private office, etc., for reasons other than routine health care. A "Yes" response to this item requires completion of page 2 of the form.

Item 12, Injury (Not Treated By Physician). If there is a history of injury not treated by a physician or a related health practitioner, check the appropriate box indicating the state of consciousness accompanying the injury. The box "Other" should be checked for states of disorientation, confusion, unknown states of consciousness, etc. A "Yes" response to this item requires further description under "Comments."

Item 13, Convulsion (Not Treated By Physician). A "Yes" response is called for if the informant reports convulsions, or seizures, or involuntary movements, or fits associated with disturbances of consciousness—if these have not been seen or treated by a physician or other health practitioner. A "Yes" response to this item requires further description under "Comments."

Item 14, Other Medical Event (Not Treated By Physician). Report here whether or not there has been some medical event, other than injury or convulsion, which was not treated or seen by a physician. A "Yes" response requires further description under "Comments."

Item 15, Comments. A written comment is required for each "Yes" response to items 9, 12, 13 and 14. Identify each comment by the number of the item to which it refers.

Items 16 to 27. These items are to be completed for each "Yes" response to either item 10 or item 11. (A separate page 2 is to be completed for each discrete medical event checked in item 10 or item 11.)

Item 16, Patient Identification. Same as item 1.

Item 17, History At Age. Same as item 2. The same box will be checked in this item as was checked in item 2.

Item 18, Location of Medical Records. Check the appropriate box to indicate the professional facility that may have records on the medical event being described.

Item 19, Name And Address Of Facility. If a category other than the "Study Facility" is checked in item 18, record here the name and address of the facility checked.

Item 20, Date Hospitalized Or Seen By Physician. Record here the calendar date on which the child was hospitalized or otherwise seen by a physician.

Item 21, Age Of Child At Onset Of Event. Record here the age of the child, in completed months, at which the onset of the medical event occurred for which the child was hospitalized or otherwise seen by a physician.

Item 22, Duration of Event. Record here the approximate duration of the medical event from its onset to its termination. If not

terminated, record "To the present" in this space.

Item 23, Diagnosis. Record here the diagnosis or diagnoses as given by the informant.

Item 24, Summary. Summarize in narrative form the main features of the medical event for which the child was hospitalized or otherwise seen by a physician.

Items 25 to 27. These items are to be completed by the reviewing physician after a review of the information in the foregoing items.

Item 25, Verification. Record here whether the medical event described on page 2 is to be verified. This decision will be based on the physician's assessment of the likelihood that the medical event described may have caused some brain damage. Verified information is to be reported on Form PED-29.

Item 26, Examination. Record here whether the child is to be recalled for a diagnostic examination. This decision will be based on the physician's assessment of the likelihood that this child may have had some brain damage.

Item 27, Referred To. If the decision has been made to recall the child for a diagnostic examination, record here whether the examination has been arranged for at the Study Facility, a private physician, or another medical facility. The results of the examination are to be reported on a Form CP-5, appropriately identified as to purpose, when the examination is done at the Study Facility.

[illegible]

1. PATIENT IDENTIFICATION

FOLLOW-UP INTERVAL HISTORY

2. HISTORY IN CONNECTION WITH
- 4 Month Pediatric Examination
- 8 Month Psychological Examination
- 1 Year Neurological Examination
- Other (Specify)

3. DATE OF HISTORY — MO. — DAY — YEAR

4. INTERVIEWER'S NAME — 5. TITLE OR POSITION

6. INFORMANT (Relationship to child)
- Mother
- Other (Specify) ____________

FEEDING

7. NUMBER OF FEEDINGS PER DAY ____________

8. MILK AND OTHER LIQUIDS FROM (Check all that apply)
- Bottle
- Cup
- Breast
- Other (Specify)

9. TYPE OF MILK (other than breast)
- Regular Evap., Regular dry, or whole cow's milk
- Proprietary milk product or milk-substitute (Give trade name) ____________

10. SOLID FOODS BY SPOON
- Yes
- No (Give reason)

11. FEEDING PROBLEMS
- No
- Difficult or excessively slow (Describe)
- Excessively fast (Describe)
- Vomiting (Describe)
- Colic (Describe)
- Rumination (Describe)
- Other (Describe)

ELIMINATION

12. NUMBER OF BOWEL MOVEMENTS PER DAY ____________

13. CONSISTENCY OF USUAL BOWEL MOVEMENTS
- Variable, soft or firm
- Watery
- Very hard

SLEEPING

14. USUAL DAILY PATTERN OF SLEEPING (Number of hours)

Night ____________ Daytime Naps ____________

15. UNUSUAL SLEEPING HABITS
- No
- Yes (Describe)

INSTRUCTIONS:

The Manual should be carefully followed in collecting and recording this information.

Describe all unusual or abnormal conditions.

16. COMMENTS

Collaborative Study
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

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Page of

FOLLOW-UP INTERVAL HISTORY
(Continued)

☐ [illegible] ☐ [illegible] ☐ [illegible] ☐ Other

17. PATIENT IDENTIFICATION

18. COMMENTS

ACTIVITY WHEN AWAKE

18. UNUSUAL AMOUNT OF ACTIVITY
- ☐ No
- ☐ [illegible] (Describe)
- ☐ [illegible] (Describe)

19. UNUSUAL TYPE OF ACTIVITY (Check all that apply)
- ☐ No
- ☐ [illegible] (Describe)
- ☐ [illegible] (Describe)
- ☐ [illegible] (Describe)
- ☐ Other [illegible] (Describe)
- ☐ Other (Describe)

CRYING

20. UNUSUAL AMOUNT OR TYPE OF CRYING
- ☐ No
- ☐ More than expected amount (Describe)
- ☐ Less than expected amount (Describe)
- ☐ Other (Describe)

21. RESPONSE TO COMFORTING: CRIES FOR LONG PERIODS IN SPITE OF ATTEMPTS AT COMFORTING
- ☐ No
- ☐ Yes (Describe)

SOCIAL RESPONSE

	Pos.	Int.	Neg.	W/A.	Unkn.
22. TO APPROACH OF MOTHER	☐	☐	☐	☐	☐
23. TO APPROACH OF OTHER FAMILIAR PERSONS	☐	☐	☐	☐	☐
24. TO APPROACH OF STRANGE PERSONS	☐	☐	☐	☐	☐
25. TO BEING HELD AND CUDDLED	☐	☐	☐	☐	☐
26. TO ROUGH PLAY	☐	☐	☐	☐	☐
27. TO BEING BATHED	☐	☐	☐	☐	☐
28. TO BEING FED	☐	☐	☐	☐	☐
29. TO BEING DRESSED	☐	☐	☐	☐	☐

KEY TO RECORDING

- Pos. - POSITIVE [illegible]
- Int. - INTERMEDIATE [illegible]
- Neg. - NEGATIVE [illegible]
- W/A. - WITHDRAWN [illegible]
- Unkn. - UNKNOWN [illegible]

FOLLOW-UP INTERVAL HISTORY
(Continued)

PAST MEDICAL HISTORY

28. COMMENTS

[illegible]

FOLLOW-UP INTERVAL HISTORY
(Continued)

[illegible]

[illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]

[illegible]

Month Day Year

[illegible]

[illegible]

[illegible]

Yes No Explain

[illegible]

[illegible]

DO NOT USE THIS SPACE

[illegible]

[illegible]

- High Fever
- Convulsions
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- Operation

[illegible]

[illegible]

PED-20

FOLLOW-UP INTERVAL HISTORY

INSTRUCTIONS: Every numbered item should be checked (✓) [illegible]. Findings should be checked (✓) and described [illegible] at right.

1. EXAMINED BY	2. BIRTH DATE (Mo-Day-Yr)
3. STATUS	4. DATE (Mo-Day-Yr)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

A - PRESENT STATUS OF CHILD

5. MOTHER'S ESTIMATE OF INFANT'S PRESENT HEALTH

☐ [illegible]

☐ OTHER (Describe)

6. MOTHER'S COMPLAINTS REGARDING INFANT'S HEALTH

☐ NONE

☐ OTHER (Describe)

B - INFANT'S INTERVAL HISTORY

7. ILLNESSES (if more than one, describe in column at right [illegible])

☐ NO ☐ YES (Complete items below - describe at right)

8. [illegible] ______

9. ESTABLISHED BY ______

10. TREATMENT ______

11. DURATION ______

12. COMPLICATIONS ______

13. AGE AT ONSET ______

14. SPECIFIC SYMPTOMS

15. HIGH FEVER ☐ NO ☐ YES

16. HIGHEST TEMPERATURE ______

17. DURATION ______

18. [illegible] DIARRHEA ☐ NO ☐ YES

19. [illegible] ☐ NO ☐ YES

DURATION ______

20. [illegible] ☐ NO ☐ YES

DURATION ______

21. [illegible] ☐ NO ☐ YES

22. [illegible] ☐ NO ☐ YES

23. [illegible] ☐ NO ☐ YES

24. [illegible] WEIGHT LOSS [illegible]

☐ NO ☐ YES

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FOLLOW-UP INTERVAL HISTORY
(Continued)

SPECIFIC SYMPTOMS (Continued)

25. DEVELOPMENTAL REGRESSION ☐ NO ☐ YES

26. ANEMIA ☐ NO ☐ YES

27. OTHER ☐ NO ☐ YES

28. ACCIDENTS

☐ NONE

29. TRAUMA - HEAD ☐ NO ☐ YES

30. TRAUMA - UNCONSCIOUSNESS ☐ NO ☐ YES

31. TRAUMA - OTHER (Describe) ☐ NO ☐ YES

32. HOSPITALIZATION

☐ NONE

☐ OTHER (Describe)

33. OPERATIONS

☐ NONE

☐ OTHER (Describe)

34. RADIATION

☐ NONE

☐ OTHER (Describe)

35. IMMUNIZATIONS

☐ NONE

☐ D.P.T. ____________ TIMES

☐ POLIO ____________ TIMES

☐ OTHER (Describe)

36. REACTIONS ☐ NO ☐ YES

37. ELIMINATION (Bowel and bladder)

☐ NORMAL

☐ ABNORMAL (Describe)

38. ALLERGY

☐ ABSENT

☐ PRESENT (Describe)

Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reason for not evaluating any item.

FOLLOW-UP INTERVAL HISTORY (Continued)

39. FEEDING

40. MILK ____________ AMOUNT/DAY

41. SOLIDS ____________ AMOUNT/DAY

42. VITAMINS ☐ NO ☐ YES

43. FEEDING PROBLEMS

☐ ABSENT

☐ PRESENT

44. DEVELOPMENTAL MILESTONES

			AGE ATTAINED (IN MONTHS)
45. HEAD UP	☐ NO	☐ YES	46. ________
47. CHEST UP	☐ NO	☐ YES	48. ________
49. SAT WITH SUPPORT	☐ NO	☐ YES	50. ________
51. SAT ALONE	☐ NO	☐ YES	52. ________
53. STOOD HOLDING ON	☐ NO	☐ YES	54. ________
55. STOOD ALONE	☐ NO	☐ YES	56. ________
57. WALKED ALONE	☐ NO	☐ YES	58. ________
59. SAID RECOGNIZABLE WORDS	☐ NO	☐ YES	60. ________
61. CONDITIONED TRICKS	☐ NO	☐ YES	62. ________

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

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PHS-[illegible]
REV. [illegible]

FOLLOW-UP INTERVAL HISTORY

1. PATIENT IDENTIFICATION

2. HISTORY IN CONNECTION WITH

- [ ] 4 Month Pediatric Examination
- [ ] 8 Month Psychological Examination
- [ ] 1 Year Neurological Examination
- [ ] Other (Specify)

INSTRUCTIONS:
The Interview Guide and the Manual should be carefully followed in collecting and reporting the data for this form.
Describe all unusual or abnormal conditions.

3. DATE MO. | DAY | YEAR

16. COMMENTS

4. INTERVIEWER'S NAME

5. STATUS

6. INFORMANT (Relationship to child)

FEEDING

7. NUMBER OF FEEDINGS PER DAY ________

8. MILK FROM

- [ ] Bottle only
- [ ] Breast only
- [ ] Breast and bottle
- [ ] Other (Specify)

9. TYPE OF MILK ________

10. SOLID FOODS BY SPOON

- [ ] Yes
- [ ] No (Give reason)

11. FEEDING PROBLEMS

- [ ] No
- [ ] Difficult or excessively slow (Describe)
- [ ] Excessively fast (Describe)
- [ ] Vomiting (Describe)
- [ ] Colic (Describe)
- [ ] Other (Describe)

ELIMINATION

12. NUMBER OF BOWEL MOVEMENTS PER DAY ________

13. CONSISTENCY OF USUAL BOWEL MOVEMENTS

- [ ] Variable, soft or firm
- [ ] Watery
- [ ] Very hard

SLEEPING

14. USUAL DAILY PATTERN OF SLEEPING (Number of hours)

Night ________ A.M. Nap ________ P.M. Nap ________

15. UNUSUAL SLEEPING HABITS

- [ ] No
- [ ] Yes (Describe)

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Test Form

[illegible]
REV. [illegible]

FOLLOW-UP INTERVAL HISTORY
(Continued)

☐ [illegible] Month ☐ [illegible] Month ☐ 1 Year ☐ Other

17. PATIENT IDENTIFICATION

[illegible] CLLR-3004-20
[illegible] 3-61

30. COMMENTS

ACTIVITY WHEN AWAKE

18. UNUSUAL AMOUNT OF ACTIVITY

☐ No ☐ Unusually inactive (Describe)
☐ Excessively active (Describe)

19. UNUSUAL TYPE OF ACTIVITY (Check all that apply)

☐ No ☐ Breath holding spells (Describe)
☐ Temper tantrums (Describe)
☐ Head banging (Describe)
☐ Other rhythmic banging or rocking (Describe)
☐ Rumination (Describe)
☐ Other (Describe)

CRYING

20. UNUSUAL AMOUNT OR TYPE OF CRYING

☐ No ☐ More than expected amount (Describe)
☐ Less than expected amount (Describe)
☐ Other (Describe)

21. RESPONSE TO COMFORTING: CRIES FOR LONG PERIODS IN SPITE OF ATTEMPTS AT COMFORTING

☐ No ☐ Yes (Describe)

SOCIAL RESPONSE

	Pos.	Int.	Neg.	W/d.	Unkn.
22. TO APPROACH OF MOTHER	☐	☐	☐	☐	☐
23. TO APPROACH OF OTHER FAMILIAR PERSONS	☐	☐	☐	☐	☐
24. TO APPROACH OF STRANGE PERSON'S	☐	☐	☐	☐	☐
25. TO BEING HELD AND CUDDLED	☐	☐	☐	☐	☐
26. TO ROUGH PLAY	☐	☐	☐	☐	☐
27. TO BEING BATHED	☐	☐	☐	☐	☐
28. TO BEING FED	☐	☐	☐	☐	☐
29. TO BEING DRESSED	☐	☐	☐	☐	☐

KEY TO RECORDING:

Pos. – POSITIVE: Consistently smiles, coos and laughs, reaches towards or actively participates.

Int. – INTERMEDIATE: Variable between positive and negative, mildly positive or negative most of the time, or Neutral, such as being alert without active participation.

Neg. – NEGATIVE: Consistently cries, [illegible], resists, [illegible] [illegible] or stiff.

W/d. – WITHDRAWN: Completely unaware of the situation.

Unkn. – UNKNOWN: Child has not been in the situation, or informant is unable to provide sufficient information to categorize the response.

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Test Form [illegible]

U.S. GOVERNMENT PRINTING OFFICE [illegible]

[illegible]
REV. [illegible]

FOLLOW-UP INTERVAL HISTORY
(Continued)

☐ 4 Month ☐ 8 Month ☐ 1 Year ☐ Other

31. PATIENT IDENTIFICATION

see COL R-3008-20
rev 3-61

PAST MEDICAL HISTORY

32. THINGS TAKEN BY MOUTH (Other than food, vitamins, and drugs which are reported on Page 4)

☐ No ☐ Yes (Describe)

33. INJURY

☐ No

☐ Head injury with loss of consciousness (Describe)

☐ Head injury without loss of consciousness (Describe)

☐ Other (Describe)

34. ILLNESSES (Other than "colds", diaper rash, and "teething")

☐ No (NOTE: All the symptoms and procedures listed on Page 4 must be inquired about. If any confirmed check "yes" and complete Page 4)

☐ Yes, Number ______ (Report on Page 4, use separate sheet for each illness)

SOCIO-ECONOMIC ENVIRONMENT

35. DIFFICULTIES, UNUSUAL SITUATIONS, OR MAJOR EVENTS OR CHANGES IN THE HOME AND FAMILY (Community, or [illegible])

☐ No ☐ Yes (Describe)

OTHER

36. UNUSUAL THINGS ABOUT THE CHILD NOT REPORTED ELSEWHERE

☐ No ☐ Yes (Describe)

QUALITY OF DATA

37. INTERVIEWER'S EVALUATION OF INFORMATION RECORDED ABOVE (Including Page 4)

☐ Satisfactory

☐ Incomplete because (Describe)

☐ Other qualifications (Describe)

38. COMMENTS

U.S. GOVERNMENT PRINTING OFFICE [illegible]

FOLLOW-UP INTERVAL HISTORY
(Continued)

☐ 4 Month ☐ 8 Month ☐ 1 Year ☐ Other

39. PATIENT IDENTIFICATION

Gee CCCR-3007-20
rev. 3-61

REPORT OF ILLNESS OR HOSPITALIZATION

40. HOSPITAL (Name and address)

☐ No

41. PHYSICIAN (Name and address)

☐ No

42. DATE SEEN BY PHYSICIAN OR ADMITTED TO HOSPITAL ______ (Month) (Day) (Year)

43. AGE OF CHILD AT ONSET OF ILLNESS ______

44. DIAGNOSIS

45. DURATION OF ILLNESS

SYMPTOMS (Check those that apply, list others, and describe all)

46. ☐ Convulsions
47. ☐ Unconsciousness
48. ☐ Dehydration
49. ☐ Draining ear
50. ☐ Cyanotic spells
51. ☐ Other

TESTS, PROCEDURES, AND TREATMENT (Check those that apply, list others, and describe all)

52. ☐ Spinal tap
53. ☐ X-Ray or fluoroscopy
54. ☐ Operation
55. ☐ Other

56. COURSE AND COMPLICATIONS (Describe)

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Test Form 4-60

PED-29 Summary of Medical Records of
Illness or Hospitalization

Form PED-29 was used to provide an abstract of recorded information about an illness, injury, condition or hospitalization of the child that may have caused, influenced or indicated the presence of central nervous system disorder. First implemented in January 1961, the form was never revised. Data are available on microfilm only.

COLM 3007/80
1-61

1. PATIENT IDENTIFICATION

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

2. SUMMARY DONE BY

3. TITLE OR POSITION

4. DATE OF SUMM.
Mo. | Day | Year

5. SOURCE OF MEDICAL RECORDS
- Study Facility
- Other Hospital or Clinic
- Private Physician
- Visiting Nurse Service
- Other (Specify)

6. NAME AND ADDRESS IF OTHER THAN STUDY FACILITY

7. RECORD NUMBER
(Local patient identification name, number or code if different from Item 1 above.)

8. SUMMARY INCLUDES RECORDS DATED
Mo. | Day | Year | Through | Mo. | Day | Year

9. AGE OF CHILD AT ONSET OF ILLNESS

10. DURATION OF ILLNESS

11. DIAGNOSIS

20. (Do not use this space)

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications.)

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THE ILLNESS.

13. High fever
Max. ________ °F.

14. Convulsions

15. Unconsciousness

16. Diarrhea

17. Dehydration

18. Draining ear

19. Cyanotic spells

20. Reaction to injections

21. Spinal tap

22. X-ray or fluoroscopy

23. Operation

(Continue on Form CP-3, Continuation Sheet)

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION
(PED-29 January 1961)

I. INTRODUCTION

The purpose of the summary of medical records is to provide in a fairly systematic way an abstract of recorded information about an illness, injury, condition or hospitalization of the child which may have caused, influenced, or indicated the presence of Central Nervous System disease. For simplicity the term "illness" as used hereafter will include:

A. Infectious, metabolic, and neoplastic diseases for which medical treatment is given.

B. Congenital or acquired malformations or conditions for which medical diagnosis or treatment is given.

C. Accidents or injuries including burns or poisonings for which medical treatment is rendered.

D. Emotional or psychiatric conditions or illnesses for which professional diagnostic or therapeutic service is rendered.

E. Any other hospitalization or outpatient clinic care for diagnosis or treatment of serious or potentially serious conditions.

In general it is not considered worthwhile for the purposes of this Study to obtain and report medical records on routine well-baby care visits, immunizations, or the diagnosis or treatment of such mild and common conditions as common cold and diaper rash.

II. SOURCE OF INFORMATION

The types of records which may be used for verifying the facts of, and providing pertinent details of, an illness in the child may include visiting nurse service records, social worker or public welfare case worker records, records of health insurance or city outpatient clinics, as well as private physicians' records and hospital inpatient or outpatient records. Any of these may be used as authorative sources for further information on the child. This is not to imply that all these possible sources must be consulted for each case.

III. PERSON DOING THE SUMMARY

1) Records from the Study hospital or outpatient facility may be abstracted by a medical records librarian or project secretary or nurse at the discretion of the local pediatrician-in-chief.

January 1961

2) Records from outside sources such as other hospitals, private physicians, visiting nurse service, etc., should be abstracted by a Study pediatrician, or under his direct supervision. This is felt advisable in order that the Study pediatrician's knowledge of the idiosyncrasies of medical practice in other facilities may be used in interpreting and reporting this information.

3) This form, with a very abbreviated manual or preferably a letter of explanation, may be sent to private physician, visiting nurse, or physician-in-charge of an outpatient clinic for completion by or under the direct supervision of the professional involved.

4) In some well-supervised situations it may be desirable to send this form with an accompanying abbreviated manual or letter of explanation to the medical records librarian of another hospital rather than requesting from that hospital a discharge summary or copy of hospital records.

5) Whether to handle outside hospital records by the procedure in paragraph (2) or (3) or the procedure in paragraph (4) shall be left to the discretion of the Project Director or Pediatric Coordinator.

IV. HOW THE FORM IS STARTED

Usually the person initiating this form will be the Interval History interviewer, who obtains from the mother the history that the child was ill and was seen by a physician or in a clinic, etc. However, the use of this form should not be limited to such situations but should also include the abstract of any medical records which become known to the Study personnel.

V. CONSTRUCTION OF THE FORM

This record sheet is structured in the form of a skeleton outline of a traditional case summary:

1. Who? - Item 1
2. Where? - Items 5, 6 and 7
3. When? - Items 8, 9 and 10
4. What was the illness? - Item 11
5. How was the illness manifested?
   What did the physician do?
   What was the outcome? - Item 12.

Item 12 is to be a brief narrative summary of the illness. For this reason the space for recording this summary is not divided into discrete blocks, and provision is made for extending this summary onto additional record sheets.

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Items 13-23 are to be used as a coarse code for the presence of certain features of illness or treatment that are thought to be of special relevance to Central Nervous System disease. These items in no way restrict or limit the need for the narrative summary.

VI. INSTRUCTIONS AND DEFINITIONS FOR COMPLETING THE ITEMS ON THIS FORM

Item 1, Patient Identification. This should be completed using the patient's name plate, containing at least the following information: patient's name, NINDB number, date of birth, birth weight, sex and race.

Item 2, Summary Done By. Here record the name of the person who abstracted the medical records and formulated this report.

Item 3, Title or Position. Here record the professional status of the person who's name appears in Item 2 (as Nurse, Medical Records Librarian, Pediatrician, etc.).

Item 4, Date of Summary. Here record the date the summary was done.

Item 5, Source of Medical Records. This item is to indicate what type of record is being summarized on this form.

The first category "Study Facility" refers to the reporting hospital inpatient, outpatient, and emergency ward services, and any other service administratively connected to the Study institution.

The second category "Other Hospital or Clinic" includes not only the inpatient, outpatient, and emergency ward services of another hospital, but also Health Insurance Plan, city, or other group pediatric out-patient clinics.

The third category "Private Physician" refers to the situation where the child was seen by the physician on an outpatient basis, and to the possible situation where the child was seen in a hospital or general clinic but the records are kept by the physician rather than by the hospital or clinic.

The fourth category "Visiting Nurse Service" refers to any public health nursing service. If the primary diagnosis and treatment for this illness were done by a visiting nurse, it is likely the Visiting Nurse Service would have a record of this. It will be more frequently the case that the Visiting Nurse Service conducts follow-up visits including observation and treatment for an illness or condition for which the child was previously seen by a physician or in a hospital. In this

situation the medical records in the hospital or from the physician and the records from the Visiting Nurse Service would apply to the same illness and may be reported together on one form. If this is the case both appropriate boxes should be checked.

The fifth category "Other" refers to any other source of recorded medical information such as consulting psychologist, social worker, or adoption agency records.

Item 6, Name and Address if Other than Study Facility. If any category other than #0 "Study Facility" is checked in Item 5, the name and address of the hospital, clinic, private physician, visiting nurse service, etc. should be given. If only "Study Facility" is checked, no recording is necessary in this space.

Item 7, Record Number. If this form is being used for a summary of medical records from the Study Hospital, the identification of this record may be contained in the patient identification stamp (Item 1). If the patient's name or record identification code or number are different from those in Item 1 or do not appear in Item 1, they should be recorded in this space.

If the record is from an outside source, the unit number, code, or name necessary to positively identify that record should be recorded in this blank. This is important in order that it may be possible to return at some later date to the original record for further information if necessary.

Item 8, Summary Includes Records Dated: ______ Through ______. Report in the appropriate blanks the first and last dates appearing on the records being summarized. If there is only one date, record it in the first blank and indicate that there were no subsequent records available (i.e., May 7, 1959 only).

The dates reported in these blanks should include all available records applying to the illness summarized.

Item 9, Age of Child at Onset of Illness. Here record the age of the child at the time the illness for which this record is being prepared was first noticed, or in retrospect first became manifest. For acute conditions this would usually correspond very closely to the first date recorded in Item 8. However, for chronic illnesses or congenital conditions this will not necessarily be the case. As a guideline for the detail desired, the following are suggested: (a) If the age is under four months report in weeks; (b) If the age is under two years report

in months; (c) If the age is over two years report to the nearest year or half year. This is a suggestion, and the availability of information may make more or less detail desirable.

Item 10, Duration of Illness. Here report the approximate duration of the illness from the age at onset to the age at complete recovery or return to normal. For acute conditions this will usually be clear; however, for chronic, mild, or congenital conditions this may either not be clear or may continue to the present. If the condition is still present write "To the present" in this blank. ("The present" will be the second date reported in Item 8).

Item 11, Diagnosis. Here report as clearly as possible the major and all ancillary diagnoses of this illness. As nearly as possible the diagnoses should be expressed in standard medical terms such as those used in the Standard Nomenclature of Diseases and Operations.

Item 2A, Do Not Use This Space. This space is to be used by special NINDB coders for coding the diagnoses. Please do not write in this space.

Item 12, Salient Features of Illness or Condition. Record in narrative or outline fashion a very brief summary of the important features of the illness or condition. Special attention should be given to manifestations and complications of severe dehydration, technique and complications of general anesthesia, results of procedures involving the central nervous system (skull films, L.P., EMG, PEG), and positive neurological findings on examination or history. In most cases it is not necessary to list all laboratory findings, details of therapy, or details of physical examination findings.

Four sample records are included in the appendix to this manual as guidelines for the type of data desired on this record.

Items 13-23, In Addition to Summary, Check Below All that Apply to the Illness. The examiner is asked to code the presence of certain features of the illness that are considered of particular relevance to Central Nervous System disease, in addition to stating and describing them in the narrative summary. The presence of these items on the far right in no way implies that the summary should be limited to these features. Although there are many other particular features of illnesses that might have been included, this list was adopted, after careful consideration of all recommendations, for use on both Page 4 of PED-20 and on this record.

January 1961

Although it is difficult to provide a concise definition for most of these items, some guidelines are suggested.

Item 13, "High fever" should be considered any temperature as high as 103°F rectally, or 102°F orally. A prolonged fever which does not quite reach this arbitrary level may also be reported as "High fever." In the blank adjacent to this item report the maximum temperature recorded and indicate whether it was rectal or oral.

Item 14, "Convulsions" should be checked if the record reports "convulsions" or "seizures," or describes tonic or clonic movements associated with disturbance of consciousness. Any description suggesting a diagnosis of convulsions should also be reported.

Item 15, "Unconsciousness" should include stupor but not mild drowsiness. This sign should be unequivocal and needs no further definition here.

Item 16, "Diarrhea" is difficult to define, but as a rough guideline four or five watery stools per day for more than one day should be considered diarrhea.

Item 17, "Dehydration" should be checked if there was clinical evidence of hemoconcentration or loss of body fluids sufficient to require parenteral fluid therapy. However, there may be appreciable dehydration described without reported evidence of hemoconcentration, and adequately treated by oral fluids. This, too, should be reported. Dryness of the skin, per se, is usually not adequate clinical evidence for significant dehydration.

Item 18, "Draining ear" should include either serous or suppurative discharge from the middle ear. Otitis without perforation should be described in the narrative summary, but not coded here.

Item 19, "Cyanotic spells" should be checked if there is either episodic or persistent cyanosis, even of the hands or feet. While peripheral cyanosis (of the hands and feet only) is sufficiently common in the newborn nursery to be of questionable meaning, it is probably worth reporting in a child beyond the newborn period.

Item 20, "Reaction to injections" should include both febrile and allergic reactions to drugs or biologicals (vaccines or antisera) given by injection. Reactions to oral medications should be described in the narrative summary, but not coded here.

January 1961

Item 21, "Spinal tap" should include any procedure involving insertion of a needle into the spinal or cranial cavity, i.e. ventricular tap, subdural tap, pneumoencephalogram, etc. The results of the procedure should be specified in the summary.

Item 22, "X-ray or fluoroscopy" is self-explanatory. The X-ray report may be summarized on this record, or a copy of the original report attached.

Item 23, "Operation" should be checked for only those surgical procedures involving general or spinal anesthesia, or resulting in a diagnostic biopsy. The former is of interest for its possible influence on later Central Nervous System function. Techniques and any complications should be clearly specified. The latter is of interest, of course, in providing or ruling out a diagnosis. The pathology report may be summarized on this record, or a copy of the original report attached.

VI. CONTINUATION

If the space on this record is inadequate to record all the information considered pertinent to this illness, continue on Form CP-5, Continuation Sheet.

VII. SENDING THE FORM TO OUTSIDE PHYSICIAN FOR COMPLETION

In those situations where it is felt by local personnel to be desirable to send the form "Summary of Medical Records" to a private physician or other medical facility, rather than requesting an abstract or copy of the records, it is strongly recommended that a letter on local Study letterhead accompany the form. This letter should explain the purpose of the request and give very brief directions as to the type of information desired. Items 1, 5, and 6 should be completed by Study personnel prior to sending the form out. Items 8, 9, and 10 may be filled in by Study personnel prior to sending the form out if this information is definitely known. However, if the dates are in doubt it is probably best to leave these to be filled in by the person completing the form.

One or more copies of record form CP-5 properly identified should be included with the record form PED-29, abbreviated manual and letter to the outside physician.

January 1961

VIII. APPENDIX

Attached are four sample records to serve as guidelines for the type of data desired; and suggestions for a form letter for use in requesting medical records from an outside hospital, a form letter for use in introducing and explaining the purpose of Form PED-29, and a one-page manual to assist in reporting the type of information desired on PED-29 if it is sent out.

Date:

Hospital Administrator
(Address)

Dear ___________:

As you know, the ______________________________ is directing a Child Growth and Development Project in conjunction with several hospitals throughout the country and the National Institute of Neurological Diseases and Blindness.

We are informed that the undermentioned patient has been hospitalized at your hospital, and we would very much appreciate a copy of the discharge summary.

We will be very grateful for your cooperation, as the success of our whole program depends on the completeness of our records.

If there are any questions concerning our Study, please do not hesitate to call.

Yours sincerely,

(Coordinator's title)

PATIENT:

Name: Birth Date:
Mother's name:
Address:

Date admitted:

January 1961

(local Study letterhead)

Date:

(inside address)

Dear Dr. ______________:

Your patient ______________________________,
the child of ______________________________
was seen by a member of our staff on ______________. As you
know this child is a participant in the ______________
__________. A history of the following illness(es): __________
____
seen and treated by you on or about __________ was obtained from
______________________ as part of our Study follow-up program.

We would be grateful for your cooperation in providing us with a summary of the pertinent features of this child's illness(es). The enclosed form is provided for your convenience in recording this information. If it would be more convenient for you to have a photocopy of your records made and sent to us that would be fine.

Thank you very much for your cooperation.

Sincerely yours,

(Pediatric Coordinator)

Enclosures: (stamped, pre-addressed envelope, Form PED-29, Page of instructions for Form PED-29, Continuation Record Sheet CP-5).

Abbreviated Manual to be sent to non-Study medical facility

The purpose of the accompanying forms (PED-29 and CP-5) is to provide for convenience in recording in a systematic fashion a brief summary of medical information on the diagnosis, treatment, and outcome of any potentially serious disease or condition in a Study baby.

Instructions and Definitions for Reporting Information on Form PED-29

Item 7, Record Number. Record the name, number or code by which the patient's record is identified by the physician or outside hospital.

Item 8, Summary Includes Records Dated ___ through ___. Record the dates which include all records summarized in this report.

Item 9, Age. Record approximate age of the child at onset of illness.

Item 10, Duration of Illness. If the condition is congenital or chronic, or if recovery is not complete at present write "to the present" in this blank.

Item 11, Diagnoses. Record the major and any auxiliary diagnosis pertaining to this illness. It is desirable that standard medical terms such as those used in the Standard Nomenclature of Diseases and Operations be used.

Item 12, Salient Features of Illness or Condition. Record in narrative or outline fashion a very brief summary of the important features of the illness or condition. Special attention should be given to manifestations and complications of severe dehydration, techniques and complications of general anesthesia, results of procedures involving the Central Nervous System (skull films, L.P., EEG, PEG), and positive neurological findings on examination or history. In most cases it is not necessary to list all laboratory findings, details of therapy, or details of the physical examination.

Items 13-23. The examiner is asked to code the presence of certain features of the illness that are thought to be of particular relevance to Central Nervous System disease. The presence of these items on the far right in no way implies that the summary should be limited to these features. As an illustration of the type of information desired the following guidelines are suggested.

"High fever" should be coded if the temperature was over 103° rectal or 102° oral, or perhaps somewhat less if prolonged. "Diarrhea" should be coded if the child has had more than four or five liquid or copious stools for more than one day. "Dehydration" should be checked if there is evidence to suggest appreciable hemoconcentration or loss of body fluid sufficient to require intensive oral or parenteral fluid therapy. "Draining ear" should be checked only if there was otitis with perforation. Otitis without perforation should be described in the summary but not coded here. "Reaction to injections" should include both febrile and allergic reactions to antibiotics or biologicals administered parenterally. Reactions to oral medications or toxins should be described but not coded here.

Continuation. Please do not feel restricted to the single sheet (PED-29) if more extensive information is pertinent. The enclosed sheets (CP-5) are provided for your convenience.

January 1961

COL-P-3000-29
1-61

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

1. PATIENT IDENTIFICATION

Whitehal, Nancy

[illegible] 7/20/[illegible] [illegible]

[illegible]

SUMMARY DONE BY

B. D. Kelly

3. TITLE OF AUTHOR

C. D. S. Ped.

4. DATE OF SUMM.

Mo.	Day	Year
12	22	60

5. SOURCE OF MEDICAL RECORDS

- [X] Study Facility
- [ ] Other Hospital or Clinic
- [ ] Private Physician
- [ ] Visiting Nurse Service
- [ ] Other (Specify)

6. NAME AND ADDRESS IF OTHER THAN STUDY FACILITY

7. RECORD NUMBER
(Local patient identification name, number or code if different from Item 1 above)

8. SUMMARY INCLUDES RECORDS DATED Mo. / Day / Year	Through	Mo. / Day / Year	9. AGE OF CHILD AT ONSET OF ILLNESS	10. DURATION OF ILLNESS
Sept. 22 '60		Nov. 8 '60	1 month	to present

11. DIAGNOSIS

1) Pneumonia, chronic, etiology unknown, 2) failure to thrive, 3) anemia, iron deficiency

11A. (Do not use this space)

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications.)

1) Pneumonia age 1 mo.
    Cass Lke Hosp. for 2 wks.
  Adm. to UMH 9/22/60
    bilateral pneumonia by X-ray, afebrile
    T.B. workup neg. to date, AFB cultures pending
    deep mycosis skin tests neg.
    C.S.F. protein 94, cells 3, sterile

2) Thin, chronically ill, Wt. 4120 gms.
    Wt. gain 400 gms. in 6½ wks. in hospital
    subdural taps X2 neg.
    bone age films, I.V.P. neg.

3) Hemoglobin 9.6 - 8.3 gms., assumed to be nutritional

Discharged with persistent infiltrate Rt. base
  no Dx. for failure to thrive
  Rx. Fer-in-sol and vitamins
  P.H. Nurse will follow
  return 1 mo. to clinic.

See attached discharge summary for more detail.

(Note: These three conditions are summarized together since they seem to be related and are parts of the same hospital course. In general, the records will make more sense and be easier to process if conditions or diagnoses that are related are reported together, and separate or unrelated conditions are reported on separate sheets.)

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THIS ILLNESS.

- 13. [ ] High fever Max. ______°F.
- 14. [ ] Convulsions
- 15. [ ] Unconsciousness
- 16. [ ] Diarrhea
- 17. [ ] Dehydration
- 18. [ ] Draining ear
- 19. [ ] Cyanotic spells
- 20. [ ] Reaction to injections
- 21. [X] Spinal tap
- 22. [X] X-ray or fluoroscopy
- 23. [ ] Operation

(Continue on Form CP-3, Continuation Sheet)

COL-[illegible]
1-61

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

1. PATIENT IDENTIFICATION

Zolotke, [illegible]
1[illegible]-10 10/1-/5[illegible] [illegible]
F. [illegible] . W.

2. SUMMARY DONE BY

R. S. MacIntyre

3. TITLE OR POSITION

C.D.P. Ped.

4. DATE OF SUMM. Mo. 9 Day 27 Year '60

5. SOURCE OF MEDICAL RECORDS

- [ ] Study Facility
- [x] Other Hospital or Clinic
- [ ] Private Physician
- [ ] Visiting Nurse Service
- [ ] Other (Specify)

6. NAME AND ADDRESS IF OTHER THAN STUDY FACILITY

City Health Clinic
7th and D, S.W.
Providence, R. I.

7. RECORD NUMBER 32-[illegible]
(Local patient identification either, number or mode of difference from item 1 above)

8. SUMMARY INCLUDES RECORDS DATED

Mo.	Day	Year	Through	Mo.	Day	Year
7	20	'60		8	24	'60

9. AGE OF CHILD AT ONSET OF ILLNESS: 9 mo.

10. DURATION OF ILLNESS: 5 wks.

11. DIAGNOSIS

Purulent Otitis Media A.D., recurrent

11a. (Do not use this space)

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications.)

U.R. and low-grade fever 3 days, then drainage A.D. 7/20/60
Rx. 300,000 u. Bucillin I.M., Textrex drops 100 mg/day for 10 days.
Slow response, healing of drum.

Recurrence 8/1[illegible]/60
Rx. Ilosone drops 50 mg t.i.d. for 8 days

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THE ILLNESS.

13. [ ] High fever Max._____°F.
14. [ ] Convulsions
15. [ ] Unconsciousness
16. [ ] Diarrhea
17. [ ] Dehydration
18. [x] Draining ear
19. [ ] Cyanotic spells
20. [ ] Reaction to injections
21. [ ] Spinal tap
22. [ ] X-ray or fluoroscopy
23. [ ] Operation

(Continue on Form CP-5, Continuation Sheet)

CCL-N-2086-29
1-61

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

1. PATIENT IDENTIFICATION
Jones, Patrick
[illegible]
[illegible]

SUMMARY DONE BY
J. R. Paluson, M. D.

2. TITLE OR POSITION
Family physician

3. DATE OF SUMM.
Mo. 10 Day 19 Year 60

4. SOURCE OF MEDICAL RECORDS
☐ Study Facility
☐ Visiting Nurse Service
☐ Other Hospital or Clinic
☐ Other (Specify)
☒ Private Physician

6. NAME AND ADDRESS IF OTHER THAN STUDY FACILITY
Dr. J. R. Paluson
7213 Adjacent Ave., Warwick, R.I.

7. RECORD NUMBER Name, as above
(Local patient identification name, number or code if different from item 1 above)

8. SUMMARY INCLUDES RECORDS DATED

Mo.	Day	Year	Through	Mo.	Day	Year
5	3	'60		5	28	'60

9. AGE OF CHILD AT ONSET OF ILLNESS
8 mo.

10. DURATION OF ILLNESS
3 wks.

11. DIAGNOSIS
1) Bronchitis, 2) Iron deficiency anemia
3) Normal X-ray examination of hips (ruled out congenital hips)

(Do not use this space)

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications.)

1) Cough for 3 days, fever (est. 103°F) for 12 hours.
Rx. Tempra and Tetracyclene
Recovery ok

2) Appeared anemic, Hgb. not done
Rx. Fer-in-sol
failed to return for follow-up exam.

3) Suspicion of congenital hips on P.E.,
X-ray examination 5/28/60 read as normal,
no evidence of dysplasia of either hip.

(Note: This form was sent to Dr. Paluson for verification of the PED-20 history of bronchitis and fever. He reports two additional conditions. This is to our benefit. However, if all three conditions had been suspected from the history, a separate sheet for each condition would have made the data more convenient to process.)

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THE ILLNESS.

13. ☒ High fever
Max. 103 °F. 12 hours
14. ☐ Convulsions
15. ☐ Unconsciousness
16. ☐ Diarrhea
17. ☐ Dehydration
18. ☐ Draining ear
19. ☐ Cyanotic spells
20. ☐ Reaction to injections
21. ☐ Spinal tap
22. ☒ X-ray or fluoroscopy
23. ☐ Operation

(Continue on Form CP-5, Continuation Sheet)

COLR-1060-00
1-61

PATIENT IDENTIFICATION

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

SUMMARY DONE BY

M. Laughlin, R. N.

TITLE OR POSITION

C.D.P. Nurse

DATE OF SUMM.: Mo. 11 | Day 16 | Year '60

NAME AND ADDRESS IF OTHER THAN STUDY FACILITY

SOURCE OF MEDICAL RECORDS

- [ ] Study Facility
- [x] Visiting Nurse Service
- [ ] Other Hospital or Clinic
- [ ] Other (Specify)
- [ ] Private Physician

RECORD NUMBER (Local patient identification name, number or code if different from item 1 above)

SUMMARY INCLUDES RECORDS DATED

Mo.	Day	Year	Through	Mo.	Day	Year	Age of child at onset of illness	Duration of illness
10	28	'60	only				14 mo.	1 wk.

DIAGNOSIS

Measles

(Do not use this space)

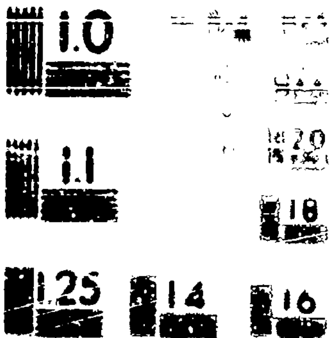
SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications)

Measles last week of Sept. reported by mother. Older brother and neighbor children had measles in early Sept., so Dx. seems OK. Not seen by doctor. Illness apparently not severe, no complications.

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THIS ILLNESS.

13. [ ] High fever Max.________°F.
14. [ ] Convulsions
15. [ ] Unconsciousness
16. [ ] Diarrhea
17. [ ] Dehydration
18. [ ] Cashing out
19. [ ] Cyanotic spells
20. [ ] Reaction to injections
21. [ ] Spinal tap
22. [ ] X-ray or fluoroscopy
23. [ ] Operation

(Continue on Form CP-1, Continuation Sheet)



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