



MELISA® Questionnaire for Autistic Children

The MELISA® Medica Foundation is dedicated to the study of metal allergy, a condition which can be a risk factor in many diseases. In allergic children, not only skin but any other organ, including the brain, may be affected by metal-induced inflammation. Theoretically, vaccine additives such as thimerosal or aluminum could trigger such reactions. This questionnaire may help you to identify present and past exposure of your child to environmental pollutants, especially mercury. Mercury is implicated by some researchers as a risk-factor in the development of autism and other psychiatric disorders. The possibility that your child suffers from metal hypersensitivity will also be examined.

This questionnaire will be evaluated by Prof. Vera Stejskal, in return for a donation of US\$50 to the MELISA® Medica Foundation. Details are at the end of this document.

PERSONAL INFORMATION

Name of parent(s): _____

Child's family name: _____ Given names: _____

Date of birth: _____ Date diagnosed as autistic (month/year): _____

Date of birth of parents: Mother: _____ Father: _____

Address: _____

Daytime telephone number: _____ E-mail: _____

***Throughout this questionnaire, "you" means the mother.
Please circle the correct answer.***

1. HEALTH OF YOUR CHILD

1.1 Was your child born healthy? YES | NO
If not, please detail _____
_____ *(continue on separate page if necessary)*

1.2 Child's APGAR score at birth: _____

1.3 Developmental landmarks, please approximate the age:

Crawling: _____	<i>Delayed in your opinion?</i>	YES NO
Sitting: _____	<i>Delayed in your opinion?</i>	YES NO
Walking: _____	<i>Delayed in your opinion?</i>	YES NO
Talking: _____	<i>Delayed in your opinion?</i>	YES NO



1.4 Did any of the previous landmarks change post-vaccination? YES | NO
If so, what changed and how long after vaccination? _____

(continue on separate page if necessary)

2. VACCINATION HISTORY

(This field is very important. Please give type of vaccine, date, and, if possible, the manufacturer).

(continue on separate page if necessary)

3. LABORATORY TESTS *Have you sent hair, blood or any other sample of your child to a laboratory for testing? If so, please give details. If you have tested for the presence of heavy metals, it would be helpful if you could indicate if any provocation agent was used, such as DMSA or DMPS.*

(continue on separate page if necessary)

4. ILLNESSES AND ALLERGIES

4.1 Please detail the symptoms of autism/delayed development detected in your child.

(continue on separate page if necessary)

4.2 Does your child suffer from any respiratory/breathing problems? YES | NO
If yes, please specify: _____

(continue on separate page if necessary)

4.3 Does your child suffer from digestive problems such as gas, bloating, "tummy aches", cramping, chronic diarrhea, constipation, food sensitivities? YES | NO
If yes, please describe: _____

(continue on separate page if necessary)



4.4 Has your child ever had skin lesions/eczema/rashes of any kind? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

4.5 Is your child's skin irritated by any forms of metal (for example, jeans fasteners, costume jewelry, earrings etc)? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

4.6 Does your child take any medication? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

4.7 Does your child take any minerals or vitamins? YES | NO

If yes, please detail: _____

_____ (continue on separate page if necessary)

5. SOURCES OF EXPOSURE TO METALS

5.1 Does your child have any silver/mercury dental fillings? YES | NO

If so, how many? _____

When were they placed?

5.2 Does your child wear dental braces? YES | NO

If yes, when were they fitted? _____

5.3 Does your child have any white fillings? YES | NO

If yes, since when and how many? _____

6. THE MOTHER: SOURCES OF METAL EXPOSURE

6.1 Do you have silver/mercury fillings? YES | NO

If yes, approximately how many? _____

6.2 Did you have the same number of fillings during your child's pregnancy? YES | NO

6.3 Did you have dental treatment during your pregnancy? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

6.4 Was the child breastfed? YES | NO

6.5 Did you have other dental metals fitted (i.e. titanium, stainless steel, gold, metal based ceramics)? YES | NO

Did you during the pregnancy? YES | NO

During breastfeeding? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

6.7 Were you given any vaccinations prior or during pregnancy/breastfeeding? YES | NO

If yes, please list:

Date	Vaccination	Manufacturer (if known)
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_____ (continue on separate page if necessary)

6.8 Did you use any creams (especially those containing mercurochrome) against varicose veins or against eczema prior or during pregnancy and breastfeeding?

YES | NO

6.9 Did you receive Rhogam injections (for RH-negative mothers) just after childbirth?

YES | NO

If yes, please specify when the injection took place: _____

6.10 Are you allergic to make-up and cosmetics? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)



6.11 Did you use eye drops during pregnancy or breastfeeding? YES | NO

6.12 Are you allergic to any medication? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

6.13 Were you taking antibiotics prior to or during pregnancy/breastfeeding? YES | NO

6.14 Did you live near a factory, industry, coal smelter, crematorium, highway or airport prior or during the pregnancy? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

SMOKING

6.15 Have you ever been a regular smoker? Please give details (how many cigarettes a day, and for how long) _____

_____ (continue on separate page if necessary)

6.16 Did you smoke during pregnancy? YES | NO

6.17 Were you passively exposed to smoke during pregnancy? YES | NO

6.18 Were you or your child involved in a car accident or another serious accident which may have led to brain concussion (such as falling, stumbling, etc)? YES | NO

If yes, please specify: _____

_____ (continue on separate page if necessary)

7. FAMILY HEALTH AND EXPOSURE

7.1 Do any brothers or sisters of your child have autism, learning difficulties or other psychiatric disorders?

YES | NO

If yes, which ones and how old are they? _____

_____ (continue on separate page if necessary)

7.2 Did your family used to drink water from your own well, or private supply? YES | NO
(Some families who live in rural area may not have access to the central water network)

If yes, do you know the content of minerals/pollutants in this water? YES | NO

If yes, what was the result? _____

_____ (continue on separate page if necessary)



Please return this form, either by fax or post, to Prof. Vera Stejskal, who will reply within ten working days. If you are online, please send an email to info@melisa.org to inform us that the fax has been sent. Or you can telephone on +46 8753 2322.

**Prof. Vera Stejskal, MELISA Medica Foundation, August Wahlströms väg 10,
182 31, Danderyd, Stockholm, Sweden. Fax: +46 8753 2322**

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For a donation of US\$50 your questionnaire will be reviewed by Prof. Stejskal and the evaluation sent back to you within 14 days. For maximum safety send your credit card information by fax.

Your credit card information

Credit card company: Visa | MasterCard

Credit Card number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Credit Card Expiration Date: month __ year __

I agree to let you debit US\$50 to my credit card as a donation for research to the MELISA® Medica Foundation. Please sign below.

_____ Place: _____ Date: _____

I want the evaluation of the questionnaire sent to me by: (check the box of your choice)

Mail Fax E-mail

