

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. <input type="checkbox"/> Human milk	ai. <input type="checkbox"/> Breast milk                      aii. <input type="checkbox"/> Banked milk
b. <input type="checkbox"/> Cow's milk based formula	bi. <input type="checkbox"/> Standard infant formula                      bii. <input type="checkbox"/> Follow-on formula
c. <input type="checkbox"/> Cow's milk	ci. <input type="checkbox"/> Whole                      cii. <input type="checkbox"/> 2%                      ciii. <input type="checkbox"/> Skim
d. <input type="checkbox"/> Soy formula	di. <input type="checkbox"/> Prosobee                      dii. <input type="checkbox"/> Isomil                      diii. <input type="checkbox"/> Other _____
e. <input type="checkbox"/> Specialized formula	ei. <input type="checkbox"/> Alimentum                      eii. <input type="checkbox"/> Pregestimil                      eiii. <input type="checkbox"/> Neocate eiv. <input type="checkbox"/> Low lactose                      ev. <input type="checkbox"/> Nutramigen                      evi. <input type="checkbox"/> Other _____
f. <input type="checkbox"/> Parenteral nutrition	fi. <input type="checkbox"/> Total                      fii. <input type="checkbox"/> Partial
g. <input type="checkbox"/> Solid food	
h. <input type="checkbox"/> 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

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**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 P004.** 1.  None → **Go to D1**

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

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

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**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. <input type="checkbox"/> Ursodeoxycholic acid*	_____ mg

D2. Other antibiotics 1.  No → Go to D3

Medication	Total Daily Dose
a. <input type="checkbox"/> Trimethoprim/sulfamethoxazole*	_____ mg TMP
b. <input type="checkbox"/> Other : _____	_____ mg
c. <input type="checkbox"/> Other : _____	_____ mg
d. <input type="checkbox"/> Other : _____	_____ mg
e. <input type="checkbox"/> Other : _____	_____ mg

D3. Diuretics 1.  No → Go to D4

Medication	Total Daily Dose
a. <input type="checkbox"/> Furosemide (e.g. Lasix)	_____ mg
b. <input type="checkbox"/> Spironolactone (e.g. Aldactone)	_____ mg
c. <input type="checkbox"/> Other : _____	_____ mg

D4. Other steroids 1.  No → Go to D5

Medication	Total Daily Dose
a. <input type="checkbox"/> Prednisone	_____ mg
b. <input type="checkbox"/> Prednisolone	_____ mg
c. <input type="checkbox"/> Methylprednisolone (e.g. Solumedrol)	_____ mg
d. <input type="checkbox"/> Other : _____	_____ mg

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

Medication
a. <input type="checkbox"/> Rifampin
b. <input type="checkbox"/> Antihistamines
c. <input type="checkbox"/> Cholestyramine (e.g. Questran)
d. <input type="checkbox"/> Other : _____

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

