DAISY Form: SOC_Indiv

DAISY_ID: ______________

Today's Date: ___________

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?)

Rev. 1/1/98

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	[ ]
11. 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 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															
[illegible]mula -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 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?

	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)		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
b. Dust	[ ] 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
a. Chicken Pox	[ ] 1	_____	M Y	[ ]	[ ] 2
b. Measles	[ ] 1	_____	M Y	[ ]	[ ] 2
c. German measles (rubella)	[ ] 1	_____	M Y	[ ]	[ ] 2
d. Mumps	[ ] 1	_____	M Y	[ ]	[ ] 2
e. Colic	[ ] 1	_____	M Y	[ ]	[ ] 2
f. Chronic ear infections	[ ] 1	_____	M Y	[ ]	[ ] 2
g. Severe diarrhea	[ ] 1	_____	M Y	[ ]	[ ] 2
h. Croup	[ ] 1	_____	M Y	[ ]	[ ] 2
I. Pneumonia	[ ] 1	_____	M Y	[ ]	[ ] 2
j. Bronchitis	[ ] 1	_____	M Y	[ ]	[ ] 2
k. Strep infection	[ ] 1	_____	M Y	[ ]	[ ] 2
l. Gastrointestinal infection	[ ] 1	_____	M Y	[ ]	[ ] 2
m. Intestinal parasite	[ ] 1	_____	M Y	[ ]	[ ] 2
n. Yellow skin (jaundice)	[ ] 1	_____	M Y	[ ]	[ ] 2
o. Meningitis	[ ] 1	_____	M Y	[ ]	[ ] 2

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 <u>in the past 3 months</u>?

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 animals did you have as pets or on a farm in the first 6 months? 0 = none	*Please 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	**What *type of contact* did ___ have with the animal?** 0= no contact 1 = occasionally touches 2 = in same room of house or farm building 3 = touches animal regularly 4 = sleeps with animal
Dog		Circle the	1 2 3 4	1 2 3 4	0 1 2 3 4
Cat		correct	1 2 3 4	1 2 3 4	0 1 2 3 4
Rabbit		number——>	1 2 3 4	1 2 3 4	0 1 2 3 4
Mouse / Rat / Hamster/ Guinea Pig			1 2 3 4	1 2 3 4	0 1 2 3 4
Parakeet / Parrot / Bird			1 2 3 4	1 2 3 4	0 1 2 3 4
Turtle			1 2 3 4	1 2 3 4	0 1 2 3 4
Chicken / Duck / Goose			1 2 3 4	1 2 3 4	0 1 2 3 4
Pig			1 2 3 4	1 2 3 4	0 1 2 3 4
Cattle			1 2 3 4	1 2 3 4	0 1 2 3 4
Sheep			1 2 3 4	1 2 3 4	0 1 2 3 4
Horse			1 2 3 4	1 2 3 4	0 1 2 3 4
Other ________			1 2 3 4	1 2 3 4	0 1 2 3 4

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 ______ State ______ Zip ______	___/___ to ___/___	[ ] Private well [ ] City or town supply [ ] Other ______
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: _______________________

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.