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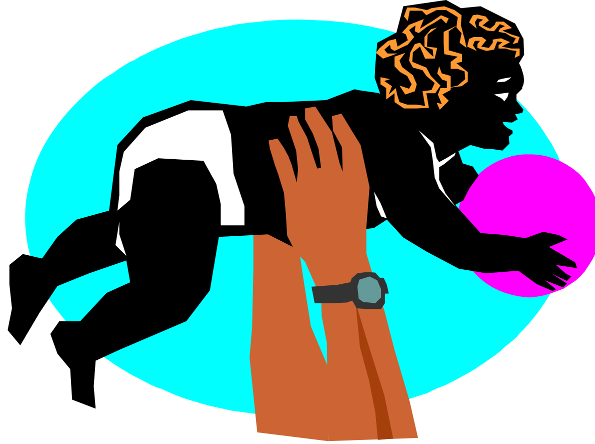
CMH Food Allergy Baseline Interview Questionnaire



Today's date [|] / [|] / [|]

Interviewer's Name [| | | | | | | | | | | | | |]

Interview is ○ Complete ○ Incomplete

Location of Interview [| | | | | | | | | | | | | |]

If incomplete date of future visit [|] / [|] / [|]

Family ID

[ ]

Type of Questionnaire

B

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SCREENING: For Interviewers:

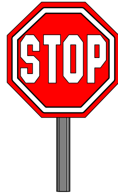
I. Eligibility

Are you this child's biological parent? ○ Yes ○ No

Are you this child's legal guardian? ○ Yes ○ No

If no to any of the above, thank participant for his/her time. Enrollment is accepted from biological mother or father only if he/she remains legal guardian of child.

If not parent and legal guardian of child:



II. Explain study purpose and procedures and obtain informed consent.
Introduction and instructions to interviewer (to be read to patient).

Everyone who participates in this study will be asked a series of questions. The questions should take about 30 minutes to answer. You may skip any question you feel uncomfortable answering. I'd like to assure you that this information is confidential and will be used solely for research purposes.

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Section I: Family Pedigree (Interviewers: fill in the information for each family member, filling in the circles for all health conditions that apply)

Mom- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [F]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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Dad- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [M]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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Index Child- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [ ]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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Sibling 1- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [ ]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

---

Sibling 2- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [ ]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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Sibling 3- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [ ]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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Sibling 4- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [ ]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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Sibling 5- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [ ]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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Sibling 6- First Initial [ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender (F,M) [ ]

○ Food Allergy ○ Eczema ○ Asthma ○ Hay Fever ○ Drug Allergy ○ Other Allergies

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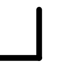

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IDENTIFYING INFORMATION TO BE DESTROYED UPON STUDY COMPLETION

Information on the parents and the index child

Child's Name: Last

First

Child's Medical Record Number:

Child's Date of Birth: - -

Gender of Child: ○ Male ○ Female

Child's Home Address:

Street #: Street Name:

Apt:

City: State: Zip Code:

Home Phone #: ( ) -

Mother's Name: Last

First

Mother's Work Phone #: ( ) -

Mother's Cell Phone #: ( ) -

Mother's E-mail:

Father's Name: Last

First

Father's Work Phone #: ( ) -

Father's Cell Phone #: ( ) -

Father's E-mail:

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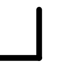

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Subject Type I

For interviewers to read aloud: THESE NEXT QUESTIONS ARE ABOUT YOUR CHILD'S HEALTH DURING HIS/HER FIRST YEAR OF LIFE, OR SINCE BIRTH IF UNDER 1 YEAR OLD.

1. How much did your child weigh at birth? [ ][ ] lbs [ ][ ] oz [ ][ ][ ][ ] grams

2. Was your child born
- ○ Before the due date? [ ][ ] weeks [ ][ ] days before due date
- ○ At the due date?
- ○ After the due date? [ ][ ] weeks [ ][ ] days after due date

3. Was your child born by C-section? ○ Yes ○ No

4. Since birth or up until your child reached one year of age, has your child ever had any of the following illnesses? (DURING THE FIRST YEAR OF LIFE ONLY)

Common Cold ○ Yes ○ No ○ Not Sure

If yes, how many times? [ ][ ] X's

Gastric / intestinal infection ○ Yes ○ No ○ Not Sure

If yes, how many times? [ ][ ] X's

Conjunctivitis / Pink Eye ○ Yes ○ No ○ Not Sure

If yes, how many times? [ ][ ] X's

RSV / Bronchiolitis ○ Yes ○ No ○ Not Sure

If yes, hospitalized? ○ Yes ○ No ○ Not Sure

Bronchitis ○ Yes ○ No ○ Not Sure

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5. Antibiotics are medicines that your doctor prescribes for illnesses caused by infections; examples of some names of commonly prescribed antibiotics are amoxicillin and penicillin. During the first year of life (or since birth IF THE CHILD IS UNDER 1 YEAR OLD), did your child take any antibiotics?

○ Yes ○ No ○ Not Sure

If NO skip to question 7

If yes, how many times was your child prescribed an antibiotic medicine since birth (IF UNDER 1 YEAR OLD) or in the FIRST YEAR OF LIFE?

☐☐ X's

6. Since birth or up until your child reached one year of age, has your child ever had any of the following illnesses? (DURING THE FIRST YEAR OF LIFE ONLY)

Ear infection ○ Yes ○ No ○ Not Sure

If yes, how many times? ☐☐ X's

Pneumonia ○ Yes ○ No ○ Not Sure

If yes, how many times? ☐☐ X's

Skin infection ○ Yes ○ No ○ Not Sure

If yes, how many times? ☐☐ X's

Urinary tract infection ○ Yes ○ No ○ Not Sure

If yes, how many times? ☐☐ X's

Parasite infection ○ Yes ○ No ○ Not Sure

Bone infection (Osteomyelitis) ○ Yes ○ No ○ Not Sure

Meningitis ○ Yes ○ No ○ Not Sure

Bacteremia / Sepsis (blood infection) ○ Yes ○ No ○ Not Sure

Sinus infection ○ Yes ○ No ○ Not Sure

7. During the first year of life (or since birth IF THE CHILD IS UNDER 1 YEARS OLD), did your child ever live in a farming environment?

○ Yes ○ No

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8. Were pets present in the home during your child's first year of life (OR SINCE BIRTH IF CHILD IS UNDER 1 YEAR OLD)?

○ Yes ○ No

If yes, specify type of pet and how many of each type (Indicate the highest number of pets at any single point in time):

○ Cat # ☐☐　　○ Reptile # ☐☐

○ Dog # ☐☐　　○ Rabbit # ☐☐

○ Fish # ☐☐　　○ Guinea Pig # ☐☐

○ Bird # ☐☐　　○ Others

Specify ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ # ☐☐

Specify ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ # ☐☐

9. How long has your child lived in your current home?

☐☐ years　　☐☐ months

10. Before the age of five, did someone other than your child's parent help in caring for your child for even part of the day? (nanny, child care, preschool, relative)

○ Yes ○ No

If yes, please answer the following questions asking where, how long, how often and # of other children in this care. Please check all that apply.

A. Child care center/preschool? #1 From ☐☐ years ☐☐ months to...

☐☐ years ☐☐ months

☐☐ # of hours/week　☐☐ # of other children in child's classroom

#2 From ☐☐ years ☐☐ months to...

☐☐ years ☐☐ months

☐☐ # of hours/week　☐☐ # of other children in child's classroom

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#3 From [ ][ ] years [ ][ ] months to...

[ ][ ] years [ ][ ] months

[ ][ ] # of hours/week [ ][ ] # of other children in child's classroom

B. Home-based child care? #1 From [ ][ ] years [ ][ ] months to...
(not in own home)

[ ][ ] years [ ][ ] months

[ ][ ] # of hours/week [ ][ ] # of other children

#2 From [ ][ ] years [ ][ ] months to...

[ ][ ] years [ ][ ] months

[ ][ ] # of hours/week [ ][ ] # of other children

C. In home care
(own home, nanny)? From [ ][ ] years [ ][ ] months to...

[ ][ ] years [ ][ ] months

[ ][ ] # of hours/week [ ][ ] # of other children

11. Did you breast feed or bottle feed your child, or both?

○ Breast only ○ Bottle only ○ Both

12. For how long did you exclusively breast feed (no formula or food)?

[ ][ ] months [ ][ ] weeks

13. For how long did you breast feed (with or without the use of formula)?

[ ][ ] months [ ][ ] weeks

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14. During breast feeding, did you take medications for gastrointestinal upset?

O Yes O No O Not Sure

if YES, which of the following medications did you take?

O Antacids (Mylanta, Rolaids, TUMS, Pepto-Bismol)

O H2 Blockers (Pepcid AC, Zantac)

O Proton Pump inhibitors (Aciphex, Prilosec, Prevacid, Nexium)

O Prokinetic agents (Urecholine, Reglan, Erythromycin)

O Not sure

O Other, specify

15. During pregnancy, did you take medications for gastrointestinal upset?

O Yes O No O Not Sure

if YES, which of the following medications did you take?

O Antacids (Mylanta, Rolaids, TUMS, Pepto-Bismol)

O H2 Blockers (Pepcid AC, Zantac)

O Proton Pump inhibitors (Aciphex, Prilosec, Prevacid, Nexium)

O Prokinetic agents (Urecholine, Reglan, Erythromycin)

O Not sure

O Other, specify

16. At what age did you introduce the following formula/milk to your child?

Cow's milk formula (Enfamil, Similac) — O Never O Not Sure — Year month days

Whey Hydrolyzed formula (Goodstart) — O Never O Not Sure — Year month days

Casein Hydrolysate formula (Nutramigen, Pregestimil, Alimentum) — O Never O Not Sure — Year month days

Elemental formula (Neocate, Elecare, EO28) — O Never O Not Sure — Year month days

Whole Cow's Milk — O Never O Not Sure — Year month days

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Soy formula
(Isomil, Prosobee, Alsoy)

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Soy Milk

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

17. Is your child **younger** than **7 years old**? ○ Yes ○ No

If NO skip to question 21

18. In a typical week during a period of breast feeding, how often did you (**THE MOTHER)** eat the following foods?

Cow's Milk/Dairy Products/ Cheese

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Egg

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Peanut (including peanut butter)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Tree nuts (i.e. almond, cashew, filbert/hazel, walnut, brazil, macadamia, pecan, pine, pistachio)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

---

Fish (i.e. salmon, tuna, catfish, cod, flounder, halibut, trout, bass)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Shellfish (i.e., shrimp, crab, lobster, clam, oyster, mussels)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Wheat (i.e., pasta, bread, cereal)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Soy/Tofu

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

---

Seeds (i.e. sesame, sunflower, pumpkin)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

---

Green vegetables

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Orange vegetables (carrots, squash, etc.)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

---

Fruits

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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Meats (beef, poultry, pork)

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

---

Beans

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [ ][ ] years [ ][ ] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

---

Rice

Initially: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Changed diet when child was: [|] years [|] months

New frequency: ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

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19. At what age did you first introduce solid food to your child?

○ Never ○ Not Sure

At [|] Year [|] month [|] days

20. At what age did you first introduce the following foods to your child?

Cow's milk/Dairy Products/ Cheese

○ Never ○ Not sure

[|] Year [|] Month

Egg

○ Never ○ Not Sure

[|] Year [|] month [|] days

Peanut (incl. peanut butter)

○ Never ○ Not Sure

[|] Year [|] month [|] days

Tree Nuts (i.e. almond, cashew, filbert/hazel, walnut, brazil, macadamia, pecan, pine, pistachio)

○ Never ○ Not Sure

[|] Year [|] month [|] days

Fish (i.e. tuna, salmon, cod, flounder, catfish, halibut, trout, bass)

○ Never ○ Not Sure

[|] Year [|] month [|] days

Shellfish (i.e. shrimp, crab, lobster, clam, oyster, mussels)

○ Never ○ Not Sure

[|] Year [|] month [|] days

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Wheat (i.e. pasta, bread, cereal)

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Soy/Tofu

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Seeds (i.e. sesame, sunflower, pumpkin)

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Jar Vegetables (baby food)

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Green Vegetables

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Orange Vegetables

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Fruit Juice

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Jar Fruits (baby food)

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Fresh Fruits

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Meat

○ Never ○ Not Sure

At [ ][ ] Year [ ][ ] month [ ][ ] days

Rice Cereal

○ Never ○ Not Sure

At [|] Year [|] month [|] days

21. At present, does your child take any nutritional supplements or vitamins?

○ Yes ○ No **If NO skip to question 27**

22. On average how many days per week does your child take a multivitamin/polyvisol?

○ None ○ 1-2 days ○ 3-4 days ○ 5-6 days ○ everyday

a) Is the multivitamin infused with iron?

○ Yes ○ No ○ Not Sure

b) Is the multivitamin infused with calcium?

○ Yes ○ No ○ Not Sure

23. On average how many days per week does your child take Trivisol (Vitamins A,C,D)?

○ None ○ 1-2 days ○ 3-4 days ○ 5-6 days ○ everyday

24. On average how many days per week does your child take a Calcium supplement?

○ None ○ 1-2 days ○ 3-4 days ○ 5-6 days ○ everyday

25. On average how many days per week does your child take Pediasure/Ensure?

○ None ○ 1-2 days ○ 3-4 days ○ 5-6 days ○ everyday

26. Other (specify): [| | | | | | | | | | | | | |]

○ None ○ 1-2 days ○ 3-4 days ○ 5-6 days ○ everyday

Other (specify): [| | | | | | | | | | | | | |]

○ None ○ 1-2 days ○ 3-4 days ○ 5-6 days ○ everyday

27. At present, how often does your child eat the following foods per week?

Cow's milk/Dairy Products/Cheese

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Egg ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Peanut(including peanut butter)

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Tree Nuts (i.e. almond,cashew,filbert/hazel,walnut,brazil,macadamia,pecan,pine pistachio)

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Fish (i.e. tuna, salmon, cod, flounder, catfish, halibut, trout, bass)

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Shellfish (i.e. Shrimp, crab, lobster, clam, oyster, mussels)

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Wheat (i.e. pasta, bread, cereal)

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Soy/Tofu ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Seeds (i.e. sesame, sunflower, pumpkin)

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Green Vegetables

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Orange Vegetables (carrots, squash, etc)

○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Fruits ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Fruit juice (without calcium) ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Calcium fortified fruit juice ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Meat ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Beans ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

Rice ○ None ○ <1 day ○ 1-2 days ○ 3-5 days ○ 6-7 days

28. Does your child have Eczema?

○ No

○ Yes, only when he/she was a baby, but outgrew by age [|] Year(s) [|] Months

○ Yes, he/she has it now

If **YES**, was your child's eczema diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor?

[|] Year(s) [|] Months [|] Weeks

29. Have you ever used a cream, lotion, or ointment containing steroids on your child's skin; for example: hydrocortisone cream or triamcinolone cream?

○ Yes ○ No

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30. Has your child ever had asthma?

- ○ No
- ○ Yes, only when she/he was a baby, but outgrew by age [ ][ ] Year(s) [ ][ ] Months
- ○ Yes, he/she has it now

If **YES**, was your child's asthma diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor?

[ ][ ] Year(s) [ ][ ] Months

31. Has your child ever used an inhaler or nebulizer? ○ Yes ○ No

32. Has your child ever had hay fever or seasonal allergies?

- ○ No
- ○ Yes, only when she/he was a baby, but outgrew by age [ ][ ] Year(s) [ ][ ] Months
- ○ Yes, he/she has it now

If **YES**, was your child's hay fever diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor?

[ ][ ] Year(s) [ ][ ] Months

During which season does he/she have seasonal allergies?

○ Spring ○ Summer ○ Autumn ○ Winter ○ Year round

33. Has your child ever had pet allergies? ○ Yes ○ No

If NO skip to question 34

Has your child ever had a **cat** allergy?

- ○ No
- ○ Yes, only when she/he was a baby, but outgrew by age [ ][ ] Year(s) [ ][ ] Months
- ○ Yes, he/she has it now

If **YES**, was your child's cat allergy diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor?

[ ][ ] Year(s) [ ][ ] Months

Has your child ever had a **dog** allergy?

- ○ No
- ○ Yes, only when she/he was a baby, but outgrew by age [ ][ ] Year(s) [ ][ ] Months
- ○ Yes, he/she has it now

If **YES**, was your child's dog allergy diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Has your child ever had any **other** pet allergies? ○ Yes ○ No **If No, skip to 34**

Other pet allergy #1, specify: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

- ○ Yes, only when she/he was a baby, but outgrew by age [ ][ ] Year(s) [ ][ ] Months
- ○ Yes, she/he has it now

If **YES**, was your child's allergy diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Other pet allergy #2, Specify: [ ]

- ○ Yes, only when she/he was a baby, but outgrew by age [ ] Year(s) [ ] Months
- ○ Yes, she/he has it now

If **YES**, was your child's allergy diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor? [ ] Year(s) [ ] Months

34. Does your child have any of the following environmental allergies that have been diagnosed by your doctor?

○ Pollen ○ Dust Mite ○ Cockroach ○ Mold ○ Other ○ None

Specify [ ]

Specify [ ]

Specify [ ]

35. Has your child ever used anti-allergy medications? (i.e., Benadryl, Zyrtec, Claritin, Atarax)

○ Yes ○ No

36. Has your child ever used medications for gastrointestinal upset?

○ Yes ○ No

If YES, which medications has he/she taken?

- ○ Antacids (Mylanta, Rolaids, TUMS, Pepto-Bismol)
- ○ H2 Blockers (Pepcid AC, Zantac)
- ○ Proton Pump inhibitors (Aciphex, Prilosec, Prevacid, Nexium)
- ○ Prokinetic agents (Urecholine, Reglan, Erythromycin)
- ○ Not sure
- ○ Other, specify [ ]

37. Does your child have any drug allergies?

○ Yes ○ No

Specify drug: [ ]

Was this drug allergy diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor? [ ] Year(s) [ ] Months

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Specify drug: [ ]

Was this drug allergy diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor? [ ] Year(s) [ ] Months

Specify drug: [ ]

Was this drug allergy diagnosed by a doctor? ○ Yes ○ No

How old was your child when first diagnosed by a doctor? [ ] Year(s) [ ] Months

38. Has your child been diagnosed with G6PD deficiency? ○ Yes ○ No

39. Is your child allergic to insect stings? (for example bee, wasp, yellow jacket. Mosquitoes and spiders don't count)

○ Yes ○ No ○ Don't know/Never been stung

If **Yes,** is it a severe allergy (that is, difficulty breathing, need epi pen or to go to the hospital)?

○ Yes ○ No

40. Is your child allergic to any food(s) at present? ○ Yes ○ No

41. Has your child ever been allergic to any foods in the past that they have since outgrown? ○ Yes ○ No

If NO to question 40 AND 41, skip to Pediatric Sleep Questionnaire (question A1)

Dairy products/ Cheese/ Milk ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ] years [ ] months

If Outgrown, at what age? [ ] years [ ] months

Egg

○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ] years [ ] months

If Outgrown, at what age? [ ] years [ ] months

Peanuts ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ] years [ ] months

If Outgrown, at what age? [ ] years [ ] months

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Tree Nut ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ][ ] years [ ][ ] months

If **Current,** please choose the specific type (select all that apply):

○ Almond ○ Cashew ○ Filbert/hazel ○ Walnut

○ Brazil ○ Macadamia ○ Pecan ○ Pine

○ Pistachio ○ Other

If Outgrown, at what age? [ ][ ] years [ ][ ] months

If **Outgrown,** please choose the specific type (select all that apply):

○ Almond ○ Cashew ○ Filbert/hazel ○ Walnut

○ Brazil ○ Macadamia ○ Pecan ○ Pine

○ Pistachio ○ Other

Fish ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ][ ] years [ ][ ] months

If **Current,** please choose the specific type (select all that apply)

○ Salmon ○ Tuna ○ Catfish ○ Cod ○ Flounder ○ Halibut ○ Trout ○ Bass

Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

If Outgrown, at what age? [ ][ ] years [ ][ ] months

If **Outgrown,** please choose the specific type (select all that apply)

○ Salmon ○ Tuna ○ Catfish ○ Cod ○ Flounder ○ Halibut ○ Trout ○ Bass

Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Shellfish ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ][ ] years [ ][ ] months

If **Current**, please choose the specific type (select all that apply)

○ Shrimp ○ Crab ○ Lobster ○ Clam ○ Oyster ○ Mussels

If Outgrown, at what age? [ ][ ] years [ ][ ] months

If **Outgrown,** please choose the specific type (select all that apply)

○ Shrimp ○ Crab ○ Lobster ○ Clam ○ Oyster ○ Mussels

Wheat ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ][ ] years [ ][ ] months

If Outgrown, at what age? [ ][ ] years [ ][ ] months

Soy/ Tofu ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ][ ] years [ ][ ] months

If Outgrown, at what age? [ ][ ] years [ ][ ] months

Seeds ○ Current ○ Outgrown ○ Never

If Current/Outgrown, how old was your child when you first noticed his/her food allergy? [ ][ ] years [ ][ ] months

If **current,** please choose the specific type (select all that apply):

○ Sesame ○ Sunflower ○ Pumpkin Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

If Outgrown, at what age? [ ][ ] years [ ][ ] months

If **outgrown,** please choose the specific type (select all that apply):

○ Sesame ○ Sunflower ○ Pumpkin Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

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Other Foods (specify)

○ Current ○ Outgrown

How old was your child when you first noticed his/her food allergy?

years months

If Outgrown, at what age?

years months

○ Current ○ Outgrown

How old was your child when you first noticed his/her food allergy?

years months

If Outgrown, at what age?

years months

○ Current ○ Outgrown

How old was your child when you first noticed his/her food allergy?

years months

If Outgrown, at what age?

years months

○ Current ○ Outgrown

How old was your child when you first noticed his/her food allergy?

years months

If Outgrown, at what age?

years months

○ Current ○ Outgrown

How old was your child when you first noticed his/her food allergy?

years months

If Outgrown, at what age?

years months

○ Current ○ Outgrown

How old was your child when you first noticed his/her food allergy?

years months

If Outgrown, at what age?

years months

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42. Has your child ever experienced symptoms to any food that was passed exclusively through breast milk?

- Yes
- No

If yes, to which foods?

- Dairy products/Cheese/Milk
- Egg
- Peanuts
- Tree Nuts
- Fish
- Shellfish
- Wheat
- Soy/Tofu
- Seeds
- Other

If other, list other foods:

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43. Specific symptoms of food allergy:

43a. Mouth

Type of Food	Lips Itching/ Tingling	Lips Swelling	Tongue Itching/ Tingling	Tongue Swelling
Cow's Milk/Dairy Products/Cheese	○	○	○	○
Egg	○	○	○	○
Peanut	○	○	○	○
Tree Nuts	○	○	○	○
Fish	○	○	○	○
Shellfish	○	○	○	○
Wheat	○	○	○	○
Soy/Tofu	○	○	○	○
Seeds	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○

43 b/c. Eye/Nose

Type of Food	Red/Watery/ Itchy Eye	Swollen Eye	Stuffy/Runny Nose	Sneezing	Itchy Nose
Cow's Milk/Dairy Products/Cheese	○	○	○	○	○
Egg	○	○	○	○	○
Peanut	○	○	○	○	○
Tree Nuts	○	○	○	○	○
Fish	○	○	○	○	○
Shellfish	○	○	○	○	○
Wheat	○	○	○	○	○
Soy/Tofu	○	○	○	○	○
Seeds	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○

43 d. Throat

Type of Food	Itching and/or tightness in the throat	Hoarseness/ change of voice	Choking/ Difficulty Swallowing	Throat Clearing
Cow's Milk/Dairy Products/Cheese	○	○	○	○
Egg	○	○	○	○
Peanut	○	○	○	○
Tree Nuts	○	○	○	○
Fish	○	○	○	○
Shellfish	○	○	○	○
Wheat	○	○	○	○
Soy/Tofu	○	○	○	○
Seeds	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○

43 e. Skin

Type of Food	Itching	Hives	Swelling of the face and/or extremities	Redness of the skin
Cow's Milk/Dairy Products/Cheese	○	○	○	○
Egg	○	○	○	○
Peanut	○	○	○	○
Tree Nuts	○	○	○	○
Fish	○	○	○	○
Shellfish	○	○	○	○
Wheat	○	○	○	○
Soy/Tofu	○	○	○	○
Seeds	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○

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43 f. Lung

Type of Food	Shortness of breath	Repetitive coughing	Wheezing	Chest Tightness
Cow's Milk/Dairy Products/Cheese	○	○	○	○
Egg	○	○	○	○
Peanut	○	○	○	○
Tree Nuts	○	○	○	○
Fish	○	○	○	○
Shellfish	○	○	○	○
Wheat	○	○	○	○
Soy/Tofu	○	○	○	○
Seeds	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○

43 g. Gut

Type of Food	Stomach cramps/pain	Nausea	Vomiting	Diarrhea	Bloating (swelling, gassy feeling)
Cow's Milk/Dairy Products/Cheese	○	○	○	○	○
Egg	○	○	○	○	○
Peanut	○	○	○	○	○
Tree Nuts	○	○	○	○	○
Fish	○	○	○	○	○
Shellfish	○	○	○	○	○
Wheat	○	○	○	○	○
Soy/Tofu	○	○	○	○	○
Seeds	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○

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43 h. Cardiovascular

Type of Food	Pale or turn blue	Dizzy/Light-headed	Passing out/Fainting
Cow's Milk/Dairy Products/Cheese	O	O	O
Egg	O	O	O
Peanut	O	O	O
Tree Nuts	O	O	O
Fish	O	O	O
Shellfish	O	O	O
Wheat	O	O	O
Soy/Tofu	O	O	O
Seeds	O	O	O
	O	O	O
	O	O	O
	O	O	O
	O	O	O
	O	O	O
	O	O	O

44. Has your child ever experienced a severe allergic reaction that affected the throat, lungs, and/or cardiovascular system? O Yes O No

45. If yes, to what foods? (Select all that apply)

Type of Food	Doctor Diagnosed?	Number of episodes (lifetime)	Number of Episodes (in last year)
Cow's Milk/Dairy Products/Cheese	O Yes O No		
Egg	O Yes O No		
Peanut	O Yes O No		
Tree Nuts	O Yes O No		
Fish	O Yes O No		
Shellfish	O Yes O No		
Wheat	O Yes O No		
Soy/Tofu	O Yes O No		
Seeds	O Yes O No		
	O Yes O No		
	O Yes O No		
	O Yes O No		
	O Yes O No		
	O Yes O No		
	O Yes O No		

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46. How long does it usually take from eating the food to the onset of the allergic symptoms?

Type of Food	Time until onset of allergic symptoms		
Cow's Milk/Dairy Products/Cheese	Days	Hours	Minutes
Egg	Days	Hours	Minutes
Peanut	Days	Hours	Minutes
Tree Nuts	Days	Hours	Minutes
Fish	Days	Hours	Minutes
Shellfish	Days	Hours	Minutes
Wheat	Days	Hours	Minutes
Soy/Tofu	Days	Hours	Minutes
Seeds	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes

47. Has your child ever had an allergic reaction that improved completely and then came back? ○ Yes ○ No

If yes, timing to onset of recurrent symptoms:

Type of Food	Time until onset of recurrent symptoms		
Cow's Milk/Dairy Products/Cheese	Days	Hours	Minutes
Egg	Days	Hours	Minutes
Peanut	Days	Hours	Minutes
Tree Nuts	Days	Hours	Minutes
Fish	Days	Hours	Minutes
Shellfish	Days	Hours	Minutes
Wheat	Days	Hours	Minutes
Soy/Tofu	Days	Hours	Minutes
Seeds	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes
	Days	Hours	Minutes

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Pediatric Sleep Questionnaire

Please answer the following questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general, not necessarily during the past few days. When you see the word "usually" it means "more than half the time" or "on more than half the nights."

A. Nighttime and sleep behavior

A1. While sleeping, does your child ever snore?

O Yes O No O Don't know **If NO skip to question A5**

A2. Does your child snore more than half the time (half the time he/she sleeps)?

O Yes O No O Don't Know

A3. Does your child always snore? O Yes O No O Don't Know

A4. Does your child snore loudly? O Yes O No O Don't Know

A5. While sleeping, does your child have "heavy" or loud breathing?

O Yes O No O Don't Know

A6. While sleeping, does your child have trouble breathing or struggle to breathe?

O Yes O No O Don't Know

A7. Have you ever seen your child stop breathing during the night?

O Yes O No O Don't Know

If so, please describe what happened:

____

____

A8. Have you ever been concerned about your child's breathing during the night?

O Yes O No O Don't Know

A9. Have you ever had to shake your sleeping child to get him or her to breathe or wake up and breathe? O Yes O No O Don't know

A11. Have you ever seen your child wake up with a snorting sound?

O Yes O No O Don't Know

A12. Does your child have restless sleep? O Yes O No O Don't Know

A13. Does your child describe restlessness of the legs when in bed?

O Yes O No O Don't Know

A13a. Does your child have "growing pains" (unexplained leg pains)?

O Yes O No O Don't Know

A13b. Does your child have growing pains that are worst in bed?

O Yes O No O Don't Know

A14. While your child sleeps, have you seen brief kicks of one leg or both legs?

O Yes O No O Don't Know

A14a. While your child sleeps, have you seen repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)?

O Yes O No O Don't Know

A15. At night, does your child usually become sweaty, or do the pajamas usually become wet with perspiration?

○ Yes ○ No ○ Don't know

A16. At night does your child usually get out of bed (for any reason)?

○ Yes ○ No ○ Don't Know

A17. At night, does your child get out of bed to urinate?

○ Yes ○ No ○ Don't Know

A17a. If yes, how many times each night, on average? [ ][ ]

A21. Does your child usually sleep with the mouth open? ○ Yes ○ No ○ Don't Know

A22. Is your child's nose usually congested or "stuffed" at night?

○ Yes ○ No ○ Don't Know

A23. Do any allergies affect your child's ability to breathe through the nose?

○ Yes ○ No ○ Don't Know

A24. Does your child tend to breathe through the mouth during the day?

○ Yes ○ No ○ Don't Know

A25. Does your child have a dry mouth upon waking up in the morning?

○ Yes ○ No ○ Don't Know

A27. Does your child complain of an upset stomach at night?

○ Yes ○ No ○ Don't Know

A29. Does your child get a burning feeling in the throat at night?

○ Yes ○ No ○ Don't Know

A30. Does your child grind his or her teeth at night? ○ Yes ○ No ○ Don't Know

A32. Does your child occasionally wet the bed? ○ Yes ○ No ○ Don't Know

A33. Has your child ever walked during sleep ("sleep walking")?

○ Yes ○ No ○ Don't Know

A34. Have you ever heard your child talk during sleep ("sleep talking")?

○ Yes ○ No ○ Don't Know

A35. Does your child have nightmares or awaken at night afraid or appearing tearful once a week or more on average?

○ Yes ○ No ○ Don't know

A35a. If yes, after awakening from one of these episodes, can your child tell you about the dream?

○ Yes ○ No ○ Don't know

A36. Has your child ever woken up screaming during the night? ○ Yes ○ No ○ Don't Know

A37. Has your child ever moved or behaved at night in a way that made you think your child was neither completely awake nor asleep?

○ Yes ○ No ○ Don't know

If so, please describe what happened:

____

____

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A40. Does your child have difficulty falling asleep at night? O Yes O No O Don't Know

A41. How long does it take your child to fall asleep at night? [ ][ ] hrs. [ ][ ] min

A42. At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly? O Yes O No O Don't know

A43. Does your child bang his/her head or rock his/her body when going to sleep?
O Yes O No O Don't Know

A44. Does your child wake up more than twice a night on average?
O Yes O No O Don't Know

A45. Does your child have trouble falling back asleep if he or she wakes up at night?
O Yes O No O Don't Know

A46. Does your child wake up early in the morning and have difficulty going back to sleep? O Yes O No O Don't know

A47. Does the time at which your child goes to bed change a lot from day to day?
O Yes O No O Don't Know

A48. Does the time at which your child gets up from bed change a lot from day to day?
O Yes O No O Don't Know

A49. What time does your child usually go to bed (fall asleep) during the week?
[ ][ ] : [ ][ ]

A50. What time does your child usually go to bed (fall asleep) on the weekend or vacation?
[ ][ ] : [ ][ ]

A51. What time does your child usually get out of bed (wake up) on weekday mornings?
[ ][ ] : [ ][ ]

A52. What time does your child usually get out of bed (wake up) on weekend or vacation mornings? [ ][ ] : [ ][ ]

A53. How many hours of sleep does your child usually get on school nights?
[ ][ ] hr(s) [ ][ ] min

A54. How many hours of sleep does your child usually get on non-school nights?
[ ][ ] hr(s) [ ][ ] min

B. Daytime behavior and other possible problems:

B1. Does your child wake up feeling unrefreshed in the morning? O Yes O No O Don't Know

B2. Does you child have a problem with sleepiness during the day? O Yes O No O Don't Know

B3. Does your child complain that he or she feels sleepy during the day?
O Yes O No O Don't Know

B4. Has a teacher or other supervisor commented that your child appears sleepy during the day? O Yes O No O Don't know

B5. Does your child usually nap during the day? O Yes O No O Don't Know

B5a. If no, during a usual week, how many times does this child take a nap for 5 minutes or more? (Write in "0" if he/she does not take any naps.)
[ ][ ] naps/week

B6. Is it hard to wake your child up in the morning? O Yes O No O Don't Know

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B7. Does your child wake up with headaches in the morning? O Yes O No O Don't Know

B8. Does your child get a headache at least once a month, on average?
O Yes O No O Don't Know

B9. Did your child stop growing at a normal rate at any time since birth?
O Yes O No O Don't Know

If so, please describe what happened:

B10. Does your child still have tonsils and/or adenoids? O Yes O No O Don't Know

If not, when were they removed? [ ][ ] yr [ ][ ] mo

B11. Has your child ever had a condition causing difficulty with breathing?
O Yes O No O Don't Know

If so, please describe:

B12. Has your child ever had surgery? O Yes O No O Don't Know

B12a. If yes, did any difficulties with breathing occur before, during, or after surgery?
O Yes O No O Don't Know

B13. Has your child ever become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?
O Yes O No O Don't know

B15. Has your child ever felt unable to move for a short period, in bed, though awake and able to look around?
O Yes O No O Don't know

B16. Has your child ever felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?
O Yes O No O Don't know

B17. Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?
O Yes O No O Don't know

B18. Does your child drink caffinated beverages on a typical day (cola, tea, coffee)?
O Yes O No O Don't know

B17a. If yes, how many cups or cans per day? [ ][ ]

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A19. Does your child use any recreational drugs? ○ Yes ○ No ○ Don't Know

If so, which ones and how often?

Marijuana ☐☐ days/month

Heroin ☐☐ days/month Cocaine ☐☐ days/month

Speed ☐☐ days/month PCP ☐☐ days/month

Benzos Valium ☐☐ days/month

LSD Hallucinogens ☐☐ days/month

Crack ☐☐ days/month

Paint glue inhalant ☐☐ days/month

Barbituates ☐☐ days/month

Ecstasy ☐☐ days/month

Oxycodone ☐☐ days/month

Other ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ days/month

B20. Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products?

○ Yes ○ No ○ Don't Know

If so, which ones and how often?

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ days/month

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ days/month

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ days/month

B22. Is your child overweight? ○ Yes ○ No ○ Don't Know

B20a. If so, at what age did this first develop? ☐☐ yrs.

B23. Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?

○ Yes ○ No ○ Don't know

B24. Has your child ever taken Ritalin (methylphenidate) for behavioral problems?

○ Yes ○ No ○ Don't know

B25. Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?

○ Yes ○ No ○ Don't know

B26. How would you assess this child's activity level compared to other children of his or her age?

Much Less		Same		Much More
O 1	O 2	O 3	O 4	O 5

Modified Epworth Sleepiness Scale

How likely is your child to doze off or fall asleep in the situation described below, in contrast to just feeling tired?

0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing

Situation	**Chance of dozing**
Sitting and reading	☐
Watching TV	☐
Sitting inactive in a public place (i.e., movie theater or classroom)	☐
As a passenger in a car for an hour without a break	☐
Laying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after lunch	☐
In a car, while stopped for a few minutes in traffic	☐

Subject Type

M

II.B Questions about the mother:

Now I would like to ask you some questions about yourself (the child's biological mother)

48. Do you consider yourself Hispanic/ Latino? ○ Yes ○ No

49. Which of these groups best describes your racial background?

○ Black/African American
○ White
○ Asian
○ American Indian/Alaska Native
○ Native Hawaiian or other Pacific Islander
○ More than one race
○ Unknown

50. Were you born in the U.S.? ○ Yes ○ No

○ other country (specify) [ ]

If U.S. skip to question 52

51. If born outside the U.S.: How long have you lived in the U.S.?

[ ] Years [ ] Months

52. Was your mother born in the U.S.? ○ Yes ○ No

○ other country (specify) [ ]

53. Was your father born in the U.S.? ○ Yes ○ No

○ other country (specify) [ ]

54. What is your native language?

○ English ○ Spanish ○ Haitian Creole ○ French ○ Portuguese

○ Other (Specify) [ ]

55. What is your present marital status?

○ Married ○ Widowed ○ Divorced ○ Separated ○ Single

56. What is the highest grade of school you have completed to date?

○ Elementary School
○ Some secondary school (9th grade and above)
○ High school graduate or GED
○ Some college
○ College degree
○ Graduate school degree
○ Post graduate (PhD / MD/ other)

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57. Are you currently working for pay? ○ Yes ○ No ○ Retired

58. What is your occupation/ job title?

59. What field does your occupation fall under?

- ○ Not Applicable
- ○ Management/ Business/ Administration
- ○ Financial/ Computer/ Mathematical
- ○ Architecture and Engineering
- ○ Life, Physical, and Social Science
- ○ Legal occupations
- ○ Education, Training, and Library
- ○ Sales, Arts, Design, Entertainment, and Media
- ○ Athletics (Sports, Dancing, etc)
- ○ Healthcare
- ○ Food preparation and Serving
- ○ Building and Grounds cleaning and Maintenance
- ○ Personal Care and Service
- ○ Farming, Fishing, and Forestry
- ○ Construction Trades
- ○ Extraction Workers
- ○ Installation, Maintenance, and Repair Workers
- ○ Production Occupations
- ○ Transportation and Material Moving
- ○ Military Specific
- ○ Other ____________________

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60. Do you have a personal history of asthma?

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ year (s)
- ○ Yes, I have it now

If **YES**, was your asthma diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

61. Have you ever used an inhaler or nebulizer? ○ Yes ○ No

62. Do you have a personal history of eczema?

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ Year (s)
- ○ Yes, I have it now

If **YES**, was your eczema diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

63. Have you ever used a cream, lotion, or ointment containing steroids on your skin; for example: hydrocortisone cream or triamcinolone cream? ○ Yes ○ No

64. Do you have hay fever or seasonal allergies?

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ Year (s)
- ○ Yes, I have it now

If **YES**, was your hay fever diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

Which season(s) do you have seasonal allergies?

○ Spring ○ Summer ○ Autumn ○ Winter ○ Year round

65. Do you have any drug allergies? ○ Yes ○ No

If **YES**, specify the drug ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If **YES**, was your drug allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

Specify 2nd drug: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Was this drug allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

66. Have you ever used any anti-allergy medications? (i.e. Benadryl, Zyrtec, Claritin, Atarax) ○ Yes ○ No

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67. Do you have any of the following environmental allergies that have been diagnosed by your doctor?

- Cat
- Dog
- Pollen
- Dust Mite
- Cockroach
- Mold
- Other
- None

specify

68. Are you allergic to insect stings? (for example bee, wasp, yellow jacket. Mosquitoes and spiders don't count)

- Yes
- No
- Don't know/Never been stung

If **Yes,** is it a severe allergy (that is, difficulty breathing, need epi pen or to go to the hospital)?

- Yes
- No

69. Do you have food allergies?
- Yes
- No

If NO skip to The BERLIN QUESTIONNAIRE

70. If you ever had a food allergy, to which food(s) were you allergic...

Milk/Dairy Products/Cheese

- No
- Yes, only when I was a child, but outgrew by [ ][ ] years
- Yes, current allergy

If YES, was your food allergy diagnosed by a doctor? Yes No

How old were you when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Egg

- No
- Yes, only when I was a child, but outgrew by [ ][ ] years
- Yes, current allergy

If YES, was your food allergy diagnosed by a doctor? Yes No

How old were you when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

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Peanut

- ○ No
- ○ Yes, only when I was a child, but outgrew by [ ][ ] years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Tree nut

- ○ No
- ○ Yes, only when I was a child, but outgrew by [ ][ ] years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

○ Almond ○ Cashew ○ Filbert/hazel ○ Walnut
○ Brazil ○ Macadamia ○ Pecan ○ Pine
○ Pistachio ○ Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Fish

- ○ No
- ○ Yes, only when I was a child, but outgrew by [ ][ ] years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

○ Salmon ○ Tuna ○ Catfish ○ Cod ○ Flounder ○ Halibut ○ Trout ○ Bass

Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Shellfish

- ○ No
- ○ Yes, only when I was a child, but outgrew by [ ][ ] years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

○ Shrimp ○ Crab ○ Lobster ○ Clam ○ Oyster ○ Mussels

Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Seeds

- ○ No
- ○ Yes, only when I was a child, but outgrew by [ ][ ] years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

○ Sesame ○ Sunflower ○ Pumpkin Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

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Wheat

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

Soy/Tofu

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

Other Foods

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- ○ No
- ○ Yes, only when I was a child, but outgrew by ☐☐ years
- ○ Yes, current allergy

If **YES**, was your food allergy diagnosed by a doctor? ○ Yes ○ No

How old were you when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

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The Berlin Questionnaire

1. Do you snore? ○ Yes ○ No ○ Don't Know

   If NO skip to question 5

2. Snoring loudness ○ Loud as breathing ○ Loud as talking ○ Louder than talking ○ Very Loud

3. Snoring frequency
   ○ Almost every day ○ 3 to 4 times per week
   ○ 1 to 2 times per week ○ 1 to 2 times per month
   ○ Never to almost never

4. Does your snoring bother other people? ○ Yes ○ No ○ Don't Know

5. Has anyone ever noticed that you quit breathing during your sleep?
   ○ Almost every day ○ 3 to 4 times per week
   ○ 1 to 2 times per week ○ 1 to 2 times per month
   ○ Never to almost never

6. How often do you feel tired or fatigued after sleep?
   ○ Almost every day ○ 3 to 4 times per week
   ○ 1 to 2 times per week ○ 1 to 2 times per month
   ○ Never to almost never

7. How often do you feel tired during waketime?
   ○ Almost every day ○ 3 to 4 times per week
   ○ 1 to 2 times per week ○ 1 to 2 times per month
   ○ Never to almost never

8. Have you ever nodded off or fallen asleep while driving a vehicle? ○ Yes ○ No

9. Do you have high blood pressure? ○ Yes ○ No ○ Don't Know

Pittsburgh Sleep Quality Index (PSQI)

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month

1. During the past month, when have you usually gone to bed? ☐☐ : ☐☐

2. During the past month how long (in minutes) has it taken you to fall asleep each night? ☐☐☐

3. During the past month, when have you usually gotten up in the morning? ☐☐ : ☐☐

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4. How many actual hours of sleep do you get at night? ☐☐.☐

5. During the past month, how often have you had trouble sleeping because you...

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. Cannot get to sleep within 30 minutes	O	O	O	O
b. Wake up in the middle of the night or early morning	O	O	O	O
c. Have to get up to use the bathroom	O	O	O	O
d. Cannot breathe comfortably	O	O	O	O
e. Cough or snore loudly	O	O	O	O
f. Feel too cold	O	O	O	O
g. Feel too hot	O	O	O	O
h. Have bad dreams	O	O	O	O
i. Have pain	O	O	O	O
j. Other reasons	O	O	O	O
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?	O	O	O	O
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	O	O	O	O
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	O	O	O	O

If so, please describe the other reasons:

____

____

9. During the past month, how would you rate your sleep quality overall?

O Very Good O Fairly Good O Fairly Bad O Very Bad

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Modified Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situation described below, in contrast to just feeling tired?

0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing

Situation	Chance of dozing
Sitting and reading	☐
Watching TV	☐
Sitting inactive in a public place (i.e., movie theater or a meeting)	☐
As a passenger in a car for an hour without a break	☐
Laying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after lunch	☐
In a car, while stopped for a few minutes in traffic	☐
Total	☐☐

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Subject Type

F

II.C Questions about the Child's Father

Now I would like to ask you some questions about your child's biological father

71. Is the biological father of your child Hispanic/Latino? ○ Yes ○ No

72. Which one of these groups best describes his racial background?

- ○ Black/African American
- ○ White
- ○ Asian
- ○ American Indian/Alaska Native
- ○ Native Hawaiian or other Pacific Islander
- ○ More than one race
- ○ Unknown

73. Was the child's father born in the US? ○ Yes ○ No

○ other country (specify) [ ]

74. What is the highest grade of school he has completed to date?

- ○ Elementary School
- ○ Some secondary school (9th grade and above)
- ○ High school graduate or GED
- ○ Some college
- ○ College degree
- ○ Graduate school degree
- ○ Post graduate (PhD / MD/ other)

75. Is he currently working for pay? ○ Yes ○ No ○ Retired

76. What is his occupation/ job title?

[ ]

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What field does his occupation fall under?

- ○ Not Applicable
- ○ Management/ Business/ Administration
- ○ Financial/ Computer/ Mathematical
- ○ Architecture and Engineering
- ○ Life, Physical, and Social Science
- ○ Legal occupations
- ○ Education, Training, and Library
- ○ Sales, Arts, Design, Entertainment, and Media
- ○ Athletics (Sports, Dancing, etc)
- ○ Healthcare
- ○ Food preparation and Serving
- ○ Building and Grounds cleaning and Maintenance
- ○ Personal Care and Service
- ○ Farming, Fishing, and Forestry
- ○ Construction Trades
- ○ Extraction Workers
- ○ Installation, Maintenance, and Repair Workers
- ○ Production Occupations
- ○ Transportation and Material Moving
- ○ Military Specific
- ○ Other ____________________

77. What is his current height? [ ] feet [ ][ ] inches or [ ][ ][ ] cm

78. What is his current weight? [ ][ ][ ] lbs or [ ][ ][ ] kg

79. Does he have a personal history of asthma?

- ○ No
- ○ Yes, only when he was a child, but outgrew by [ ][ ] Years
- ○ Yes, he has it now
- ○ Not sure

If YES, was his asthma diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

80. Has he ever used an inhaler or nebulizer? ○ Yes ○ No

81. Does he have a personal history of Eczema?

- ○ No
- ○ Yes, only when he was a child, but outgrew by [ ][ ] Years
- ○ Yes, he has it now
- ○ Not sure

If YES, was his eczema diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

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82. Has he ever used a cream, lotion, or ointment containing steroids on his skin; for example: hydrocortisone cream or triamcinolone cream? ○ Yes ○ No ○ Not sure

83. Does he have any hay fever or seasonal allergies?
- ○ No
- ○ Yes, only when he was a child, but outgrew by ☐☐ Years
- ○ Yes, he has it now
- ○ Not sure

If YES, was his hay fever diagnosed by a doctor? ○ Yes ○ No ○ Not sure

How old was he when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

Which season does he have seasonal allergies?
○ Spring ○ Summer ○ Autumn ○ Winter ○ Year round

84. Does the child's father have any drug allergies? ○ Yes ○ No

If **YES**, specify the drug ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If **YES**, was his drug allergy diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

Specify 2nd drug: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Was this drug allergy diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

85. Has he ever used any anti-allergy medications? (i.e. Benadryl, Zyrtec, Claritin, Atarax) ○ Yes ○ No ○ Not Sure

86. Does he have any of the following environmental allergies that have been diagnosed by your doctor?

○ Cat ○ Dog ○ Pollen ○ Dust Mite ○ Cockroach ○ Mold ○ Other ○ None

specify ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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87. Is he allergic to insect stings? (for example bee, wasp, yellow jacket. Mosquitoes and spiders don't count)

○ Yes ○ No ○ Don't know/Never been stung

If **Yes,** is it a severe allergy (that is, difficulty breathing, need epi pen or to go to the hospital)?

○ Yes ○ No

88. Does he or has he ever had any food allergies? ○ Yes ○ No

If NO skip to questions concerning the HOME ENVIRONMENT

89. If he ever had a food allergy, to which food(s) is/was he allergic...

Milk/Dairy Products/Cheese

○ No

○ Yes, only when he was a child, but outgrew by [ ][ ] years

○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Egg

○ No

○ Yes, only when he was a child, but outgrew by [ ][ ] years

○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Peanut

○ No

○ Yes, only when he was a child, but outgrew by [ ][ ] years

○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Tree nut

○ No

○ Yes, only when he was a child, but outgrew by [ ][ ] years

○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

○ Almond	○ Cashew	○ Filbert/hazel	○ Walnut
○ Brazil	○ Macadamia	○ Pecan	○ Pine
○ Pistachio	○ Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]		

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Fish

- O No
- O Yes, only when he was a child, but outgrew by [ ][ ] years
- O Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? O Yes O No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

O Salmon O Tuna O Catfish O Cod O Flounder O Halibut O Trout O Bass

Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Shellfish

- O No
- O Yes, only when he was a child, but outgrew by [ ][ ] years
- O Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? O Yes O No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

O Shrimp O Crab O Lobster O Clam O Oyster O Mussels

Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Seeds

- O No
- O Yes, only when he was a child, but outgrew by [ ][ ] years
- O Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? O Yes O No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

If yes, please choose the specific type (select all that apply):

O Sesame O Sunflower O Pumpkin Other [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Wheat

- O No
- O Yes, only when he was a child, but outgrew by [ ][ ] years
- O Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? O Yes O No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

Soy/Tofu

- O No
- O Yes, only when he was a child, but outgrew by [ ][ ] years
- O Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? O Yes O No

How old was he when first diagnosed by a doctor? [ ][ ] Year(s) [ ][ ] Months

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Other Foods

○ Yes, only when he was a child, but outgrew by ☐☐ years
○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No
How old was he when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

○ Yes, only when he was a child, but outgrew by ☐☐ years
○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No
How old was he when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

○ Yes, only when he was a child, but outgrew by ☐☐ years
○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No
How old was he when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

○ Yes, only when he was a child, but outgrew by ☐☐ years
○ Yes, current allergy

If **YES**, was his food allergy diagnosed by a doctor? ○ Yes ○ No
How old was he when first diagnosed by a doctor? ☐☐ Year(s) ☐☐ Months

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III. Home Environment

90. What was your household income last year, before taxes? (INCLUDING PUBLIC ASSISTANCE)

- ○ <$5,000
- ○ $5,000-9,999
- ○ $10,000-14,999
- ○ 15,000-19,999
- ○ $20,000-24,000
- ○ $25,000-29,999
- ○ $30,000-34,999
- ○ $35,000-39,999
- ○ $40,000-49,999
- ○ $50,000-59,999
- ○ $60,000-79,999
- ○ $80,000-99,999
- ○ >$100,000
- ○ Don't know

91. Here are some questions about your current home:

a) How long have you lived in your current home?

☐☐ Year(s) ☐☐ Months

b) What type of housing is your home?

○ Single Family ○ Duplex ○ Row House ○ Condo/Apartment ○ Trailer Home ○ Shelter

c) # of bedrooms ☐☐

d) # of bathrooms ☐☐.☐

e) # of people who permanently live in your home ☐☐

f) What type of fuel do you use for heating your home?

○ Oil ○ Electricity ○ Gas Other ☐☐☐☐☐☐☐☐☐☐

g) What type of fuel do you use for cooking?

○ Gas ○ Electric Other ☐☐☐☐☐☐☐☐☐☐

h) Do you have any wall to wall carpet in your home? ○ Yes ○ No

If yes, specify location:

- ○ Living room
- ○ Family room
- ○ Dining room
- ○ Kitchen
- ○ Bedroom (master) parents
- ○ Bedroom Index Child
- ○ Bedroom Sib #1
- ○ Bedroom Sib #2
- ○ Basement
- ○ Bathroom

i) Approximately how old is the building/apartment/home you live in?

○ 10 years or less ○ 11-25 years ○ 26-50 years ○ 51-75 years ○ greater than 75 years

92. Do you (mother of the child) currently smoke or have you ever smoked cigarettes, cigars, or pipes?

- ○ No, I never smoked
- ○ I used to smoke but I quit before becoming pregnant with index child
- ○ I used to smoke but I quit after becoming pregnant with index child
- ○ Yes, I currently smoke, however I did not smoke during pregnancy with index child
- ○ Yes, I currently smoke and I did smoke during pregnancy with the index child

If **YES**

What do/did you smoke? ○ cigarettes ○ cigars ○ pipes

Do you smoke inside the home? ○ Yes ○ No

How many (cigarettes, cigars, pipes) do you smoke per day? [ ][ ]
(Regardless of indoor or outdoor)

93. Does your child's father currently smoke or has he ever smoked cigarettes, cigars, or pipes?

- ○ No, he never smoked
- ○ He used to smoke but quit before I became pregnant with index child
- ○ He used to smoke but quit after I became pregnant with index child
- ○ Yes, he currently smokes

If **YES**

What does/did he smoke? ○ cigarettes ○ cigars ○ pipes

Does he smoke inside the child's home? ○ Yes ○ No

How many (cigarettes, cigars, pipes) does he smoke per day? [ ][ ]

94. Do other people who live in your home smoke cigarettes, cigars or pipes? (not including the mother and father of the child)?

○ Yes ○ No # of people [ ][ ]

How many of them smoke inside the home? [ ][ ]

95. Total number of cigarettes smoked inside your home per day [ ][ ]

(Not including amount smoked by the mother and father of the child)

96. Do you currently have any pets in your home? ○ Yes ○ No

If yes, specify the type of pet and how many of each type:

○ Cat #

○ Reptile #

○ Dog #

○ Rabbit #

○ Fish #

○ Guinea Pig #

○ Bird #

Others ○ Yes ○ No

#

#

#

97. Does the house you live in have any cockroaches? ○ Yes ○ No

98. Does the house you live in have any mice/rats? ○ Yes ○ No

99. Does the house you live in have any visible mold, mildew, water damage, leakage, or seepage? ○ Yes ○ No

100. Do you currently live in a farming environment? ○ Yes ○ No