DAISY_ID: _____

DAISY Form: NEC_Indiv

Today's Date: _____

Pregnancy and Infancy

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 call our study nurse, Michelle Hoffman, at (303) 270-7852. Please remember to mail the questionnaire in the envelope provided.

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	[ ]

Question 1, continued

	Yes	No	Don't Know
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 K ow

↓

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 <u>you</u> drank at this time:

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

7. a. On average, how many glasses of cow's milk did <u>you</u> drink per day 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

The next two questions ask about your past diet, while you were pregnant with _____.

b. On average, how many servings of foods made with wheat, oats, barley or rye did <u>you</u> eat per day (include breads, cookies, cakes, 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

c. 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

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

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	[ ]
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. 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+

11. 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+

12. 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+

DAISY_ID: _____

Health Care Professionals Form

13. 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

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Pregnancy, Infancy and Early Childhood

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