Pregnancy, Infancy and Early Childhood

Every time you see "_____" in the following questions, we are referring to your child

______________________.

The questions below are phrased as if we are asking ______'s mother the questions. If someone other than _____'s mother is filling out this questionnaire, please remember to interpret and answer the questions as if we were asking them of ______'s mother.

Person completing the questionnaire (please check)

[ ] 1 Mother
[ ] 2 Father
[ ] 3 Both mother and father
[ ] 4 Grandmother/Grandfather
[ ] 5 Other (please specify ____)

This questionnaire will ask you about things that occurred during ________'s life, starting with the time you were pregnant with _________. We would like to know about exposures that may have occurred in the past. While some of the answers may be difficult to remember, we hope you will take your time and complete the entire questionnaire. If you have any questions, you can ask our study nurse at the clinic. Please remember to bring the questionnaire to clinic with you.

The first section will ask you questions about your pregnancy with ________. It may help you to think about the time you were pregnant with __________, (such as, What year was that? What seasons occurred during your pregnancy? Where did you live?)

1. When you were pregnant with _______, did you have any of the conditions listed below? Check all that apply.

	Yes	No	Don't Know
a. Gestational diabetes	[ ] 1	[ ] 2	[ ]
b. Bad cold or influenza	[ ] 1	[ ] 2	[ ]
c. Sore throat or tonsillitis	[ ] 1	[ ] 2	[ ]
d. Bronchitis	[ ] 1	[ ] 2	[ ]
e. Pneumonia	[ ] 1	[ ] 2	[ ]
f. Sinus infection	[ ] 1	[ ] 2	[ ]
g. Chronic earache	[ ] 1	[ ] 2	[ ]
h. Diarrhea/gastroenteritis	[ ] 1	[ ] 2	[ ]
I. Rash	[ ] 1	[ ] 2	[ ]
j. Skin infection	[ ] 1	[ ] 2	[ ]
k. Kidney or urine infection	[ ] 1	[ ] 2	[ ]
l. Other infection or fever	[ ] 1	[ ] 2	[ ]
m. Yellow skin (jaundice)	[ ] 1	[ ] 2	[ ]
n. High blood pressure	[ ] 1	[ ] 2	[ ]
o. Swelling of the face/hands	[ ] 1	[ ] 2	[ ]
p. Pre-eclampsia or toxemia	[ ] 1	[ ] 2	[ ]
q. Severe morning sickness	[ ] 1	[ ] 2	[ ]
r. Incompetent cervix	[ ] 1	[ ] 2	[ ]
s. Spotting or bleeding	[ ] 1	[ ] 2	[ ]
t. Placenta previa	[ ] 1	[ ] 2	[ ]
u. Abruptio placenta	[ ] 1	[ ] 2	[ ]
v. Premature rupture of membranes	[ ] 1	[ ] 2	[ ]
w. Prolonged labor	[ ] 1	[ ] 2	[ ]
x. Pinched nerve	[ ] 1	[ ] 2	[ ]
y. Anemia	[ ] 1	[ ] 2	[ ]
z. Premature Labor	[ ] 1	[ ] 2	[ ]

2. While you were pregnant with ____________, did you take any vitamins?

[ ] 1 Yes [ ] 2 No ———> If No, skip to Question 3.

If Yes, did the vitamin tablet contain:

	Yes	No	Don't Know
Vitamin A (not beta-carotene)	[ ] 1	[ ] 2	[ ]
Beta-carotene	[ ] 1	[ ] 2	[ ]
Vitamin C	[ ] 1	[ ] 2	[ ]
Vitamin E	[ ] 1	[ ] 2	[ ]
Iron	[ ] 1	[ ] 2	[ ]
Folic Acid	[ ] 1	[ ] 2	[ ]

3. While you were pregnant with ___________, did you have at least 6 drinks of any kind of alcoholic beverage?

[ ] 1 Yes [ ] 2 No ——> If No, skip to Question 4.
[ ] Don't Know

If Yes, about how many drinks did you usually have?
Please include beer, wine and hard liquor.

[ ][ ] Drinks per: 1 [ ] Day

2 [ ] Week

3 [ ] Month

4. While you were pregnant with ___________, did you smoke at least 50 cigarettes?

[ ] 1 Yes
[ ] 2 No———> If No, skip to Question 5.
[ ] Don't Know

↓

If Yes, about how many cigarettes did you smoke during the pregnancy?

cigarettes per:
1 [ ] Day
2 [ ] Week
3 [ ] Month

5. While you were pregnant with _____________, did you work outside the home?

[ ] 1 Yes, Full-time
[ ] 2 Yes, Part-time
[ ] 3 No

The next set of questions ask about non-alcoholic beverages you drank at this time:

6. On average, how many glasses of tap water did you drink per day (include drinks that you make with water, like tea, juice, Kool-aid):

a. While you were pregnant with _______?

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

b. While _______ was less than 6 months old?

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

7. On average, how many glasses of cow's milk did you drink per day:

a. While you were pregnant with _______?

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

b. While _______ was less than 6 months old?

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

8. Now, please recall the circumstances of __________'s birth.
What was his/her:

a. Birth weight ______lb _______oz

b. Gestational age:

[ ] 1 premature ___________ weeks early

[ ] 2 term

[ ] 3 postterm ___________ weeks late

c. Type of delivery

[ ] 1 vaginal uncomplicated

[ ] 2 vaginal complicated (e.g., breech, forceps, vacuum)

[ ] 3 cesarean section

Question 8, continued

d. 5 minute Apgar score (a number 1-10 describing his/her well-being at birth)

__________ [ ] Don't know

9. When ____________ was born and in the first week of life, did s(he) have any of the conditions listed below? Check all that apply.

		Yes	No	Don't Know
a.	Respiration problems	[ ] 1	[ ] 2	[ ]
b.	Cold or runny nose	[ ] 1	[ ] 2	[ ]
c.	Meningitis	[ ] 1	[ ] 2	[ ]
d.	Blood poisoning (sepsis)	[ ] 1	[ ] 2	[ ]
e.	Pneumonia	[ ] 1	[ ] 2	[ ]
f.	Diarrhea	[ ] 1	[ ] 2	[ ]
g.	Eye discharge	[ ] 1	[ ] 2	[ ]
h.	Rash	[ ] 1	[ ] 2	[ ]
i.	Other infection or fever	[ ] 1	[ ] 2	[ ]
j.	Yellow skin (jaundice)	[ ] 1	[ ] 2	[ ]
k.	Blood group incompatibility (Rh or ABO)	[ ] 1	[ ] 2	[ ]
l.	Blood transfusion	[ ] 1	[ ] 2	[ ]
m.	Light therapy (phototherapy)	[ ] 1	[ ] 2	[ ]
n.	Anemia	[ ] 1	[ ] 2	[ ]
o.	Birth defect (congenital abnormality)	[ ] 1	[ ] 2	[ ]
p.	Birth trauma	[ ] 1	[ ] 2	[ ]
q.	Meconium aspiration	[ ] 1	[ ] 2	[ ]

Question 9, continued

		Yes	No	Don't Know
r.	Periods of no breathing (apnea)	[ ] 1	[ ] 2	[ ]
s.	Edema or swelling	[ ] 1	[ ] 2	[ ]
t.	Seizures	[ ] 1	[ ] 2	[ ]
u.	Low blood sugar (hypoglycemia)	[ ] 1	[ ] 2	[ ]
v.	Bloody stool	[ ] 1	[ ] 2	[ ]
w.	Bleeding	[ ] 1	[ ] 2	[ ]
x.	Surgery	[ ] 1	[ ] 2	[ ]

10. Did you breast-feed ______?

[ ] 1 Yes [ ] 2 No ——————> If No, go to question 11.

If Yes, answer the following questions.

a. While you were breast-feeding _____, did you have any of the following conditions? Check all that apply.

	Yes	No	Don't Know
1. Breast inflammation	[ ] 1	[ ] 2	[ ]
2. Pneumonia	[ ] 1	[ ] 2	[ ]
3. Sore throat or tonsillitis	[ ] 1	[ ] 2	[ ]
4. Chronic earache	[ ] 1	[ ] 2	[ ]
5. Bad cold or influenza	[ ] 1	[ ] 2	[ ]
6. Bronchitis	[ ] 1	[ ] 2	[ ]
7. Sinus infection	[ ] 1	[ ] 2	[ ]

Question 10, continued

8.	Kidney or urine infection	[ ] 1	[ ] 2	[ ]
9.	Diarrhea or gastroenteritis	[ ] 1	[ ] 2	[ ]
10	Rash	[ ] 1	[ ] 2	[ ]
10.	Skin infection	[ ] 1	[ ] 2	[ ]
12.	Eye discharge or pink eye	[ ] 1	[ ] 2	[ ]
13.	Other infection or fever	[ ] 1	[ ] 2	[ ]

b. While you were breast-feeding, was ______ sensitive to any foods that you ate? Check all that apply.

[ ] 1 Yes, spicy foods

[ ] 2 Yes, chocolate

[ ] 3 Yes, tomatoes

[ ] 4 Yes, citrus fruits

[ ] 5 Yes, dairy products

[ ] 6 Yes, other: specify __________________

[ ] 7 No

c. How old was _________ when you completely stopped breast-feeding him/her? Please specify weeks, months or years.

Age: _______ [ ] week(s) [ ] Don't know
[ ] month(s)
[ ] year(s)

Infant Diet History

11. ***The next set of questions ask you to remember the diet of _____ when he/she was less than 15 months old. Please fill out the chart on the following page so that it reflects the entire diet of ___________ at this time. This chart lists milks, formulas and foods that are typically in an infant's diet.***

Please write the number of times <u>a day</u> (on average over the span of a month) you gave ___________ each of the milks, formulas and foods listed below and place that number in the correct box that corresponds to the age when the food was eaten. So, if something was introduced into the diet between 1 and 2 months of age, then you would record the frequency (i.e. number of times a day) in the 2nd column of the grid on the next page; if introduced between 2 and 3 months, record the frequency in the 3rd column, etc. See the next page for the diet table and an actual example of how to record this information.

For example, if the baby was breast-fed 5 times a day and given a bottle of Enfamil once a day when she was less than 1 month old, a "5" should be placed in the <1 month age column in the breast-milk row and a "1" should be placed in the milk-based formula row in the <1 month column (see example below). Please see next page for a listing of typical formulas and their type. Since the code for Enfamil is "11," on this listing, "11" should be entered in the blank space for Formula-1 (example). Fill in the table up to when ____________ was 15 months old or up to his/her current age, if less than 15 months of age.

Age in Months

	< 1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11	-12	-13	-14	-15
Breast Milk															
Formula -1___________(code)															
Breast Milk															
Formula -1___________(code)															
Formula -2___________(code)															
Formula -3___________(code)															
Fresh Cow's milk															
Other Fresh Milk specify ___________________															
Fruit juice															
Cereal -1 ____________(code)															
Cereal -2 ____________(code)															
Strained Fruit															
Strained Vegetables															
Strained Meat															
Zwieback, toast, bread, crackers, tortillas															
Cheese, yogurt, ice cream, cottage cheese															
Eggs															
Cookies, candies, cakes															
Potato chips, corn chips, pretzels, etc.															
Other: specify ___________________															
Other: specify ___________________															
Vitamins: Check box if yes → Brand or type:															

See next page for a list of formulas and cereals and their codes.

Formula

Code Brand

11:Enfamil
12:Enfamil with Iron
13:Enfamil Premature
14:Enfamil Human Milk Fortifier
15:Similac
16:Similac with Iron
17:Similac Natural Care
18:Similac Special Care
19:Similac Special Care with Iron
20:Similac PM 60/40
21:Advance
22:SMA
23:SMA Lo-Iron
24:Preemie SMA
25:Good Start
26:Carnation Follow-up Formula
27:Gerber Baby Formula
28:Gerber Baby Formula with Iron
29:Isomil
30:Isomil SF
31:Nursoy
32:Soyalac
33:I-Soyalac
34:Prosobee
35:RCF
36:Nutramigen
37:Pregestimil
38:Portagen
39:Preterm Human Milk
40:Alimentum
41:Calcilo XD
42:Impact
43:Lipisorb
44:Product 3200 AB
45:Product 3200 K
46:Product 3232 A
47:S-14
48:S-29
49:S-44

50:Homemade formula Please list ingredients of formula:

Cereals

Code Type

71:Rice
72:Wheat
73:Oatmeal
74:Barley
75:Mixed
76:High Protein

The next few questions ask about your diet while you were pregnant with _______, and when was an infant. Please answer to the best of your memory.

While you were pregnant with _____________.

12. On average, how many servings of foods made with wheat, oats, barley or rye did <u>you</u> eat per day (include breads, cookies, pies, pastas, cereals, pretzels and crackers that contain wheat, oats, barley, or rye flour)? Assume an average serving size for each.

    [ ] 1 Rarely or Never consumed these foods
    [ ] 2 Less than one serving per day (and at least one serving per week)
    [ ] 3 One to two servings per day
    [ ] 4 Three to five servings per day
    [ ] 5 Six or more servings per day

13. On average, how many servings of corn, rice or potatoes, or foods made with corn, rice or potato did <u>you</u> eat per day (also include breads, cookies, cakes, pies, pastas, cereals, chips, and crackers that contain corn, rice or potato flour)? Assume an average serving size for each.

    [ ] 1 Rarely or Never consumed these foods
    [ ] 2 Less than one serving per day (and at least one serving per week)
    [ ] 3 One to two servings per day
    [ ] 4 Three to five servings per day
    [ ] 5 Six or more servings per day

When ________________ was less than 6 months old,

14. On average, how many servings of foods made with wheat, oats, barley or rye did <u>you</u> eat per day (include breads, cookies, pies, pastas, cereals, pretzels and crackers that contain wheat, oats, barley, or rye flour)? Assume an average serving size for each.

    [ ] 1 Rarely or Never consumed these foods
    [ ] 2 Less than one serving per day (and at least one serving per week)
    [ ] 3 One to two servings per day
    [ ] 4 Three to five servings per day
    [ ] 5 Six or more servings per day

15. On average, how many servings of corn, rice or potatoes, or foods made with corn, rice or potato did <u>you</u> eat per day (also include breads, cookies, cakes, pies, pastas, cereals, chips, and crackers that contain corn, rice or potato flour)? Assume an average serving size for each.

    [ ] 1 Rarely or Never consumed these foods
    [ ] 2 Less than one serving per day (and at least one serving per week)
    [ ] 3 One to two servings per day
    [ ] 4 Three to five servings per day
    [ ] 5 Six or more servings per day

16. On average, how many glasses of tap water did _____ drink per day (include drinks that are made with water, like tea, juice, Kool-aid):

a. Now?

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

b. When he/she was 2 years old? [ ] Check here if ______ is not yet 2 years old.

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

17. On average, how many glasses of cow's milk did _____ drink per day:

a. Now?

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

Question 17, continued

b. When he/she was 2 years old? [ ] Check here if ___________ is not yet 2 years old.

[ ] None

[ ] One (8 oz) glass

[ ] Two to three (8 oz) glasses

[ ] Four to six (8 oz) glasses

[ ] Greater than six (8 oz) glasses

18. Is ________ allergic to any of the following foods?

	Yes ↓ Check Box	If Yes: Age symptoms started (write age and circle M for months or Y for years)		If Yes: Diagnosed by a health professional? (if Yes, check box)	No ↓ Check Box	Not Exposed ↓
a. Cow's milk/ dairy products	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
b. Infant formula	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
c. Chocolate	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
d. Peanuts/nuts	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
e. Citrus fruit	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
f. Tomatoes	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
g. Other fruit	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
h. Eggs	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
I. Shellfish	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
j. Wheat	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3
k. Other: Specify _____________	[ ] 1	______	M Y	[ ]	[ ] 2	[ ] 3

19. Is ___________ allergic to any substances other than food (see below)?

	Yes ↓ Check Box	If Yes: Age symptoms started (write age and circle M for months or Y for years)	If Yes: Diagnosed by a health professional? (if Yes, check box)	No ↓ Check Box	Not Exposed ↓
a. Bee sting	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
b. Dust	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
c. Penicillin	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
d. Pollen	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
e. Cats or dogs	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
f. Perfume or soap	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
g. Ragweed/grass	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
h. Other: Specify _____________	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3

20. Does (did) ______ have any of the diseases listed below?

	Yes ↓ Check Box	If Yes: Age symptoms started (write age and circle M for months or Y for years)	If Yes: Diagnosed by a health professional? (if Yes, check box)	No ↓ Check Box	Not Exposed ↓
a. Chicken Pox	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
b. Measles	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
c. German measles (rubella)	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
d. Mumps	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
e. Colic	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
f. Chronic ear infections	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
g. Severe diarrhea	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
h. Croup	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
i. Pneumonia	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
j. Bronchitis	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
j. Strep infection	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
I. Gastrointestinal infection	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
m. Intestinal parasite	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
n. Yellow skin (Jaundice)	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3
o. Meningitis	[ ] 1	______ M Y	[ ]	[ ] 2	[ ] 3

21. When _______ was 6 months old:

   a. How many people lived in your household?

      _____ number of people

   b. How many rooms were there in your home? (include the kitchen and finished basement rooms but not the bathrooms)

      _____ number of rooms

22. Did ______ ever attend day care (family day care home or day care center) or preschool on a regular basis?

      [ ] 1 Yes
      [ ] 2 No

If Yes,

   a. At what age did ______begin attending day care or pre-school? (write age in blank and circle M for months or Y for years) ________ M Y

   b. What was the size of the <u>first</u> day care group (either in a home or center) or pre-school class in which he/she spent at least 2 weeks? _____ (estimate the number of children)

   c. For the <u>first</u> day care group or pre-school class in which ______ spent at least two weeks, how many days per week and hours per day on average was _______ there?

      ______ days per week and ______ hours per day

   d. How long did ________ stay in his/her <u>first</u> day care group or pre-school class in which he/she spent at least 2 weeks? (write quantity of time in the blank, then circle W for weeks, M for months, or Y for years. For example, if he/she was in his/her first day care group for 6 weeks, you would write "6" in the blank and circle the "W".

      __________ W M Y

23. How many episodes of the following infections has _________ had in the past 3 months?

a. Cold, runny nose [ ] None ______ #
b. Diarrhea [ ] None ______ #
c. Skin infections [ ] None ______ #
d. Ear infections [ ] None ______ #
e. Eye discharge or pink eye [ ] None ______ #
f. Other infections [ ] None ______ #

24. The next set of questions list stressful things that can happen to people during their lives. Think of the list in terms of _____'s entire life and please answer whether or not each of these has happened. For those events that ________ has experienced, please tell us the year in which it happened. It is also possible that none of these events have happened to ______. Remember to think in terms of events that happened to ______, not to you.

List of Events	Yes	If Yes, when?	No
a. Serious illness, injury or operation that required hospitalization	[ ] 1	____/____ mm yy ____/____ mm yy	[ ] 2
b. Serious illness, injury or or operation of parent	[ ] 1	____/____ mm yy ____/____ mm yy	[ ] 2
c. Serious illness, injury or operation of sibling	[ ] 1	____/____ mm yy ____/____ mm yy	[ ] 2
d. Bad auto accident	[ ] 1	____/____ mm yy ____/____ mm yy	[ ] 2
e. Marital separation/divorce of parents	[ ] 1	____/____ mm yy ____/____ mm yy	[ ] 2
f. Death of a parent	[ ] 1	____/____ mm yy ____/____ mm yy	[ ] 2
g. Death of a sibling	[ ] 1	____/____ mm yy ____/____ mm yy	[ ] 2
h. Moving/changing schools	[ ] 1	____/____ mm yy ____/____ mm yy ____/____ mm yy ____/____ mm yy	[ ] 2

25.What is the highest grade or level of schooling that _____'s natural mother had completed by the time _____ was born? (please circle the last grade year completed when ______ was born)

Grade school k 1 2 3 4 5 6 7 8

High school 9 10 11 12 (if GED, circle 12)

College 13 14 15 16

Graduate School 17+

26.What is the highest grade or level of schooling that _____'s natural father had completed by the time _____ was born? (please circle the last grade year completed when ______ was born)

Grade school k 1 2 3 4 5 6 7 8

High school 9 10 11 12 (if GED, circle 12)

College 13 14 15 16

Graduate School 17+

27.What was your household's total income, before taxes, the year ______ was born? Include income received from all sources by any family member or partner living in your home.

[ ] 1 less than $10,000

[ ] 2 $10,000 - 19,999

[ ] 3 $20,000 - 29,999

[ ] 4 $30,000 - 39,999

[ ] 5 $40,000 - 49,999

[ ] 6 $50,000 - 74,999

[ ] 7 $75,000+

28. Did ________ have any contact with pets or farm animals during the first 6 months of his/her life?

1 = Yes

2 = No

If Yes: Please complete the following questions.

	How many	*Please*			

	animals did you have as pets or on a farm in the first 6 months? 0 = none	*answer these next questions ----------> for any of the animals you checked.*	Where does the animal usually live? 1 = animal not on property 2 = animal lives on property, never in house 3 = animal in house occasionally 4 = animal lives in house	What *amount of contact* did ___ have with this animal in the first 6 months of life ? 1 = none 2 = less than once per week 3 = once or more times per week 4 = daily or almost daily	Wh hav 0= 1 = 2 = 3 = 4 =
Dog		Circle the	1 2 3 4	1 2 3 4	0
Cat		correct	1 2 3 4	1 2 3 4	0
Rabbit		number---->	1 2 3 4	1 2 3 4	0
Mouse / Rat / Hamster/ Guinea Pig			1 2 3 4	1 2 3 4	0
Parakeet / Parrot / Bird			1 2 3 4	1 2 3 4	0
Turtle			1 2 3 4	1 2 3 4	0
Chicken / Duck / Goose			1 2 3 4	1 2 3 4	0
Pig			1 2 3 4	1 2 3 4	0
Cattle			1 2 3 4	1 2 3 4	0
Sheep			1 2 3 4	1 2 3 4	0
Horse			1 2 3 4	1 2 3 4	0
Other ___________ _			1 2 3 4	1 2 3 4	0

Health Care Professionals Form

29. Please list the names and addresses of the health care professionals that ______ has seen for routine pediatric care, and list the age of ________ when he/she was being seen by each health care professional.

Name of clinic or provider	City	State	Phone #	Child's age
Name of clinic or provider	City	State	Phone #	Child's age
Name of clinic or provider	City	State	Phone #	Child's age

For Study Use Only

Updates: mm__/yy__ mm__/yy__ mm__/yy

Initials: ______ ______

30. IMMUNIZATIONS

Vaccine		Enter date each immunization was given (mm/dd/yy)				
Circle 1: DPT DTaP	Diphtheria/Pertussis/ Tetanus					
Td/DT	Diphtheria/Tetanus					
IPV	Polio (injected)					
OPV	Polio (oral)					
Hib	Hemophilus influenza type b					
Measles/ Mumps/ Rubella						
HB	Hepatitis B					
Varicella	Chicken Pox					

Did __________ have any severe reactions to immunization, e.g. seizures, hospitalization, severe diarrhea, nerve paralysis, fever >2 days? [ ] No [ ] Yes

If yes, give dates and specify which reactions

Date (mm/dd/yy)_____________ Reaction __________________________

Date (mm/dd/yy)_____________ Reaction __________________________

Date (mm/dd/yy)_____________ Reaction __________________________

Date (mm/dd/yy)_____________ Reaction __________________________

Residential History Form

We would like to ask you about where you have lived.

Please answer the following questions about all the homes you have lived in from time you were first pregnant with _______ until now. Please start with your first home and end with your current home.

Home	Address	When did you live there?	What was your home's source of water for drinking and cooking?
1st	Street______________________ City _______________________ State ____________Zip ________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other __________________
2nd	Street______________________ City _______________________ State ____________Zip ________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other ____________________
3rd	Street ______________________ City________________________ State ____________Zip ________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other ____________________
4th	Street ______________________ City _______________________ State ____________Zip ________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other ____________________
5th	Street ______________________ City ______________________ State ____________Zip ________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other ____________________
6th	Street ______________________ City _______________________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other

	State ____________Zip ________		____________________
7th	Street _____________________ City _______________________ State ____________Zip ________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other ____________________
8th	Street ______________________ City _______________________ State ____________Zip ________	____/____ to ____/____	[ ] Private well [ ] City or town supply [ ] Other ____________________

One of the most valuable parts of this study is the ability to follow your children over time. For this reason, we would like to know the names of two people who would know how to reach you in case you move. Do not include anyone who is now living with you. These people will only be contacted if we are unable to reach you directly.

Name:

Address:

City: ______________ State: _________ Zip Code:

Telephone: (______)

Relationship to you:

Name:

Address:

City: ______________ State: _________ Zip Code:

Telephone: (______)

Relationship to you:

Supplement to Soc_Indiv

Child's Name: __________________________

DAISY ID: _______

1. Has ___________ ever taken vitamins?

    [ ] no (end supplement here)
    [ ] yes (If yes, please continue with questions)

If yes,
2. At what age did ______ start taking vitamins? ________ age

3. Is ________ currently taking vitamins?

    [ ] no
    [ ] yes (If yes, please answer questions 4, 5 and 6)

4. If yes, what brand of vitamin does _______ take?

    _______________________ (please specify exact brand name)

5. If yes, what type of vitamin does _____ currently take?

    [ ] 1 multiple vitamin
    [ ] 2 Vitamin A, only (please specify dose _______IU)
    [ ] 3 Vitamin C, only (dose _______mg)
    [ ] 4 Vitamin D, only (dose _______IU)
    [ ] 5 Vitamin E, only (dose _______IU)
    [ ] 6 Vitamin B or B Complex, only (dose _______mg)
    [ ] 7 Iron, only
    [ ] 8 Other, please specify _______________________________

6. If yes, how often does _______ currently take the vitamins?

    [ ] 2 or less times per week
    [ ] 3-5 times per week
    [ ] 6-9 times per week
    [ ] 10 or more times per week

Thank you.