

ANNUAL UPDATE INTERVIEW VITAMINS

1. In the past year has the DAISY participant taken vitamins/supplements or probiotics?

Yes No **No Change** If yes, continue to questions 2-7. Record all brands/types *separately*.

2. What type of supplement? (Please include mg/IU of the vitamin, do not list number of pills)

Reference the summary of the last interview if needed.

<input type="checkbox"/> Multiple vitamin	<input type="checkbox"/> Multiple vitamin	<input type="checkbox"/> Multiple vitamin	<input type="checkbox"/> Multiple vitamin
<input type="checkbox"/> Vit A (IU)	<input type="checkbox"/> Vit A (IU)	<input type="checkbox"/> Vit A (IU)	<input type="checkbox"/> Vit A (IU)
<input type="checkbox"/> Vit C (mg)	<input type="checkbox"/> Vit C (mg)	<input type="checkbox"/> Vit C (mg)	<input type="checkbox"/> Vit C (mg)
<input type="checkbox"/> Vit D (IU)	<input type="checkbox"/> Vit D (IU)	<input type="checkbox"/> Vit D (IU)	<input type="checkbox"/> Vit D (IU)
<input type="checkbox"/> Vit E (IU)	<input type="checkbox"/> Vit E (IU)	<input type="checkbox"/> Vit E (IU)	<input type="checkbox"/> Vit E (IU)
<input type="checkbox"/> Vit B/B complex (mg)	<input type="checkbox"/> Vit B/B complex (mg)	<input type="checkbox"/> Vit B/B complex (mg)	<input type="checkbox"/> Vit B/B complex (mg)
<input type="checkbox"/> Iron (IU)	<input type="checkbox"/> Iron (IU)	<input type="checkbox"/> Iron (IU)	<input type="checkbox"/> Iron (IU)
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Other Specify:
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> IU <input type="checkbox"/> mg	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> IU <input type="checkbox"/> mg	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> IU <input type="checkbox"/> mg	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> IU <input type="checkbox"/> mg

3. What is the brand name of the vitamin/supplement/probiotic? (is this with extra C, or iron, etc)

Brand 1	Brand 2	Brand 3	Brand 4
<hr style="width: 80%; margin: 0 auto;"/> Code <input type="text"/> <input type="text"/> <input type="text"/>	<hr style="width: 80%; margin: 0 auto;"/> Code <input type="text"/> <input type="text"/> <input type="text"/>	<hr style="width: 80%; margin: 0 auto;"/> Code <input type="text"/> <input type="text"/> <input type="text"/>	<hr style="width: 80%; margin: 0 auto;"/> Code <input type="text"/> <input type="text"/> <input type="text"/>

4. Each time it is taken, indicate how many droppers full or pills?

<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills <input type="text"/> <input type="text"/>	<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills <input type="text"/> <input type="text"/>	<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills <input type="text"/> <input type="text"/>	<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills <input type="text"/> <input type="text"/>
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5. When taking a vitamin/supplement/probiotic, how many times per week is it taken?

<input type="checkbox"/> 2 or less <input type="checkbox"/> 6-9 <input type="checkbox"/> 3-5 <input type="checkbox"/> ≥ 10	<input type="checkbox"/> 2 or less <input type="checkbox"/> 6-9 <input type="checkbox"/> 3-5 <input type="checkbox"/> ≥ 10	<input type="checkbox"/> 2 or less <input type="checkbox"/> 6-9 <input type="checkbox"/> 3-5 <input type="checkbox"/> ≥ 10	<input type="checkbox"/> 2 or less <input type="checkbox"/> 6-9 <input type="checkbox"/> 3-5 <input type="checkbox"/> ≥ 10
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6. Since the last interview (~52 weeks), how many weeks was the vitamin/supplement/probiotic taken, in weeks?

If "All Weeks" stop after this question, if less than all weeks get the number and continue to question 7.

<input type="checkbox"/> All Weeks <input type="text"/> <input type="text"/> Weeks ↓	<input type="checkbox"/> All Weeks <input type="text"/> <input type="text"/> Weeks ↓	<input type="checkbox"/> All Weeks <input type="text"/> <input type="text"/> Weeks ↓	<input type="checkbox"/> All Weeks <input type="text"/> <input type="text"/> Weeks ↓
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7. Was the vitamin/supplement/probiotic taken for a period of time (school year, winter...), or spread out, off and on, over the whole year? *If the supplement was taken during a specific time get start and stop dates.*

<input type="checkbox"/> Off and On or Start date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Stop date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Off and On or Start date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Stop date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Off and On or Start date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Stop date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Off and On or Start date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Stop date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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DIET

1. On average, over the past year, how many servings of tap water does the DAISY participant have per day (include drinks that are made with tap water, like tea, juice from concentrate, Kool-aid)?

1 serving = 8 oz. Do not include bottled water.

- None
 1 serving
 2-3 servings
 4-6 servings
 >6 servings

2. On average, over the past year, how many servings of cow's milk does the DAISY participant have per day? Do not include soy, rice, or goat's milk.

1 serving = 8 oz.

- None
 1 serving
 2-3 servings
 4-6 servings
 >6 servings

3. On average, how many servings per day does the DAISY participant eat of foods made with wheat, oats, barley and rye? This includes breads (dark and white), cookies, pies, pasta, cereals, pretzels, and crackers. (1 slice of bread = 1 serving)

- None
 Less than 1
 1-2
 3-5
 6 or more

4. On average, how many servings per day does the participant eat corn, rice, or potatoes and foods made with corn, rice and potatoes? This includes fries, rice cakes, breads, cookies, pies, pasta, cereals, pretzels, and crackers. (½ cup of cooked rice = 1 serving)

- None
 Less than 1
 1-2
 3-5
 6 or more

5. We are interested in direct and indirect exposure to smoke from tobacco, e-cigarettes, and marijuana. Please indicate if the participant is exposed to smoke from any of the sources below:

	Cigarette (any tobacco)			E-Cigarette			Marijuana		
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Mom									
Mom-in home									
Mom-in car									
Dad									
Dad-in home									
Dad-in car									
Participant									
Regular exposure from another individual (roommate, significant other, grandparent)									

No Changes to Smoke Exposure

The next set of questions asks about allergies, symptoms and illnesses of that have occurred in the last year. Indicate NE if the participant has never been exposed to the food or substance. Indicate NE if the participant has indicated an allergy but has NOT been exposed to the allergen in the last year.

Diagnosed? = Diagnosed by health professional

NE = Not Exposed

7. Is the DAISY participant allergic to any of the following foods?

FOOD ALLERGEN	Allergic?	Age Symptoms Began	Diagnosed?
Cow's Milk/Dairy Products	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chocolate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Peanuts/Peanut Butter/Nuts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Citrus Fruits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tomatoes/Spaghetti Sauce/Ketchup	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Fruits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eggs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shellfish	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Food (Specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Non-Food (Specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NE	<input type="text"/> <input type="text"/> <input type="checkbox"/> Years <input type="checkbox"/> Months	<input type="checkbox"/> Yes <input type="checkbox"/> No

No Known Allergies

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ILLNESSES

1. In the last year, how many times has the DAISY participant been sick? (“sick” means unable to participate in normal activities)?

Number of times sick:

2. What illness or symptoms did the DAISY participant have during each sick episode?

Check the box on following page if the illness or symptom was present. If the answer is ‘flu’ prompt for the specific symptoms listed.

Illness	Further details	SICK EPISODE					
		1	2	3	4	5	6
Pneumonia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Croup	Barking cough, includes RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear infection		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin infections	Boils, impetigo, not eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strep throat		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ask about the above 8 illnesses first. Then ask about each of the symptoms in the following table whether or not a specific illness was used to describe the sick episode.

Specific Symptoms	Further details	SICK EPISODE					
		1	2	3	4	5	6
Cold/runny nose		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	Bronchiolitis, reactive airway disease, not due to asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	3 or more times in 24 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	Over 100 degrees F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	Not just spitting up; vomits 3 or more times in 24 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores	Includes ulcers, cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Rash	Not diaper rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye discharge/pinkeye	Not due to blocked tear ducts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other infection/ illness (specify)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	SICK EPISODES					
	1	2	3	4	5	6
How long did each illness last? (# days , including days of symptoms and treatment)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Seen by a doctor or health professional?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
How many episodes of a similar illness did they have that is <i>not</i> described in a separate episode?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

3. What is your current health insurance carrier?

Check all that apply.

- Kaiser Permanente
 Medicaid
 Multiple Plans
 Other HMO/PPO/Private
 CHP
 No Health Insurance

STRESSFUL EVENTS

The next set of questions list stressful things that can happen to people during their lives. Think of the list in terms of the DAISY participant's life in the past year and please answer whether or not each of these has happened. For those events that the DAISY participant has experienced, please indicate the month/year when it occurred. It is also possible that none of these events have happened to the DAISY participant. Remember to think in terms of events that happened to the DAISY participant, not to the primary caretaker.

Events of the DAISY participant	Yes or No	Date of Event
1. Serious illness, injury or surgery to DAISY participant that required hospitalization	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> mm yy
2. Serious illness, injury or surgery to parent of participant	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> mm yy
3. Serious illness, injury or surgery to sibling of participant	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> mm yy
4. Serious illness, injury or surgery to other family member	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> mm yy

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(specify who)			mm	yy
5. Bad auto accident involving DAISY participant		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy
6. Marital separation/divorce of participant's parents		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy
7. Relationship change of the DAISY participant (got married, separation from significant other/spouse, divorce)		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy
8. Death of a: (check all that apply)	<input type="checkbox"/> Parent	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy
	<input type="checkbox"/> Sibling	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy
	<input type="checkbox"/> Spouse	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy
	<input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
		mm	yy	
<input type="checkbox"/> Other family member	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
		mm	yy	
<input type="checkbox"/> Friend	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
		mm	yy	
<input type="checkbox"/> Pet	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
		mm	yy	
9. New addition to participant's immediate family (check all that apply)	<input type="checkbox"/> Sibling	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy
	<input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
		mm	yy	
<input type="checkbox"/> Pet	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
		mm	yy	
9. Moving		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
			mm	yy

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10. Change in school and/or job	<input type="checkbox"/> Y <input type="checkbox"/> N	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">mm</td> <td></td> <td colspan="2" style="text-align: center;">yy</td> </tr> </table>			/			mm			yy	
		/										
mm			yy									
11. Other (specify)	<input type="checkbox"/> Y <input type="checkbox"/> N	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">mm</td> <td></td> <td colspan="2" style="text-align: center;">yy</td> </tr> </table>			/			mm			yy	
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mm			yy									

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