Non Alcoholic Fatty Liver Disease in School Children aged 5-10 Years,
Prevalence in Overweight/obese & Normal Weight Children
& its Association with Metabolic Syndrome

CLINICAL ASSESSMENT FORM

Date | | | | | | | Unique ID | | | | | |

Start time (in 24 hrs) | | | | | End time | | | | |

Name of the school _____

Name of the child _____

Name of the father _____

Address of the child _____

_____

Contact no. 1. _____ 2. _____

Email _____ , _____

Date of birth (dd/mm/yy) | | | | | | |

Age in completed months | | |

Sex (1-Male, 2- Female) |

Class/Section | | / | |

Screening ID | | | | | |

Consent form signed (1-Yes, 0- No) |

Location of assessment _____

Assessment components	(Mark ✓sign , if done)	Done by
Clinical assessment		
Dietary assessment		
Physical activity assessment		
Sociodemographic Assessment		
Blood sample collection		

Accompanying person | Father | Mother | / | Sibling/No. | other

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For Office Only

Form completed (1- Yes, 0- No) |

Checked by _____ Date | | | | | | |

Data entred by _____ Date | | | | | | |

Reviewd by Investigator _____ Date | | | | | | |

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History of present illness

(Mark 1- Yes, 0- No)

1.Does your child has any symptom now? |

if yes, please specify — Duration (months)

_____ | | |

_____ | | |

_____ | | |

_____ | | |

Past medical history

2.Did you child has?	Yes/No	Duration(months)
2.1 Jaundice		
2.3 Pain abdomen/abdominal distention/lump		
2.4 Vomiting		
2.5 Diarrhoea		
2.6 Neurological disorders (movement disorders)		
2.7 Lethargy/ malaise		
2.8 Repeated skin lesions		
2.9 Repeated episodes of fever		
2.10: Arthalgia/arthritis (joint pain)		

3. Did your child ever receive blood transfusion |

3.1 if yes, how many numbers of times? | |

(dd/m/yy)

3.2 First transfusion — Date | | | | | | |

3.3 Last transfusion — Date | | | | | | |

4. Medication history

4.1 Did your child receive continous medication other than vitamins/ minerals/or any supplement in past ? (1-Yes,0-No,9-Not known) |

if yes, specify nature of medicine _____

4.2 Any other medicines taken in last 7 days? (1-Yes,0-No,9-Not known) |

if yes, specify _____

_____

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Yes/No

5. **Did your child ever require hospitalization?** ☐

if yes, please specify

Age	Disease	Place/hospital	Period of study

6. Did your child ever undergo any surgery? ☐

Age	Reason for surgery	Nature of surgery	Place/hospital	Date of surgery

7. Any family history of chronic illness? ☐

if yes, please specify _____

_____

8. **Does any of the your family member suffer from -** (0-No, 1-Yes, 9- Not known)

8.1 Overweight/obesity ☐

8.2 Cardiac disease/ heart attack/ stroke ☐

8.3 Hypertension ☐

8.4 Diabetes mellitus ☐

8.5 Dyslypedemia ☐

8.6 Jundice/ liver disease ☐

8.7 HBV/HCV infection ☐

8.8 Any other, specify _____

9. Please mark ✓ in the box corresponding to the vaccine received by your child otherwise put ×

Doses →	0	1	2	3	Booster 1	Booster 2
OPV						
DPT						
HBV						
Hib						
Rotavirus						
HAV						

BCG ☐

Varricella ☐

Typhoid ☐

Any other ☐

If yes , specify _____ ☐

_____ ☐

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(1-Yes, 0- No, 9-Not known)

10. Consanguinity:

11. Any other significant illness/event in history?

12. Examination

12.1 Weight(in Kgs)

1 . 2 . 3 .

Mean weight (Kgs) .

12.2 Height (in Cms)

1 . 2 . 3 .

Mean height(cms) .

12.3 Waist circumference (in Cms)

1 . 2 . 3 .

Mean waist circumference (cms) .

12.4 Hip circumference (in Cms)

1 . 2 . 3 .

Mean hip circumference (cms) .

12.5 Body Mass Index (BMI) .

12.6 Waist-hip ratio (WHR) .

12.7 Blood pressure (in mm/Hg)

	1	2	3
Systolic (mm/Hg)			
Diastolic (mm/Hg)			

Mean Blood pressure Systolic mm/Hg Diastolic mm/Hg

13. General examination: Yes/No

13.1Fever

13.2Pallor

13.3 Lymph nodes

if yes, please specify the area

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Yes/No

13.4 Jaundice

13.5 Pedal odema

13.6 Purpura/echymosis/petechie

13.7 Acanthosis

13.8 Vitiligo

13.9 Talengectasia

13.10 Spider naevi

13.11 Gynaecomastia

13.12 Palmor erythema

13.13 Clubbing

13.14 Rickets

13.15 Skin Strech marks

13.16 Any other

If present,please sepcify _____

_____

14. Systamic Examination: (1- Normal, 2- Abnormal)

14.1 Chest/ Respiratory system
if abnormal, Please specify _____

14.2 Cardiovascular system
if abnormal, Please specify _____

14.3 Nervous system
if abnormal , please specify _____

14.4 Gastrointestinal
if abnormal , please specify _____

14.4.1 Liver

a) Span (Cms) | |

b) Below costal margin (Cms) | |

c) Consistency (1- Normal, 2- Firm, 3-Hard, 0- Not palpable) |

d) Surface (1- Smooth, 2- Irregular, 0- Not palpable) |

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14.5 Spleen below costal margin (Cms) | | |

Yes/No

14.6 Ascitis | |

14.7 Prominent veins on abdominal wall | |

14.8 Any other palpable mass ? | |

if yes, please specify _____

14.9 Eye | |

(Any evidence of KF ring) | |

Probable diagnosis _____

_____

Examined by _____

Confirmed by _____

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Parents/ sIblings Anthropometry

Father name _____ Age (months) | | | |

Height (in Cms) | | | | . |

Weight (in Kgs) | | | | . |

Body Mass Index | | | . |

Blood pressure(sytolic/diastiloc) in mm/Hg | | | / | |

Mother name _____ Age (months) | | | |

Height (in Cms) | | | | . |

Weight (in Kgs) | | | | . |

Body Mass Index | | | . |

Blood pressure(sytolic/diastiloc) in mm/Hg | | | / | |

Sibling 1 _____ Age (months) | | | |

Height (in Cms) | | | | . |

Weight (in Kgs) | | | | . |

Body Mass Index | | | . |

Blood pressure(sytolic/diastiloc) in mm/Hg | | | / | |

Sibling 2 _____ Age (months) | | | |

Height (in Cms) | | | | . |

Weight (in Kgs) | | | | . |

Body Mass Index | | | . |

Blood pressure(sytolic/diastiloc) in mm/Hg | | | / | |

Measured by _____ Date | | | | | | |

Verified by _____ Date | | | | | | |

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