MELISA pediatrics questionnaire

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 the skin but many other organs, including the brain, spine or gastrointestinal tract may be affected by metal-induced inflammation.

Vaccine additives such as the organic mercury compound thimerosal (merthiolate, thiomersal) or aluminum could trigger such reactions. Some researchers implicate mercury as a risk factor in the development of autism and other developmental disorders. Even ubiquitous metals that are currently regarded as "inert", might trigger inflammation in susceptible children. For example, the white pigment titanium dioxide (E171) is commonly found in toothpastes and sunscreens and is considered to be "bio-inert", but if your child is allergic to titanium it can cause health problems.

Nickel (present in cocoa, vegetables and cigarette smoke) may also have harmful effects. Cadmium, lead and arsenic are other metals that may adversely affect health and are present in the environment.

This questionnaire will help you identify present and past exposure to environmental pollutants. The information will be treated confidentially.

Personal details

Name:

Parent(s):

Child's family name:

Given names:

Date of birth:

Date diagnosed as autistic (if applicable, month/year):

Date of birth of parents:

Mother:

Father:

Address:

Daytime phone:

Email:

1 Health of your child

1.1 Was your child born healthy?

Yes ☐ No ☐

If not, please detail:

1.2 Child's Apgar score at birth:

1.3 Developmental landmarks (please provide approximate age):

Crawling

Delayed in your opinion?

Yes ☐ No ☐

Sitting

Delayed in your opinion?

Yes ☐ No ☐

Walking

Delayed in your opinion?

Yes ☐ No ☐

Talking

Delayed in your opinion?

Yes ☐ No ☐

1.4 Did any of the previous landmarks change post vaccination?

Yes ☐ No ☐

If so, what changed and how long after vaccination?

2 Vaccination history

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

3 Laboratory tests

Have you sent hair, blood or any other sample from your child to a laboratory for testing? If so, please give details including results. 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 chelating agents (so called provocation test)

4 Allergies and illnesses

4.1 Has your child been diagnosed with any disease?

Yes ☐ No ☐

If yes, which one and when?

4.2 Does your child suffer from any respiratory/ breathing problems?

Yes ☐ No ☐

If yes, please specify:

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:

4.4 Has your child ever had skin problems/eczema/ rashes of any kind?

Yes ☐ No ☐

If yes, please specify:

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:

4.6 Does your child take any medication?

Yes ☐ No ☐

If yes, please specify:

4.7 Does your child take any minerals or vitamins?

Yes ☐ No ☐

If yes, please specify:

5 Sources of exposure to metals

5.1 Does your child have any amalgam (silver/mercury) dental fillings, or any other metal crowns, implants, pins or fillings?

Yes ☐ No ☐

If so, how many:

When were they placed?

5.2 Does your child currently have, or previously had, dental braces?

Yes ☐ No ☐

If yes, when were they fitted and for how long time? Do you remember their composition (which metal alloy or plastic)?

5.3 Does your child currently 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 amalgam (silver/mercury) fillings?

Yes ☐ No ☐

If yes, approximately how many?

6.2 Did you have the same number of fillings during pregnancy with your child?

Yes ☐ No ☐

6.3 Did you have dental treatment during your pregnancy?

Yes ☐ No ☐

If yes, please specify:

6.4 Was your child breastfed?

Yes ☐ No ☐

6.5 Do you have any other metal crowns, implants, pins or fillings?

Yes ☐ No ☐

Did you have any of them fitted during the pregnancy?

Yes ☐ No ☐

During breast feeding?

Yes ☐ No ☐

If yes, please specify:

6.6 Were you given any vaccinations prior to or during pregnancy/breastfeeding?

Yes ☐ No ☐

Please list date, type of vaccination and manufacturer (if known):

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

Yes ☐ No ☐

6.8 Did you receive Rhogam (anti-D immunoglobulin) injections (for RH-negative mothers) just after child birth?

Yes ☐ No ☐

Please list date, type of vaccination and manufacturer (if known):

6.9 Do you wear earrings or other piercings?

Yes ☐ No ☐

6.10 Have you experienced any skin irritation when wearing jewellery/metallic items?

Yes ☐ No ☐

Please describe what material and what side-effects:

6.11 Did you use any eye drops or nose drops during pregnancy or breastfeeding?

Yes ☐ No ☐

6.12 Are you allergic to any medication or cosmetics?

Yes ☐ No ☐

Please specify:

6.13 Were you taking antibiotics prior to or during pregnancy/breastfeeding?

Yes ☐ No ☐

6.14 Do you or have you previously lived near a factory, industrial plant, crematorium, highway or airport prior to or during the pregnancy?

Yes ☐ No ☐

If yes, please specify:

6.15 Have you or your child's father ever been regular smokers?

Yes ☐ No ☐

If yes, please give details
(how many cigarettes a day, and for how long):

6.16 Did you smoke at home during pregnancy?

Yes ☐ No ☐

6.17 Were you passively exposed to cigarette smoke during pregnancy?

Yes ☐ No ☐

6.18 Was your child involved in a car accident or another serious accident that might have caused concussion (such as falling, stumbling, etc)?

Yes ☐ No ☐

If yes, please specify what accident and when:

7 Family health and exposure

7.1 Do your child's siblings have conditions, such as autism, learning difficulties, allergies or psychiatric disorders?

Yes ☐ No ☐

If yes, which ones and how old are they? Diagnosed at what age?

7.2 Does your family drink or did your family drink water from your own well, or private supply?

(Some families who live in rural area may not have access to the central water network)

Yes ☐ No ☐

Do you know the content of minerals/pollutants in this water?

Yes ☐ No ☐

If yes, what was the result?

8 Your family's health

8.1 Please indicate if any of the following medical conditions occurred in your family, father's family or in brothers or sisters of your child. Please indicate which conditions and who is affected

Allergies

Autoimmune diseases
(like rheumatoid arthritis, multiple sclerosis etc)

Gastrointestinal diseases such as Irritable Bowel Syndrome (IBS), Crohn's disease, ulcerative colitis

Skin diseases such as eczema

Heart/artery diseases

Diabetes

Cancers/tumors

Chemical sensitivity or electro sensitivity

Psychiatric illnesses (including old-age conditions such as Parkinson's, Alzheimer's and dementia)

Chronic fatigue, ME (Myalgic Encephalitis), fibromyalgia or other disease not clearly diagnosed

8.2 Is there any other information that you feel might be relevant to the health condition of your child?

Please give any thoughts that you may have:

For evaluation of your questionnaire please send it to:

Email: questionnaire@melisa.org (use submit button below)

MELISA Diagnostics Ltd
Phone: +44 (0)20 8133 5166
Fax: +44 (0)20 8711 5958

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