

## 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.

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
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:

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
Vitamin A (not beta-carotene)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Beta-carotene	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Vitamin C	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Vitamin E	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Iron	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>
Folic Acid	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/>

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.

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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?

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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.

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
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

		<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
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.

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
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   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> |
| 9.  | Diarrhea or gastroenteritis | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> |
| 10. | Rash                        | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> |
| 10. | Skin infection              | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> |
| 12. | Eye discharge or pink eye   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> |
| 13. | Other infection or fever    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> |

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 a day (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

Cereals

Code Brand

Code Type

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

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

50:Homemade formula      Please list ingredients of formula:

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 you 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 you 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 you 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 you 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?

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

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

	<u>Yes</u>	_____ > If Yes:		<u>No</u>	<u>Not Exposed</u>
	↓	_____	Diagnosed by	↓	↓
	Check Box	Age symptoms started (write age and circle M for months or Y for years)	a health professional? (if Yes, check box)	Check Box	
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?

	<u>Yes</u> ↓	—————→ If Yes:	<u>No</u> ↓	<u>Not Exposed</u> ↓
	Check Box	Age symptoms started (write age and circle M for months or Y for years)	Diagnosed by a health professional? (if Yes, check box)	Check Box
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 first 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 first 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 first 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.

<u>List of Events</u>	<u>Yes</u>	<u>If Yes, when?</u>	<u>No</u>
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	<i>Please</i>			
--	----------	---------------	--	--	--

	animals did you have as pets or on a farm in the first 6 months? 0 = none	<i>answer these next questions —————&gt; for any of the animals you checked.</i>	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 <i>amount of contact</i> 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 correct number---->	1    2    3    4	1    2    3    4	0
Cat			1    2    3    4	1    2    3    4	0
Rabbit			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.