

Pregnancy Registry Study

Trial ID: NN304-4016

Dear Madam,


This questionnaire contains questions about the health of your child at the age of one year. We kindly ask you to complete the questionnaire before your scheduled contact with your physician so that you are prepared for the questions your physician will ask you. Your answers will help us monitor and assess the health status of children whose mothers are in treatment for diabetes.

Thank you for taking the time to complete this questionnaire. Your answers are highly appreciated!

QUESTIONNAIRE 1 year after you gave birth

Study doctor name: _____

Study coordinator name: _____

Clinic telephone no.:  _____

Subject no.: _____

Infant no (in case of more than one child): _____

Please record the following, so that you are ready for the contact:

- Height and weight of your child
- Any occurrence of diabetes in your child
- Duration of breast feeding
- Any medical problems with your child since last contact

Date of contact (1-year follow-up):



Date: _____



Time: _____

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Body measurements of your child:																																																														
Your child's height at approximately one year of age:	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>d</td><td>d</td><td>m</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td><td> </td> </tr> </table>											d	d	m	m	m	y	y	y	y		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> • <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> cm/in																																								
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Your child's weight at approximately one year of age:	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>d</td><td>d</td><td>m</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td><td> </td> </tr> </table>											d	d	m	m	m	y	y	y	y		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> • <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> kg/lb																																								
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Has your child been diagnosed with diabetes?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Duration of your breast feeding period:	Start date	Stop date, if applicable																																								
Duration of exclusive breast feeding (your child is only fed breast milk)	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>d</td><td>d</td><td>m</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td><td> </td> </tr> </table>											d	d	m	m	m	y	y	y	y		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>d</td><td>d</td><td>m</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td><td> </td> </tr> </table>											d	d	m	m	m	y	y	y	y	
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Duration of partial breast feeding (your child is still fed breast milk, but also receive other nourishment (formula and/or solid food):	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>d</td><td>d</td><td>m</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td><td> </td> </tr> </table>											d	d	m	m	m	y	y	y	y		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>d</td><td>d</td><td>m</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td><td> </td> </tr> </table>											d	d	m	m	m	y	y	y	y	
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Medical problems for your child

Please record the following:

- Any medical problems your child has had since last contact (examples: inflammation of the eye, sore throat, flu)
- Any medication your child has been given in connection with any of these medical problems
- Your own medication for this period in case you were breast feeding at the time of the event.

Examples:

Medical problems with your child			Medication for your child			Your own medication (only if you are breast feeding at the time of the event)		
Medical problem	Start date	Stop date	Name of medication	Start date	Stop date	Name of medication	Start date	Stop date
<i>Inflammation of eye</i>	<i>18-Jun-2013</i>	<i>21-Jun-2013</i>	<i>Chloramphenicol</i>	<i>18-Jun-2013</i>	<i>25-Jun-2013</i>	<i>Paracetamol</i>	<i>19-Jun 2013</i>	<i>19 Jun 2013</i>
<i>Sore throat</i>	<i>20-Jul-2013</i>	<i>25-Jul-2013</i>	<i>Penicillin</i>	<i>20-Jul-2013</i>	<i>30-Jul-2013</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<i>Flu</i>	<i>22-Aug 2013</i>	<i>27 Aug-2013</i>	<i>None</i>	<i>N/A</i>	<i>N/A</i>	<i>Simvastatin</i>	<i>1 Jun 2013</i>	<i>ongoing</i>

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Medical problems with your child			Medication for your child			Your own medication (only if you are breast feeding at the time of the event)		
Medical problem	Start date	Stop date	Name of medication	Start date	Stop date	Name of medication	Start date	Stop date



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Medical problems with your child			Medication for your child			Your own medication (only if you are breast feeding at the time of the event)		
Medical problem	Start date	Stop date	Name of medication	Start date	Stop date	Name of medication	Start date	Stop date



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Medical problems with your child			Medication for your child			Your own medication (only if you are breast feeding at the time of the event)		
Medical problem	Start date	Stop date	Name of medication	Start date	Stop date	Name of medication	Start date	Stop date

