A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date:___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year) A3. Study Staff ID/Initials: ___ ___ ___

A4. Follow-up visit (month): 1 ☐ 2 ☐ 3 ☐ 6 ☐ OR Age: ___ ___ mo/yr To DCC ☐

A5. *This form is to be completed by interview with a subject's parent(s) or guardian(s). Please indicate below the primary source of information for this form (check all that apply):*

a. ☐ Mother b. ☐ Father c. ☐ Guardian(s)

d. ☐ Other (Specify:_____) e. ☐ Medical Record

SECTION B: DIET

B1. What do you feed your child *(check all that apply)*?

Feeding Type	Specify *(check all that apply)*:
a. ☐ Human milk	ai. ☐ Breast milk aii. ☐ Banked milk
b. ☐ Cow's milk based formula	bi. ☐ Standard infant formula bii. ☐ Follow-on formula
c. ☐ Cow's milk	ci. ☐ Whole cii. ☐ 2% ciii. ☐ Skim
d. ☐ Soy formula	di. ☐ Prosobee dii. ☐ Isomil diii. ☐ Other_____
e. ☐ Specialized formula	ei. ☐ Alimentum eii. ☐ Pregestimil eiii. ☐ Neocate eiv. ☐ Low lactose ev. ☐ Nutramigen evi. ☐ Other_____
f. ☐ Parenteral nutrition	fi. ☐ Total fii. ☐ Partial
g. ☐ Solid food	
h. ☐ Not specified	

B2. How is your child fed *(check all that apply)*?

a. ☐ Oral
b. ☐ Nasogastric
c. ☐ Nasoenteric
d. ☐ Gastrostomy
e. ☐ Gastrojejunostomy
f. ☐ Jejunostomy
g. ☐ Intravenous
h. ☐ Not specified

B3. How much milk or formula is your child fed per day (you may exclude breast milk from the calculation):

a. ___ ___ oz/day 8. ☐ NA if only breast fed 9. ☐ Unknown

b. ___ ___ ___ Kcal/oz formula 9. ☐ Unknown

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date:___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

SECTION C: VITAMINS AND DIETARY SUPPLEMENTS - * DO NOT REPORT VITAMINS OR SUPPLEMENTS PRESCRIBED IN P004.

C0. The parent/guardian brought in the subject's medications for review 1. ☐ No 2. ☐ Yes

C1. Does your child take any of the following vitamins or dietary supplements or has he/she taken any since your last visit to our clinic? **DO NOT INCLUDE MEDICATIONS PRESCRIBED FOR POO4**. 1. ☐ None → **Go to D1**

Vitamin/Supplement	Oral or Parenteral	Type	Total Daily Dose
a. ☐ Multivitamin*	1. ☐ Oral 2. ☐ Parenteral	1. ☐ Poly-vi-sol 2. ☐ ADEK 3. ☐ Other_____	_____ ml OR ____ . ____ ____ tablet
b. ☐ Vitamin A*	1. ☐ Oral 2. ☐ Parenteral	1. ☐ Aquasol A 2. ☐ Other_____	_____ ☐ µg OR ☐ IU
c. ☐ Vitamin E*	1. ☐ Oral 2. ☐ Parenteral	1. ☐ TPGS (Liqui-E) 2. ☐ Other_____	_____ ☐ mg OR ☐ IU
d. ☐ Vitamin D*	1. ☐ Oral 2. ☐ Parenteral	1. ☐ D_2 or D_3 (Drisdol) 2. ☐ 1,25 OH 2 Vit D (Rocaltrol) 3. ☐ Other_____	_____ ☐ µg OR ☐ IU
e. ☐ Vitamin K*	1. ☐ Oral 2. ☐ Parenteral	1. ☐ Mephyton 2. ☐ Other_____	_____ mg
f. ☐ Calcium	1. ☐ Oral 2. ☐ Parenteral		_____ ☐ mg OR ☐ mequ
g. ☐ Duocal or Polycose	1. ☐ Oral		
h. ☐ Branch chain amino acids	1. ☐ Oral 2. ☐ Parenteral		
i. ☐ Medium chain triglyceride (MCT) oil	1. ☐ Oral		
j. ☐ Protein supplements	1. ☐ Oral		
k. ☐ Milk thistle	1. ☐ Oral		
l. ☐ Herbal remedies or supplements	1. ☐ Oral	Specify_____	
m. ☐ Other	1. ☐ Oral 2. ☐ Parenteral	Specify_____	

IF ADDITIONAL ENTRIES ARE NEEDED, PLEASE REPORT THEM IN TABLE D6 OF THIS FORM.

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date:___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

SECTION D: OTHER PRESCRIPTION MEDICATIONS — *DO NOT REPORT MEDICATIONS PRESCRIBED IN P004

D1. Ursodeoxycholic acid (e.g. Urso, ursodiol or Actigall) 1. ☐ No → **Go to D2**

Medication	Total Daily Dose
a. ☐ Ursodeoxycholic acid*	_____ mg

D2. Other antibiotics 1. ☐ No → **Go to D3**

Medication	Total Daily Dose
a. ☐ Trimethoprim/sulfamethoxazole*	_____ mg TMP
b. ☐ Other :_____	_____ mg
c. ☐ Other :_____	_____ mg
d. ☐ Other :_____	_____ mg
e. ☐ Other :_____	_____ mg

D3. Diuretics 1. ☐ No → **Go to D4**

Medication	Total Daily Dose
a. ☐ Furosemide (e.g. Lasix)	_____ mg
b. ☐ Spironolactone (e.g. Aldactone)	_____ mg
c. ☐ Other :_____	_____ mg

D4. Other steroids 1. ☐ No → **Go to D5**

Medication	Total Daily Dose
a. ☐ Prednisone	_____ mg
b. ☐ Prednisolone	_____ mg
c. ☐ Methylprednisolone (e.g. Solumedrol)	_____ mg
d. ☐ Other :_____	_____ mg

D5. Prescription medications to treat pruritus 1. ☐ No → **Go to D6**

Medication
a. ☐ Rifampin
b. ☐ Antihistamines
c. ☐ Cholestyramine (e.g. Questran)
d. ☐ Other :_____

IF ADDITIONAL ENTRIES FOR ITEMS D1-D5 ARE NEEDED, PLEASE REPORT THEM IN TABLE D6 OF THIS FORM.

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date:___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

D6. Any other prescription medications 1. ☐ No → **END**

Item*	Medication
	a.
	b.
	c.
	d.
	e.
	f.
	g.
	h.
	i.
	j.
	k.
	l.
	m.
	n.
	o.
	p.
	q.
	r.
	s.
	t.

*If additional items from Section C or Section D1-D5 are reported here, please enter the item number in this column. For example, if you are reporting an additional item under diuretics, having already used D3c, please report the item number here as D3d. Likewise, for any additional items from Section C, please report them as C1n…C1z.