

Site Number: _____ Screening ID: _____ - ____ Participant Letters: _____

The Study Coordinator completes this form at all study follow-up visits except when there is an Infant Enrollment Visit combined with 3 Months old or Infant Enrollment Visit combined with 6 Months old visit.

A. VISIT INFORMATION

1. Date of visit (e.g. 05/Sep/2006): _____ / _____ / _____
DAY MONTH YEAR
2. Visit: (check one):

<input type="checkbox"/> 3 3 Months old	<input type="checkbox"/> 12 12 Months old	<input type="checkbox"/> 21 21 Months old	<input type="checkbox"/> 36 36 Months old
<input type="checkbox"/> 6 6 Months old	<input type="checkbox"/> 15 15 Months old	<input type="checkbox"/> 24 24 Months old	<input type="checkbox"/> 42 42 Months old
<input type="checkbox"/> 9 9 Months old	<input type="checkbox"/> 18 18 Months old	<input type="checkbox"/> 30 30 Months old	<input type="checkbox"/> 48 48 Months old
3. The participant completed visit activities (check one):

<input type="checkbox"/> 1 By phone	<input type="checkbox"/> 2 At clinic
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4. Is the mother currently nursing the eligible infant? Y N
 - If YES, also complete Nursing Mother Visit Form (NPP09).
 - a. If NO, did the mother nurse the infant previous to this visit? Y N
 - 1) If YES, when did the mother discontinue nursing the infant? _____ / _____ / _____
DAY MONTH YEAR

B. INFANT MEDICAL HISTORY

1. Has the infant had any illnesses since the last visit? Y N
 - If NO, skip to **Section C**.
 - If YES, complete the below:
- Illness 1) If YES, number of times?
(Circle number or enter # of times)

HEENT

- | | | |
|--|-----|--------------|
| a. Eye discharge/pinkeye (not blocked tear ducts) | Y N | 1 2 3 4 5 __ |
| b. Mouth sores (includes ulcers, thrush, cold sores) | Y N | 1 2 3 4 5 __ |
| c. Ear infection | Y N | 1 2 3 4 5 __ |

Respiratory

- | | | |
|-------------------------------------|-----|--------------|
| d. Respiration (breathing) problems | Y N | 1 2 3 4 5 __ |
| e. Cold or runny nose | Y N | 1 2 3 4 5 __ |
| f. Cough | Y N | 1 2 3 4 5 __ |
| g. Croup (e.g. barking cough) | Y N | 1 2 3 4 5 __ |
| h. Bronchitis/ Bronchiolitis | Y N | 1 2 3 4 5 __ |

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Write “*” if the desired information is permanently unavailable (i.e. will not be known in any future updates).

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i. Pneumonia/ RSV Y N 1 2 3 4 5 __

B. INFANT MEDICAL HISTORY (CONTINUED)

Illness

1) If YES, number of times?
(Circle number or enter # of times)

Gastrointestinal

j. Colic Y N 1 2 3 4 5 __

k. Vomiting (≥ 3 times in 24 hours) Y N 1 2 3 4 5 __

l. Diarrhea (≥ 3 times in 24 hours) Y N 1 2 3 4 5 __

m. Gastrointestinal infection Y N 1 2 3 4 5 __

n. Intestinal parasite Y N 1 2 3 4 5 __

o. Yellow skin (jaundice) Y N 1 2 3 4 5 __

p. Bloody stool Y N 1 2 3 4 5 __

Neurologic

q. Seizures Y N 1 2 3 4 5 __

r. Meningitis Y N 1 2 3 4 5 __

Infections

s. Fever (over 100°F or 37.7°C) Y N 1 2 3 4 5 __

t. Strep infection Y N 1 2 3 4 5 __

u. German measles (rubella) Y N 1 2 3 4 5 __

v. Measles Y N 1 2 3 4 5 __

w. Chickenpox Y N 1 2 3 4 5 __

x. Mumps Y N 1 2 3 4 5 __

y. Rash (not diaper rash) Y N 1 2 3 4 5 __

Hematological

z. Excessive bleeding Y N 1 2 3 4 5 __

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B. INFANT MEDICAL HISTORY (CONTINUED)

Illness

1) If YES, number of times?

(Circle number or enter # of times)

Surgery

aa. Surgery

Y	N	1	2	3	4	5	__
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2) If YES, specify surgery:

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Other

ab. Other 1:

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1	2	3	4	5	__
---	---	---	---	---	----

ac. Other 2:

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1	2	3	4	5	__
---	---	---	---	---	----

ad. Other 3:

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1	2	3	4	5	__
---	---	---	---	---	----

C. INFANT RECENT EVENTS

- | | |
|--|-------|
| 1. Did the infant have an immunization within the <u>last 14 days</u> ? | Y N |
| 2. Has the infant had any febrile infectious illness in the <u>last 14 days</u> ? | Y N |
| 3. Has the infant had any non-febrile infectious illness(es) in the <u>last 14 days</u> ? | Y N |
| 4. Did the infant taken any antibiotics within the <u>last 14 days</u> ? | Y N |
| 5. Has the infant taken steroids (oral or inhaled) or other immunosuppressive medications in the <u>last 30 days</u> ? | Y N |
| 6. Has the infant received any immunoglobulin treatments or blood products since the <u>last visit</u> ? | Y N |

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D. INFANT MEDICATIONS

1. Has the parent(s) or legal guardian given the infant any medications since the last visit (prescription and/or non-prescription NOT including omega-3 fatty acids, DHA, vitamins, or dietary supplements)? (Refer to NWK02 Concomitant Medication Worksheet. Use NPP20 Infant Vitamin and Dietary Supplement Form to record vitamins and dietary supplements) Y N

If YES, fill in the following table. List all medications given since the last visit.
(Use the Medication Category Codes to complete Category Code):

	Trade Name	1) Category Code	2) Currently taking?
a.	_____	_____	Y N
b.	_____	_____	Y N
c.	_____	_____	Y N
d.	_____	_____	Y N
e.	_____	_____	Y N

Medication Category Codes:			
<i>Use the Number Codes below to indicate the type of medication used:</i>			
001	Antibiotic	006	NSAID
002	Aspirin	007	Steroid Preparation
003	Immunization	008	Thyroid Medication
004	Immunosuppressive	999	Other
005	Non-Insulin Diabetes Medication		

Initials (first, middle, last) of person completing this form: _____
F M L

Date form completed: ____/____/____
DAY MONTH YEAR

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