

VITAMINS

1. In the past year has your child taken vitamin supplements? Yes No

If yes, continue to questions 2-7. Record all brands/types of vitamins *separately*.

2. What type of vitamin? (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="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="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="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="text"/> <input type="checkbox"/> IU <input type="checkbox"/> mg

3. What is the brand name of the vitamin? (is this with extra C, or iron, or _____...)

Brand 1	Brand 2	Brand 3	Brand 4
_____	_____	_____	_____
Code <input type="text"/> <input type="text"/> <input type="text"/>	Code <input type="text"/> <input type="text"/> <input type="text"/>	Code <input type="text"/> <input type="text"/> <input type="text"/>	Code <input type="text"/> <input type="text"/> <input type="text"/>

4. Each time you give the vitamin, how many droppers full or pills do you usually give?

<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills	<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills	<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills	<input type="checkbox"/> Droppers <input type="text"/> <input type="text"/> <input type="checkbox"/> Pills
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5. When you are giving the vitamin, how many times per week do you give it?

<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 did they take the vitamin _____ times per week?

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. Were these _____ weeks during a specific time period (school year, winter...), or spread out, off and on, over the whole year? *If the vitamin was given 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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2. On average, over the past year, how many glasses of tap water does _____ drink per day (include drinks that are made with tap water, like tea, juice from concentrate, Kool-aid)?

1 glass = 8 oz. Bottled water = 0

- None 1 glass 2-3 glasses 4-6 glasses >6 glasses

3. On average, over the past year, how many glasses of cow's milk does _____ drink per day?

1 glass = 8 oz. Do not include soy, rice, or goat's milk.

- None 1 glass 2-3 glasses 4-6 glasses >6 glasses

4. On average, how many servings a day does “___” 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)

- Rarely or Never Less than 1 1-2 3-5 6 or more

5. On average, how many servings a day does “___” 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)

- Rarely or Never Less than 1 1-2 3-5 6 or more

6. Because the results of one of our laboratory tests can be affected by exposure to smoke, we need to ask a few questions about your child's exposure to smoke from cigarettes, cigars, or pipes.

a. Does the child's mother currently smoke? Yes No

b. Does she smoke in the home? Yes No

c. Does she smoke in the car? Yes No

d. Does the child's father currently smoke? Yes No

e. Does he smoke in the home? Yes No

f. Does he smoke in the car? Yes No

g. Does the child smoke? Yes No

h. Is the child exposed on a regular basis from anyone other than the parents? Yes No

The next set of questions asks about allergies, symptoms and illnesses of _____ that occurred in the last year. For the allergy questions, let me know if he/she has not been

exposed to the food or substance.

Coding: Diagnosed? = diagnosed by health professional

NE = not exposed

7. Is _____ 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

ILLNESSES

8. *The next questions ask about episodes of illness.*

In the last year, how many times has _____ been sick? ("sick" means unable to participate in normal activities)?

Number of times sick:

What illness or symptoms did _____ 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]

SICK EPISODE

Illness	Further details	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.]

		SICK EPISODE					
Specific Symptoms	Further details	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"/>
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? (# <i>days</i> , 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"/>
Saw 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"/>

9. DAY CARE

a. Did _____ attend day care or preschool in the past year? Yes No
If yes, answer questions b-f. If no, proceed to question 10.

b. What age did he/she *first* start day care or preschool? Years
Age: Months

c. On average, what is the size of the day care or preschool class?
Number of children:

d. On average, how many days per week is he/she in day care or preschool? Days

e. On average, how many hours per day is he/she in day care or preschool? Hours

f. Is _____ currently attending day care? Yes No
If not, when did they stop? ____/____/____

g. In the past year, how many other day care centers or preschools did he/she attend?
Number:

10. SCHOOL

a. Did _____ attend school since our last interview? Yes No
If yes, answer questions b-c. If no, proceed to question 11.

b. If yes, what age did _____ *first* start school? Years N/A

c. If yes, how many children in the child's class?
Number of children: Don't Know

11. What is your current health insurance carrier?

Check all that apply.

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

12. The next set of questions list stressful things that can happen to people during their lives. Think of the list in terms of _____'s life in the past year and please answer whether or not each of these has happened. For those events that _____ has experienced, please tell me the month 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.

1 = Yes 2 = No Date = date when event occurred

Events of the DAISY child		Yes or No	Date of Event
1. Serious illness, injury or operation 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 operation of parent		<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 operation of sibling		<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 operation of other family member (specify who)		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> mm yy
5. Bad auto accident involving DAISY child		<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 child'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. Death of a: (check one)	<input type="checkbox"/> parent <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
8. Death of: (check one)	<input type="checkbox"/> other family member <input type="checkbox"/> friend <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
10. Change in school and/or daycare		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> mm yy
11. Other (specify)		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> mm yy