

ID: _____

DE #1: _____ DE #2: _____

Healthy Twins Survey
Ages 8-17 years
Michigan State University Twin Registry
Department of Psychology, Michigan State University
(517) 432-5604 | msutr@msu.edu

Thank you for your participation. All information you provide is strictly confidential.

TODAY'S DATE: _____ / _____ / _____
M D Y

FAMILY NAMES:

Mother / Parent A: _____
First Middle Last

Father / Parent B: _____
First Middle Last

Twins: _____
First Born Second Born

Individuals sometimes change their names between the time of the twins' births and the time of this assessment. This can occur because of marriages, divorces, etc. It is important for MDHHS staff to have the parents' current names and the names at the time of the twins' births in order to correctly match birth certificate data with current information. Given the above, we would ask that you please provide the name of each parent below, as they were listed on the twins' birth certificates. Please list this information even if the name has not changed.

Mother / Parent A: _____
First Middle Last

Father / Parent B: _____
First Middle Last

Please provide a phone number and email address where a parent can be reached:

Phone: (____) _____ - _____

Confirm Phone: (____) _____ - _____

Email: _____

Confirm Email: _____

NOTE: Compensation for participating will be sent to the e-mail address listed above within 30 days of completing the questionnaire. You will ONLY be contacted by phone in the event of incomplete forms and/or difficulty sending your compensation for participation.

ID: _____

DE #1: _____ DE #2: _____

E. Could one twin fool friends or family by pretending to be the other? 1 = Yes 2 = Maybe 3 = No

F. Do you think your twins are identical or fraternal? 1 = Identical 2 = Fraternal

G. What gender are your twins? 1 = Both boys 2 = Both girls 3 = Boy and Girl [boy was first-born ___]
[boy was second-born ___]

H. Current height of twins: 1st born twin: Ft. _____ In. _____ 2nd born twin: Ft. _____ In. _____

I. Current weight of twins: 1st born twin: Lbs. _____ 2nd born twin: Lbs. _____

J. Birth weight of twins: 1st born twin: Lbs. _____ Oz. _____ 2nd born twin: Lbs. _____ Oz. _____

K. Were the twins conceived with the aid of fertility treatment/medications (e.g., Clomid, IVF, etc.)? 1 = Yes 2 = No

L. Were the twins conceived through an egg donor? 1 = Yes 2 = No

M. Were the twins conceived through a sperm donor? 1 = Yes 2 = No

N. Was either twin born with a birth defect or congenital malformation? 1 = Yes 2 = No

If "Yes", please describe: _____

PERSONALITY & BEHAVIOR -- Below is a list of items that describe children. Think of what each of your twins has generally been like. Please circle "2" if the item has generally been *certainly or often true* of that twin. Circle "1" if the item has been *somewhat* or *sometimes true* of that twin. If the item is *not true* of that twin, circle "0".

	1 ST BORN TWIN			2 ND BORN TWIN		
	Not true	Somewhat true	Certainly true	Not true	Somewhat true	Certainly true
1. Very dissatisfied with body weight or shape.....	0	1	2	0	1	2
2. Often has temper tantrums or hot tempers.....	0	1	2	0	1	2
3. Definite fear of gaining weight or of becoming fat	0	1	2	0	1	2
4. Generally obedient, does what is asked of him/her.....	0	1	2	0	1	2
5. Feels fat	0	1	2	0	1	2
6. Feels guilty about what he/she eats because of the effect on body weight and/or shape.....	0	1	2	0	1	2
7. Often lies or cheats.....	0	1	2	0	1	2
8. Has vomited to control weight.....	0	1	2	0	1	2
9. Often fights with other children or bullies them.....	0	1	2	0	1	2
10. Has a strong desire to lose weight.....	0	1	2	0	1	2
11. Diets to control weight.....	0	1	2	0	1	2
12. Destroys things that belong to others.....	0	1	2	0	1	2
13. Eats lots of food and can't stop.....	0	1	2	0	1	2
14. Sets fires.....	0	1	2	0	1	2
15. Steals from home, school, or elsewhere.....	0	1	2	0	1	2
16. Body weight and/or shape influences how twin thinks about (judges) him/herself as a person.....	0	1	2	0	1	2

ID: _____

DE #1: _____ DE #2: _____

FAMILY HEALTH SURVEY: For each item below, please check "Yes" if that person has ever had the condition. Please answer for the biological or birth parents of the twins, if this information is available and can be shared.

CONDITION	1ST BORN TWIN	2ND BORN TWIN	MOTHER / PARENT A	FATHER / PARENT B
<i>Please check the "Insufficient information" box if there is not enough information to complete.</i>			<input type="checkbox"/> <i>Insufficient information</i>	<input type="checkbox"/> <i>Insufficient information</i>
1. Alcohol or Drug Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
2. Cerebral Palsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
3. Stuttering	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
4. Delinquency, ADD/ADHD, or Oppositional Defiant Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
5. Depression or Bipolar Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
6. Anorexia, Bulimia, or Binge Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
7. Anxiety Disorder (e.g., Panic Disorder, Generalized Anxiety Disorder, Social Anxiety, Obsessive Compulsive Disorder)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes