

# den norske *Mor & barn undersøkelsen*

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## Questionnaire 4 - When your child is around 6 months old

This questionnaire comes in two parts. The first part is about your child, while the other part is about yourself. It will help if you have your child's health card to hand before you start answering the questions so that you can use the information contained in it when completing this questionnaire. If you find a question difficult to answer, you can skip it and go onto the next question.

**If you have had twins or triplets, complete one questionnaire for each child.**

**The questionnaire will be processed by a computer. It is therefore important that you follow these instructions when completing it:**

- Use a blue or black ballpoint pen.
- In the small check boxes, enter a cross to indicate what you think is correct. If you make a mistake you can delete the cross by filling in the box.
- Write numbers in the large green boxes.

**It is important that you only write in the white boxes.**

Number: 

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

Please do not use this questionnaire. Contact us at [morbarn@fhi.no](mailto:morbarn@fhi.no) or phone + 47 53 20 40 40 if you need a questionnaire.

- In the case of numbered boxes with more than one square, enter a one-digit number in the right box. Example: 5 is entered as follows 

	5
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- Date boxes are split into 3 sections, with the first one for the day of the month, the second one for the month and the last one for the year.

So, enter the date as follows: 

	6		5	2	0	0	5
Day		Month		Year			

- Specific information concerning, for example, medication should be written on the lines provided. Please write clearly!

As soon as you have completed the questionnaire, return it to us in the enclosed stamped addressed envelope.

Specify the day, month and year when the questionnaire was completed

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Day

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Month

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Year

(write the year in full, e.g. 2005)

## About your child's birth

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### 1. Is your child a boy or girl?

Boy

Girl

### 2. How big was your child when he/she was born?

Birth weight: 

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 g

Length: 

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 cm

### 3. In which week of your pregnancy did you give birth?

--	--

 week

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### 4. How long was your child in hospital after the birth?

Number of days 

--	--

 or weeks 

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### 5. Was your child transferred to another department or hospital after the birth?

No

Yes

If yes, specify \_\_\_\_\_

### 6. Was your child delivered by caesarean section?

No

Yes

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**7. If yes, was the caesarean section planned?**

- No  
 Yes

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**If yes, why?**

- Breech presentation  
 Previous caesarean  
 Pregnancy complication or mother taken ill  
 Poor growth or other factor relating to the foetus  
 Own preference  
 Other

**8. Were there any complications during the birth?**

- No  
 Yes

If so, describe: \_\_\_\_\_

**9. Were you admitted or transferred to another department or other hospital due to complications in connection with the birth? (Applies both before and after the birth.)**

- No  
 Yes

**10. If yes, where?**

Department: \_\_\_\_\_

Hospital: \_\_\_\_\_

**11. How many days were you in hospital in connection with the birth?**Before the birth   Number of daysAfter the birth   Number of days**12. Did the birth go as you had expected?**

- Yes, as expected  
 No, it went better  
 Neither/nor  
 No, it was worse  
 Don't know

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**13. How true do you think the following descriptions are of the birth? (Enter a cross in a box for each item.)**

	Fairly true	Partially true	Not true
I felt safe and in good hands . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was in a lot of pain . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I received too few pain-killing drugs . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**14. Was anyone from your close family present at the birth?**

- Yes, child's father  
 Yes, someone else  
 No

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## About your child

### Nutrition

**15. What did you give your child to drink during the first week of life?**

(You can enter a cross in more than one box.)

- Breast milk  
 Water  
 Sugar water  
 Formula  
 Other, specify: \_\_\_\_\_  
 Don't know/don't remember

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**16. What has your child been given to drink during the first 6 months of his/her life?**

(Enter a cross for each month you gave your child the relevant drink.)

	Child's age in months						
	0	1	2	3	4	5	6
Breast milk . . . . .	<input type="checkbox"/>						
Standard Collett formula . . . . .	<input type="checkbox"/>						
Collett formula with Omega 3 . . . . .	<input type="checkbox"/>						
Standard NAN formula . . . . .	<input type="checkbox"/>						
Nan HA1 formula . . . . .	<input type="checkbox"/>						
Other milk, specify: _____	<input type="checkbox"/>						
Water . . . . .	<input type="checkbox"/>						
Squash/Juice . . . . .	<input type="checkbox"/>						

**17. How often do you give your child the following to drink at the moment? (Enter a cross in a box for each item.)**

Never/  
seldom      1-3 times  
a week      4-6 times  
a week      At least  
once a day

1. Breast milk . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Breast milk supplement . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Normal sweet milk, any type . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. sour milk (yogurt, buttermilk, etc.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Organic milk products (milk, yogurt) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Boiled water . . . . .	<input type="checkbox"/>	+	<input type="checkbox"/>	<input type="checkbox"/>

Cont.

+	Never/ seldom	1-3 times a week	4-6 times a week	At least once a day
7. Tap water .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Bottled water .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Bottled baby cordial .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other type of cordial, sweetened .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Cordial, artificially sweetened .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Juice .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Other, specify: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**18. How often does your child eat the following food at the moment, and how old was your child when you started giving him/her this food?**

+	How often do you give this to your child?				How old was your child when you gave him/her this food for the first time?
	Never/ seldom	1-3 times a week	4-6 times a week	At least once a day	
<b>Instant porridge</b>					
1. Rice porridge, maize porridge .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
2. Oatmeal porridge, different types .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
3. Wheat porridge, all types, rusk porridge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
<b>Home-made porridge using:</b>					
4. Wheat flour (rough/fine), rusk, semolina, oats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
5. Iron-enriched wheat flour .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
6. Helios baby flour .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
7. Millet .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
<b>Processed dinner in a jar:</b>					
8. Vegetables .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
9. Vegetables and meat .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
<b>Home-made dinner:</b>					
10. Potato/vegetable puree .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
11. Meat and vegetables/potatoes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
12. Fish and vegetables/potatoes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
13. Other type of home-made dinner .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
<b>Snack/dessert:</b>					
14. Home-made fruit puree .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
15. Fruit/berry puree in a jar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
16. Rusks/biscuits/bread .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
17. Other, specify: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>

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**19. Do you think or do you know that your child has a reaction to milk/dairy products?**

- No
- Yes

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**20. If yes, which products?**

- Whole milk
- Low-fat milk/skimmed milk
- Cream/whipped cream/ice cream
- Yogurt/sour milk
- Breast milk when mother is drinking milk
- Other

**21. Do you give your child cod liver oil, vitamins, iron or any other dietary supplement?**

- No
- Yes

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**22. If you give your child cod liver oil, vitamins, iron or another dietary supplement, specify how much you give your child each time and how often. How old was your child in months and weeks when you gave him/her the product for the first time?**

Name of product	How many teaspoons each time?		How often do you give your child this?		How old was your child when you started giving the product?	
	teaspoons	teaspoons	daily	sometimes	months	weeks
1. Cod liver oil .....	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
2. Biovit .....	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
3. Sanasol .....	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
4. Nycoplus Multi-Vitamin mixture for children	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
5. Fluoride .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
6. Iron supplement, specify: .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
7. Other dietary supplement, specify: .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

**Growth, health and use of medication**

You will find the information to help you answer the following questions on your child's health card.

**23. How many times have you been to the mother and child health centre with your child?**

- Never
- 1-2 times
- 3-5 times
- 6-10 times
- more than 10 times

**24. Has your child been given the vaccinations recommended by the health centre?**

- Yes
- No, don't want vaccination
- No, your child has been often ill
- No, vaccinations postponed for practical reasons
- Don't know

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**25. Referring to your child's health card, enter a cross for the vaccinations which your child has received and whether the vaccinations had any side-effect. (Enter a cross in a box for each item.)**

Vaccinations	Has your child received the vaccination?		Was there any side-effect after the vaccination?		Was there any side-effect resulting in contact with a doctor?		Was there any side-effect resulting in hospital admission?	
	No	Yes	No	Yes	No	Yes	No	Yes
1. DTP (Infanrix) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. DT (diphtheria/tetanus) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Polio – Hib (Act-Hib polio) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Hepatitis B (Engerix-B) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. BCG (tuberculosis) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Pneumococcus (Prevenar) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Other vaccination:.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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26. Referring to your child's health card, enter below your child's weight, length and head circumference when he/she was around 6 weeks, 3 months and 6 months.

+	Date of examination			Length	Head circumference	Weight
	Day	Month	Year			
Approx. 6 weeks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> cm	<input type="text"/> cm	<input type="text"/> g
Approx. 3 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> cm	<input type="text"/> cm	<input type="text"/> g
5-6 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> cm	<input type="text"/> cm	<input type="text"/> g

The following questions concern any illnesses or health problems your child has had. We will first ask you about more longterm problems, then about illnesses and problems of a more acute nature.

27. Does your child have or has he/she had any of the following health problems? If yes, has the mother and child health centre or someone else referred your child for further specialist investigation? (Enter a cross in a box for each item.)

+	Has(had) your child problems?	Has your child been referred for a specialist investigation?				
		No	Yes	No	Yes, referred from health centre	Yes, referred by someone else
1. Hip disorder/dislocated hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Delayed motor development (movement development)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Too little weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Too much weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Abnormal head circumference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Testicles not descended into scrotum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> +
11. Atopic eczema (childhood eczema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Food allergy/intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Delayed psychomotor development (several functions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. (Other) malformations: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. If your child was referred for a specialist investigation, what did this investigation show?

- Everything was fine
- Still some doubts/further investigations needed
- Don't know
- Given the following diagnosis: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

29. Is your child suspected of having a syndrome or chromosomal defect?

- No
- Yes, a syndrome
- Yes, a chromosomal defect
- If yes, specify the name or describe the problem: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

30. Has your child been treated for a hip problem (hip dysplasia)?

- No
- Yes, treated with a plaster cast
- Yes, treated with a cushion
- Yes, treated with braces
- If yes, how long did the treatment go on for?  months

**31. Has your child had the following illness/health problem? If yes, did you go to a doctor or hospital about it? (Enter a cross in a box for each item.)**

+	+	Has your child had health problems? of times		Number doctor/clinic	Did you go to a admitted to hospital for this? for this?		Has your child been	
		No	Yes		No	Yes	No	Yes
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Common cold .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Throat infection .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ear infection .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pseudocroup .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Bronchitis/RS virus/pneumonia .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Gastric flu/diarrhoea .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Urinary tract infection .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Conjunctivitis .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Febrile convulsions .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other convulsions (without any fever) . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
✓ 11. Colic Colic Type text here		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Nappy rash .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Other, describe .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**32. Have your child ever been given any medication?**

- No
- Yes

+

**33. If yes, give the name of the medicines and when they were given. (Include all types of medication, as well as natural medicines, taken both on a regular and occasional basis.)**

Name of medicine (e.g. Apocilin, Paracetamol)	+	How old was your child when you gave the medicine?				Number of days given in total
		<1 Month	1-2 months	3-4 months	5-6 months	
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

34. Has your child been examined at or admitted to hospital (since returning home from hospital after birth)?

- No
- Yes, specify: \_\_\_\_\_

35. Has your child been operated on or does he/she have a condition requiring an operation? +

- No
- Yes, specify: \_\_\_\_\_

## Development, childcare and life style

36. The following questions concern your child's development. If you haven't actually observed your child, spend a little time looking at what he/she can actually do. (Enter a cross in a box for each question.)

	+	Yes often	Yes, but seldom	No, not yet	Don't know
1. When your child is lying on his/her back, does he/she play by grabbing hold of his/her feet?	<input type="checkbox"/>				
2. When your child is lying on his/her tummy, does he/she raise his/her upper body off the ground with straight arms? . . . . .	<input type="checkbox"/>				
3. Does your child roll over from his/her back onto his/her tummy? . . . . .	<input type="checkbox"/>				
4. When you "chat" to your child, does he/she try to "chat" back to you? . . . . .	<input type="checkbox"/>				
5. Does your child babble and make sounds when he/she is lying on his/her own? . . . . .	<input type="checkbox"/>				
6. Can you tell how your child is just by listening to the sounds he/she is making (e.g. contented, hungry, angry, in pain)? . . . . .	<input type="checkbox"/>				
7. Do you get a smile from your child when you just smile at him/her (without touching or tickling him/her and without holding up a toy)? . . . . .	<input type="checkbox"/>				
8. When you call your child, does he/she turn towards you one of the first times you say his/her name? . . . . .	<input type="checkbox"/>				
9. Does your child grab hold of a toy you give him/her and then put it in his/her mouth or hold it? . . . . .	<input type="checkbox"/>				
10. When your child is sitting on your lap, does he/she stretch out for a toy or something else on the table in front of you? . . . . .	<input type="checkbox"/>				
11. Does your child hold onto a toy with both hands when he/she is examining it? . . . . .	<input type="checkbox"/>				

+

37. Where is your child cared for during the day?

- At home with mother/father/other family member
- At home with an unqualified childminder
- At a childminder's
- In a family day nursery
- In a day nursery

38. How many other children are there usually along with your child during the day?

children

+

39. Does your child go to baby swimming?

- No
- Yes

If yes, indicate the number of times during the last 2 months

40. How often is your child outside? (Enter just one cross.)

- Seldom
- Often, but less than 1 hour a day
- 1-3 hours a day
- More than 3 hours a day

41. Does your child use a dummy/pacifier?

- Seldom or never
- Only when he/she goes to sleep
- Often
- Most of the time

### Sleep

✓ 42. How many hours in total does your child sleep per 24 hours?

- Less than 8 hours
- 8 - 10 hours
- 11 - 13 hours
- 13 - 14 hours
- More than 14 hours

+

**43. How do you put your child down when he/she is going to sleep?**  
(Enter a cross in a box for each item.)

	On back	On side	On tummy
After the birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 2 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 4 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**44. Does your child share a bed with his/her mother/father (at least half the night)?** (Enter a cross in a box for each item.)

	No	sometimes	Often
After the birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 2 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 4 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**45. Enter a cross to indicate whether you agree or disagree with the following statements about your child's mood and temperament. Think about how he/she usually is.** (Enter a cross in a box for each item.)

	+		Totally disagree	Disagree	Slightly disagree	Neither agree or disagree	Slightly agree	Agree	Totally agree
1. Your child whimpers and cries a lot . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2. Your child is usually easy to pacify when he/she is crying . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3. It doesn't take much for your child to become upset and start crying . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
4. When your child is crying, he/she usually screams angrily and loudly . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
5. Your child is very easy to deal with . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
6. Your child demands an awful lot of attention . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
7. When your child is left alone, he/she usually plays contentedly on his/her own . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
8. Your child is so demanding that he/she would pose a major problem for most parents . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
9. Your child smiles and laughs often . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
✓ 10. Your child is easy to put down and goes to sleep quickly . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Sleep**

✓ **46. Currently how often does your child usually wake up during the night?** (Enter just one cross.)

- 3 or more times every night  
 Once or twice every night  
 A few times a week  
 Seldom or never

+

+

**Comments**

+

+

# About yourself



The last time you completed a questionnaire was around week 30 of your pregnancy. The questions we are asking you now are mainly about the period after this up until your child was 6 months old.

## Health and use of medication

**47. Did you go to your doctor/midwife/health visitor for your own health problems during the first month after the birth?**

- No  Yes  times +

**48. If yes, what was the reason for this?**

- Perineal wound/stitches  
 Caesarean section wound  
 Mastitis  
 Sore nipples  
 Breastfeeding problems  
 Other, specify: \_\_\_\_\_

**49. When you think back to the time just after the birth, did you feel depressed during that period?**

- No  Yes, specify how long:  weeks +

**50. Apart from being in hospital for the birth, have you been admitted to hospital since you completed the previous questionnaire?**

- No  
 Yes, specify hospital: \_\_\_\_\_

**51. Do you have a chronic/long-term illness which has started since you completed the previous questionnaire?**

- No  
 Yes, specify: \_\_\_\_\_

**52. Overall, how would you describe your physical health at the moment?**

- Very good  
 Good  
 Poor  
 Very poor +

**53. Have you had any of the following problems/illnesses since you completed the previous questionnaire? If yes, are you taking or have you taken medication for these problems? (This includes every type of medication, including natural medicines, taken on both a regular and occasional basis.) (Enter a cross in a box for each item.)**

Illness / problem	Have you suffered from?			If you have taken medication				Number of days taken in total
	No	Yes, last part of during pregnancy	Yes, after the birth	Name of medication taken	Last part of this pregnancy	After the birth 0-3 mth	4-6 mth	
1. Sugar in urine . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
2. Protein in urine . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
3. High blood pressure . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
4. Swelling (oedema) . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
5. Cystitis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
6. Sluggish bowels/constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
7. Diarrhoea/vomiting . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
8. Heartburn/acidity . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
9. Common cold/influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
10. Sore throat/sinusitis/earinfection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>



cont. next page

+

Illness / problem	Have you suffered from?			If you have taken medication				Number of days taken in total
	No	Yes, last part of during pregnancy	Yes, after the birth	Name of medication taken	Last part of this pregnancy	After the birth		
						0-3 mth	4-6 mth	
11. Pneumonia/bronchitis ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
12. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
13. Hay fever/other allergy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
14. Headache/other pains .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
15. Vaginitis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
16. Mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
17. Mastitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
18. Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
19. Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

54. Have you taken medicines other than those mentioned in Question 53? (For instance, sleeping tablets, sedatives or analgesics.)

No  Yes

+

55. If yes, give the name of the medicines and when you took them. (Include all types of medication, as well as natural medicines, taken both on a regular and occasional basis.)

Name of medicine (e.g. Valium, Rohypnol, Paracetamol)	Last part of pregnancy		0-3 months after the birth		4-6 months after the birth	
	Taken medication	Number of days	Taken medication	Number of days	Taken medication	Number of days
_____	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
_____	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
_____	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>

56. Do you take or have you taken cod liver oil, vitamins or other dietary supplements since the previous questionnaire?

No  Yes

+

57. If yes, which product, when did you take it and how often? (One line for each product.)

Name of product	+	When did you take the product?			How often?	
		Last part of pregnancy	0-3 months after the birth	4-6 months after the birth	Taken daily	Taken sometimes
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**58. Have you experienced any pain in your back or pelvis since you completed the previous questionnaire?**

- No
- Yes

+

+

**59. If yes, enter a cross to indicate where you have experienced pain, when and how much.**

Where was the pain?	Last part of pregnancy		0-3 months after the birth		4-6 months after the birth	
	Some pain	Major pain	Some pain	Major pain	Some pain	Major pain
Small of the back . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One of the pelvic/sacroiliac joints at the back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both pelvic/sacroiliac joints at the back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over the coccygeal bone . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the buttocks . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over the pubic bone . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groin . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other back pains . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**60. Currently, do you wake up at night because of pelvic pain?**

- No, never
- Yes, but only sometimes
- Yes, often

**61. Do you have such problems walking at the moment due to pelvic pain that you have to use a stick or crutches?**

- No, never
- Yes, but not every day
- Yes, every day

**62. Have you ever received treatment for pelvic pain?**

- No
- Yes

**63. If yes, enter a cross to indicate the type of treatment and when it was.**

	Before this pregnancy	During this pregnancy	After this birth
Physiotherapy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**64. How long was it before you resumed sexual intercourse after the birth?**

weeks

- Have not had sexual intercourse

+

**65. Do you have any of the following problems at the moment; if so, how often and to what extent? (Enter a cross in a box for each item.)**

Problem	How often do you have these problems?					How much at a time?	
	Never	1-4 times a month	1-6 times a week	Once a day	More than Once a day	Drops	Large amounts
Incontinence when coughing, sneezing or laughing . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence during physical activity (running/jumping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence with a strong need to urinate . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems retaining faeces . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with flatulence . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**66. How many times did you go for an ultrasound scan during your pregnancy?**

times

**67. Was everything OK with the ultrasound scan(s)?**

- Yes
- No

+

**68. If no, what was the problem?**

- The baby was not growing enough.
- Suspected malformation, describe:

\_\_\_\_\_

- Other, specify: \_\_\_\_\_

+

69. How much did you weigh at the end of your pregnancy and how much do you weigh now?

At end of pregnancy     kg

Now     kg +

70. Were you completely or partly on sick leave after week 30 of your pregnancy? (Don't include maternity leave)

No

Yes, partly on sick leave

Yes, completely on sick leave +

71. If you were on sick leave after week 30 of your pregnancy, complete the table below with a line for each time you were on sick leave. Give the reason and enter a cross indicating which weeks of your pregnancy you were on sick leave. Specify how many days and what percentage of the period you were on sick leave each time.

Reason for sick leave:	Was on sick leave during pregnancy weeks			Number of days	% sick leave
	30-33	34-37	38+		
<i>Example: pelvic girdle pains</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	10	50
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

## Finances – lifestyle

72. Would your current financial situation allow you to cope with an unexpected bill of NOK 10,000 for a dental visit or a repair, for a instance?

No

Yes

Don't know

73. Have you found it difficult sometimes during the last six months to cope with running expences for food, transport, rent etc.?

No, never

Yes, but infrequently

Yes, sometimes

Yes, often

74. Are there pets in the child's home?

No

Yes

+

75. If yes, which type(s)? (You can enter a cross in more than one box.)

Dog

Cat

Guinea pig, rabbit, mouse, rat, etc.

Budgie, other type of bird

Other type of animal:

\_\_\_\_\_

76. Do you have heating based on electrical heating cables under the floor in rooms where you child is? (Do not include waterborne heating)

No

Yes

77. If yes, in which rooms? (You can enter a cross in more than one box.)

Living room

Kitchen

Child's room

Bedroom

Hall

Bathroom

Other rooms

78. How often do you exercise these muscle groups at home or at the gym at present? (Enter a cross in a box for each item.)

	Never	1-3 times a month	Once a week	Twice a week	Three times or more a week
Stomach muscles	<input type="checkbox"/>				
Back muscles	<input type="checkbox"/>				
Pelvic floor muscles (muscles around the vagina, urethra, rectum)	<input type="checkbox"/>				

**79. How often are you physically active at present?** (Enter a cross in a box for each item.)

	Never	1-3 times a month	Once a week	Twice a week	Three times or more a week
1 Walking	<input type="checkbox"/>				
2 Brisk walking	<input type="checkbox"/>				
3 Running/jogging/orienteering	<input type="checkbox"/>				
4 Cycling	<input type="checkbox"/>				
5 Training studio/weight training	<input type="checkbox"/>				
6 Special gymnastics/aerobics for pregnant women	<input type="checkbox"/>				
7 Aerobics/gymnastics/dancing without running and jumping	<input type="checkbox"/>				
8 Aerobics/gymnastics/dancing with running and jumping	<input type="checkbox"/>				
9 Dancing (swing, rock, folk)	<input type="checkbox"/>				
10 Skiing	<input type="checkbox"/>				
11 Ball sport	<input type="checkbox"/>				
12 Swimming	<input type="checkbox"/>				
13 Riding	<input type="checkbox"/>				
14 Other	<input type="checkbox"/>				

**80. Currently how often are you physically active (during your spare time or at work) that you get out of breath or sweat?**

	Spare time	At work	
Never	<input type="checkbox"/>	<input type="checkbox"/>	
Less than once a week	<input type="checkbox"/>	<input type="checkbox"/>	+
Once a week	<input type="checkbox"/>	<input type="checkbox"/>	
Twice a week	<input type="checkbox"/>	<input type="checkbox"/>	
3-4 times a week	<input type="checkbox"/>	<input type="checkbox"/>	
5 times or more a week	<input type="checkbox"/>	<input type="checkbox"/>	

**81. What were your and your partner/husband's smoking habits during the last 3 months of your pregnancy and in the period after the birth?** (Enter a cross in a box for each period.)

	Yourself			Your partner/husband		
	Last 3 mths during pregnancy	0-3 mths after birth	4-6 mths after birth	Last 3 mths during pregnancy	0-3 mths after birth	4-6 mths after birth
Didn't smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoked sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoked every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If every day, number of cigarettes per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
If sometimes, number of cigarettes per week	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**82. Is your child ever present in a room where someone smokes?**

- No
- Yes, sometimes
- Yes, several times a week
- Yes, every day

If every day, number of hours

+

**83. Did you take any of the following substances during the last 3 months of your pregnancy and after the birth?** (Enter a cross in a box for each item.)

	No	Yes, last 3 month of pregnancy	Yes after birth
Hanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify:			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**84. Have you taken any of the following substances during the last 3 months of your pregnancy and after the birth?** (Enter a cross in a box for each item.)

		No	Yes, last 3 months of pregnancy	Yes, after birth	
	+				
Anabolic steroids .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	+
Testosterone preparations .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Growth hormone (e.g. genotropin/somatropin) .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**85. How often did you drink alcohol during the last 3 months of your pregnancy and how often do you drink now?** (Enter a cross in a box for each period.)

	Last 3 months of pregnancy	After the birth	
		0-3 months	4-6 months
Roughly 6-7 times a week .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly 4-5 times a week .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly 2-3 times a week .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly once a week .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly 1-3 times a month .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less often than once a month .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Never .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Alcohol units

In order compare different types of alcohol, we ask for the number of alcohol units (= 1.5 cl of pure alcohol).

In practice, this means the following:

1 glass (1/3 litre) of beer	= 1 alcohol unit
1 wine glass of red or white wine	= 1 alcohol unit
1 sherryglass of sherry	= 1 alcohol unit
1 brandy glass of spirits or liquor	= 1 alcohol unit
1 bottle of alcopop/cider	= 1 alcohol unit

+

**86. How many units of alcohol do you usually drink when you consume alcohol (complete both for the last 3 months of your pregnancy and afterwards)?** (See explanation about alcohol units.) (Enter a cross in a box for each period.)

Number of alcohol units	Last 3 months of pregnancy	After the birth	
		0-3 months	4-6 months
10 or more .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7-9 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 1 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## A little more about yourself and how you are keeping now

**87. Do you have a boyfriend/husband/partner?**

Yes

No

+

+

**88. If yes, to what extent do you agree with the following descriptions?** (Enter just one cross in a box for each item.)

	Totally agree	Agree	Slightly agree	Slightly disagree	Disagree	Totally disagree
My husband/partner and I have a close relationship . . . . .	<input type="checkbox"/>					
My partner and I have problems in our relationship . . . . .	<input type="checkbox"/>					
I am very happy in my relationship . . . . .	<input type="checkbox"/>					
My partner is usually understanding . . . . .	<input type="checkbox"/>					
I often think about ending our relationship. . . . .	<input type="checkbox"/>					
I am satisfied with my relationship with my partner . . . . .	<input type="checkbox"/>					
We often disagree about important decisions . . . . .	<input type="checkbox"/>					
I have been lucky in my choice of partner. . . . .	<input type="checkbox"/>					
We agree on how children should be raised . . . . .	<input type="checkbox"/>					
I think my partner is satisfied with our relationship . . . . .	<input type="checkbox"/>					

+

+

**89. In your daily life, how often do you** (Enter just one cross in a box for each item.)

	Seldom never	Fairly seldom	A few times	Often	Very often
Feel pleased about something	<input type="checkbox"/>				
Feel happy	<input type="checkbox"/>				
Feel joyful, as though everything is going your way	<input type="checkbox"/>				
Feel that you will scream at someone or hit something	<input type="checkbox"/>				
Feel angry, irritated or annoyed	<input type="checkbox"/>				
Feel mad at somebody	<input type="checkbox"/>				

+

**90. Indicate with a cross whether you agree or disagree with the following statements.**

(Enter just one cross in a box for each item.)

	Totally disagree	Disagree	Slightly disagree	Neither agree or disagree	Slightly agree	Agree	Totally agree
My life is largely what I wanted it to be . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My life is very good . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with my life. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have achieved so far what is important for me in my life . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I could start all over, there is very little I would do differently . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

**91. Have you experienced any of the following situations since the previous questionnaire? If yes, how painful or difficult was this for you?** (Enter a cross in a box for each item.)

	No	Yes	If yes		
			Not so bad	Painful/difficult	Very painful/difficult
Have you had problems at work or where you study? . . . . .	<input type="checkbox"/>				
Have you had financial problems?. . . . .	<input type="checkbox"/>				
Have you been divorced, separated or ended your relationship with your partner?	<input type="checkbox"/>				
Have you had problems or conflicts with family, friends or neighbours?.	<input type="checkbox"/>				
Have you been seriously worried that there is something wrong with your child?	<input type="checkbox"/>				
Have you been seriously ill or injured? . . . . .	<input type="checkbox"/>				
Has anyone close to you been seriously ill or injured? . . . . .	<input type="checkbox"/>				
Have you been involved in a serious accident, fire or robbery? . . . . .	<input type="checkbox"/>				
Have you lost someone close to you? . . . . .	<input type="checkbox"/>				
Have you been pressurized into having sexual intercourse? . . . . .	<input type="checkbox"/>				
Other . . . . .	<input type="checkbox"/>				

**92. Have you experienced any of the following feelings during the last week?** (Enter just one cross in a box for each item.)

	Yes, almost all the time	Yes, now and then	Not very often	No, never
Really reproached yourself when something went wrong . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have been anxious or worried for no reason. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have been afraid or panicked for no reason . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have been so unhappy that you've had problems sleeping . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt down or unhappy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have been so unhappy that you've cried . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**93. How do you feel about yourself?** (Enter just one cross in a box for each item.)

	Totally agree	Agree	Disagree	Totally disagree
I have a positive attitude towards myself . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel completely useless at times . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I do not have much to be proud about . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I am a valuable person, as good as anyone else . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**94. Have you been bothered by any of the following feelings during the past 2 weeks?** (Enter just one cross in a box for each item.)

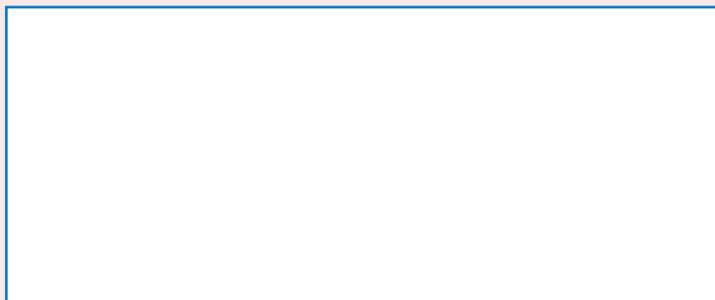
	Not bothered	A little bothered	Quite bothered	Very bothered
Feeling fearful . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness or shakiness inside . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling hopeless about the future . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling blue . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about things . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling everything is an effort . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tense or keyed up . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suddenly scared for no reason . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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***Thank you very much for your help!***

Insert the completed questionnaire in the stamped addressed envelope.



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