Follow-UP

Family ID

_____

Visit ID

_____
(IN__)

Date of last interview

_____

Interview Date

_____

Interviewer's Name

_____
(First and last name)

Location of Interview

_____

Child's home zipcode

¿Qúe es su código poste?

_____

SCREENING: FOR INTERVIEWS

Eligibility

Are you this child's legal guardian?

¿Tiene usted custodia legal de...?

◯ Yes
◯ No
(IF NO STOP)

Are you this child's biological mother?

¿Usted es la madre biológica de..., verdad?

◯ Yes
◯ No

Mother's Name Matches Query

◯ Yes
◯ No

Child's Name Matches Query

◯ Yes
◯ No

IF NO STOP

Section I. Family Pedigree

Can I ask you a few questions about your child's biological father's medical history?

¿Puedo preguntar sobre el historial médico del padre?

◯ Yes
◯ No

Father's Birth Month

¿Cuál es su fecha de nacimiento?

_____
(Month)

Father's Birth Year

¿Cuál es su fecha de nacimiento?

_____
(Year)

Father's Medical History

Usted sabe si el padre de ...tiene algunas enfermedades como

Alergias alimentarias
Eccema
Asma
Alergias estacionales
Alergias a medicinas
Otros
Reflujo de ácido

- ☐ Food Allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Drug Allergy
- ☐ Other Allergies
- ☐ EE
- ☐ GERD

Do you have any other children with her/his father? (Full sibling)

¿Tiene ud. otros hijos con el padre de (index kid)?

- ◯ Yes
- ◯ No

Full Sibling 1. Gender

- ☐ Male
- ☐ Female

Full Sibling 1 Birth Month

¿Cuál es la fecha de nacimiento de el/ella?

_____
(Month)

Full Sibling 1 Birth Year

¿Cuál es la fecha de nacimiento de el/ella?

_____
(Year)

Full Sibling 1 Medical History

Tiene algunas enfermedades como

Alergias alimentarias
Eccema
Asma
Alergias estacionales
Alergias a medicinas
Otros
Reflujo de ácido

- ☐ Food Allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Drug Allergy
- ☐ Other Allergies
- ☐ EE
- ☐ GERD

Full Sibling 2 Gender

- ◯ Male
- ◯ Female

Full Sibling 2 Birth Month

_____
(Month)

Full Sibling 2 Birth Year

_____
(year)

Full Sibling 2 Medical History

- ☐ Food Allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Drug Allergy
- ☐ Other Allergies
- ☐ EE
- ☐ GERD

Full Sibling 3 Gender

- ◯ Male
- ◯ Female

Full Sibling 3 Birth Month

_____
(Month)

Full Sibling 3 Birth Year

_____
(Year)

Full Sibling 3 Medical History

- ☐ Food Allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Drug Allergy
- ☐ Other Allergies
- ☐ EE
- ☐ GERD

Full Sibling 4 Gender

- ◯ Male
- ◯ Female

Full Sibling 4 Birth Month

_____
(Month)

Full Sibling 4 Birth Year

_____
(Year)

Full Sibling 4 Medical History

- ☐ Food Allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Drug Allergy
- ☐ Other Allergies
- ☐ EE
- ☐ GERD

Full Sibling 5 Gender

- ◯ Male
- ◯ Female

Full Sibling 5 Birth Month

_____
(Month)

Full Sibling 5 Birth Year

_____
(Year)

Full Sibling 5 Medical History

- ☐ Food Allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Drug Allergy
- ☐ Other Allergies
- ☐ EE
- ☐ GERD

1. Since the last interview, has your child had any of the following illnesses?

¿en el ultimo año, tenía...algunas enfermedades como?

	Yes	No	Unsure
Common Cold / Gripe	◯	◯	◯
Gastric/intestinal infection / Infección intestinal	◯	◯	◯
Conjunctivitis/ Pink eye / Conjunctivitis	◯	◯	◯
Strep Throat / Infeccion de garganta (faringitis estreptocócica)	◯	◯	◯
RSV/Bronchiolitis / Bronquilitis	◯	◯	◯
If yes, hospitalized	◯	◯	◯
Bronchitis / Bronquitis	◯	◯	◯
Ear Infection / Infección de oreja	◯	◯	◯
Pneumonia / Pulmonía	◯	◯	◯
Skin Infection / Infección de piel	◯	◯	◯
Urinary Tract Infection / Infección urinaria	◯	◯	◯
Parasite Infection / Infección de parasito	◯	◯	◯
Bone Infection (osteomyelitis) / Infección de hueso	◯	◯	◯
Meningitis	◯	◯	◯
Bacteremia/Sepsis (Blood Infection) / Infección de sangre	◯	◯	◯
Sinus Infection / Infección de sino	◯	◯	◯

Has your child been diagnosed with any other illnesses within the last year? / ¿En el año pasado, ... ha sido diagnosticado con algunas otras enfermedades?	◯	◯	◯

Other illness specify _____

Other illness specify _____

If yes, how many times?
Cold _____

¿Cuantas veces tenía?

If yes, how many times?
Gastric/Intestinal Infection _____

If yes, how many times?
Conjunctivitis _____

If yes, how many times?
Strep Throat _____

If yes, how many times?
Ear Infection _____

If yes, how many times?
Pneumonia _____

If yes, how many times?
Skin Infection _____

If yes, how many times?
Urinary Tract Infection _____

2. Antibiotics are medicines that your doctor prescribes for illnesses caused by infections. Examples of some names of commonly prescribed antibiotics are amoxicillin and penicillin. Since the last visit did your child take any antibiotics by oral or IV. Not topical antibiotics?

¿En el último año, tomó antibióticos?
Oral o intravenosa

◯ Yes
◯ No
◯ Unsure

If yes, how many times was your child prescribed an antibiotic medicine since the last visit?

¿Cuántas veces fue recetado un antibiótico?

_____
(times)

3a. Is the child YOUNGER than 5 years old?

◯ Yes
◯ No

3b. Currently, did anyone other than your child's parent help in caring for your child for even part of the day? (nanny, daycare, preschool, relative) Durante el día, hay alguna diferente de los padres que cuida de ... como	◯ Yes ◯ No ◯ Not sure
Childcare/preschool Days per week Una guardería Cuantas días por semana	_____ (# of days per week)
Childcare/preschool # of other children Una guardería Número de otros niños	_____
Childcare/preschool Don't Know	◯ Don't know
Home Based Child Care (not in own home) # of days per week Otra pariente / niñera en otra casa Cuantos días por semana	_____ (# of days per week)
Home Based Child Care (not in own home) # of other children Otra pariente / niñera en otra casa Número de otros niños	_____ (# of other children)
Home Based Child Care (not in own home)	◯ Don't Know
In home care (in own home, nanny) # of days per week Una niñera u otro pariente en su casa Cuantos días por semana	_____ (# of days per week)
In Home Care (in own home, nanny) # of other children Una niñera u otro pariente en su casa Número de otros niños	_____ (# of other children)
In Home Care (in own home, nanny)	◯ Don't Know
4a. Are you, the mother, currently breastfeeding this child? ¿Ud. Está dar el pecho este hijo ahora?	◯ Yes ◯ No

4b. If you are currently breastfeeding do you (the mother) take medications for gastrointestinal upset?

¿Ud. Toma medicinas para dolor del estómago?

- ◯ No
- ◯ Yes
- ◯ Unsure

If YES, which one of the following medications did you take?

- ◯ Antacids (Mylanta, Rolaids, TUMS, Pepto-Bismol)
- ◯ H2 Blockers (Pepcid AC, Zantac)
- ◯ Proton Pump inhibitors (Aciphex, Prilosec, Preveacid, Nexium)
- ◯ Prokinetic agents (Urecholine, Regland, Erythromycin)
- ◯ Unsure
- ◯ Other

If Others, specify:

_____
(Other GI medications taken during breast feeding)

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

	None	< 1 days	1-2 days	3-5 days	6-7 days	Unsure
Cow's milk/Dairy Products/Cheese (Leche, queso, productos lactos)	◯	◯	◯	◯	◯	◯
Egg (Huevos)	◯	◯	◯	◯	◯	◯
Peanut (including peanut butter) (Cacahuete/ maní (Incluyendo crema/mantequilla de maní)	◯	◯	◯	◯	◯	◯
Tree Nuts (ie almond, cashew, filbert/hazel, walnut, brazil, macadamia, pecan, pine, pistachio) / (Nueces de árbol)	◯	◯	◯	◯	◯	◯
Fish (ie salmon, tuna, catfish, cod, flounder, halibut, trout, bass) / Pescado	◯	◯	◯	◯	◯	◯
Shellfish (shrimp, crab, lobster, clam, oyster, mussels) / Mariscos	◯	◯	◯	◯	◯	◯
Wheat (ie pasta, bread, cereal) / Productos de trigo	◯	◯	◯	◯	◯	◯
Soy/Tofu / Soja/tofu	◯	◯	◯	◯	◯	◯
Seeds (ie sesame, sunflower, pumpkin) / Semilla (sésamo)	◯	◯	◯	◯	◯	◯
Green vegetables / Verduras verdes	◯	◯	◯	◯	◯	◯

Orange veggies (carrots, squash, etc) / Verduras naranjas	◯	◯	◯	◯	◯	◯
Fruits / Frutas	◯	◯	◯	◯	◯	◯
Meats / Carne	◯	◯	◯	◯	◯	◯
Beans / Frijoles	◯	◯	◯	◯	◯	◯
Rice / Arroz	◯	◯	◯	◯	◯	◯

6. At present, does your child take any nutritional supplements or vitamins?
◯ Yes
◯ No

¿Toma ... algunas vitaminas?

If YES, on average how many days per week does your child take a nutritional supplement or vitamin?

¿Cuántas días toma... vitaminas en una semana?

	None	1-2 days	3-4 days	5-6 days	Everyday
7. Multivitamin/polyvisol	◯	◯	◯	◯	◯
8. Trivisol	◯	◯	◯	◯	◯
9. Calcium Supplement	◯	◯	◯	◯	◯
10. Pediasure/Ensure	◯	◯	◯	◯	◯
11. Other	◯	◯	◯	◯	◯

Other specify: _____

7a. Does the multivitamin contain extra iron?
¿Contiene hierro adicional?
◯ Yes
◯ No
◯ Unsure

7b. Does the multivitamin contain extra calcium?
¿Contiene calcio adicional?
◯ Yes
◯ No
◯ Unsure

12a. At present, how often does your child eat the following foods per week?

¿Ahora, me diré una lista de comidas u Ud. Me dirá cuántas veces por semana... las come? Cuantos días por semana come...

	None	< 1 day	1-2 days	3-5 days	6-7 days	Unsure
Cow's milk/Dairy Products/Cheese / Leche, queso, productos lactos	◯	◯	◯	◯	◯	◯
Eggs / Huevos	◯	◯	◯	◯	◯	◯

Peanut (Including peanut butter) / Cacahuete/ maní (Incluyendo crema/mantequilla de maní)	◯	◯	◯	◯	◯	◯
Tree Nuts (ie almond, cashew, filbert/hazel, walnut, brazil, macadamia, pecan, pine, pistachio) / Nueces de árbol	◯	◯	◯	◯	◯	◯
Fish (ie salmon, tuna, catfish, cod, flounder, halibut, trout, bass) / Pescado	◯	◯	◯	◯	◯	◯
Shellfish (ie shrimp, crab, lobster, clam, oyster, mussels) / Mariscos	◯	◯	◯	◯	◯	◯
Wheat (ie pasta, bread, cereal) / Productos de trigo	◯	◯	◯	◯	◯	◯
Soy/Tofu / Soja/tofu	◯	◯	◯	◯	◯	◯
Seeds (ie sesame, sunflower, pumpkin) / Semilla (sésamo)	◯	◯	◯	◯	◯	◯
Green vegetables / Verduras verdes	◯	◯	◯	◯	◯	◯
Orange veggies (carrots, squash, etc) / Verduras naranjas	◯	◯	◯	◯	◯	◯
Fruits / Frutas	◯	◯	◯	◯	◯	◯
Fruit Juice (without calcium) / jugo de fruta (sin calcio)	◯	◯	◯	◯	◯	◯
Calcium-fortified Juice / jugo de fruta (con calcio)	◯	◯	◯	◯	◯	◯
Meats / Carne	◯	◯	◯	◯	◯	◯
Beans / Frijoles	◯	◯	◯	◯	◯	◯
Rice / Arroz	◯	◯	◯	◯	◯	◯

12b. At present, how often does your child eat breakfast per week?

¿Cuántas días por semana come el desayuno?

- ◯ None
- ◯ < 1 day
- ◯ 1-2 days
- ◯ 3-5 days
- ◯ 6-7 days
- ◯ Unsure

13. What is your child's current eczema status?
¿Ha tenido eccema?

- ◯ Current
- ◯ Outgrown since last visit
- ◯ Never had it
- ◯ Don't know

14. Do you currently use cream, lotion, or ointment containing steroids on your child's skin for eczema? (for example: hydrocortisone cream or triamcinolone cream)

¿Ud. Usa una crema que tiene esteroides (como hidrocortisona) en el piel de...?

◯ Yes
◯ No
◯ Unsure

15. Does your child have hay fever or seasonal allergies?

¿Tiene alergias estacionales?

◯ Yes, he/she has it now
◯ No
◯ Unsure

15b. Which season does your child have seasonal allergies? (select all that apply)

Primavera
Verano
Otoño
Invierno
Todo el año

☐ Spring
☐ Summer
☐ Autumn
☐ Winter
☐ Year round

16. Does your child have pet allergies?

¿Tiene algunas alergias a animales o mascotas?

◯ Yes
◯ No
◯ Don't Know

If YES, what type of pet allergy? (select all that apply)

☐ Cat
☐ Dog

If OTHER, specify:

_____
(name of other type of pet that child is allergic to)

If OTHER, specify:

_____
(name of other type of pet that child is allergic to)

17. Has your child been diagnosed by a doctor with any of the follow environmental allergies?

¿Ha diagnosticado... con una alergia de...?

	Current	Outgrown since last visit	Never	Don't know
Polleen(tree, grass, ragweed) / polen	◯	◯	◯	◯
Dustmite / Polvo	◯	◯	◯	◯
Cockroach / Cucaracha	◯	◯	◯	◯
Mold / Moho	◯	◯	◯	◯
Other 1	◯	◯	◯	◯

Other 2	◯	◯	◯	◯
Other 3	◯	◯	◯	◯

Other allergy 1 specify

_____

Other allergy 2 specify

_____

Other allergy 3 specify

_____

18. Has your child ever used anti-allergy medication? (ie Benadryl, Zyrtec, Claritin, Atarax, Dimetapp)

¿En el último año, ha usado medicina anti alergia?

◯ Yes
◯ No
◯ Don't Know

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

¿En el último año, ha usado medicina por el dolor de estómago?

◯ Yes
◯ No
◯ Don't Know

if YES, which of the following medications did he/she take?

¿Qué tipo?

◯ Antacids (Mylants, Rolaids, TUMS, Pepto-Bismol)
◯ H2 Blockers
◯ Proton Pump inhibitors (Aciphex, Prilosec, Preveacid, Nexium)
◯ Prokinetic agents (Urecholine, Reglin, Erythromycin)
◯ Unsure
◯ Other

If Others, specify:

_____

20. Does your child have any drug allergies?

¿Tiene alergias a algunas medicinas o drogas?

◯ Yes
◯ No
◯ Don't Know

If yes, specify the drug (use "," to separate):

_____

If yes, specify the drug (use "," to separate):

_____

21. Is your child allergic to insect stings?

¿Tiene alergias a algunos insectos?
¿Ha sido picado por una abeja o auispa?

◯ Yes
◯ No
◯ Don't know/Child has never been stung

22. Has your child ever had E.E. (Eosinophilic esophagitis)?

¿Tiene ... esofagitis eosinofilica?

◯ No
◯ Yes, only when she/he was a baby, but outgrew by age
◯ Yes, he/she has it now
◯ Don't know

If outgrown, at what age did your child outgrow?
Year(s)

_____
(Years)

If outgrown, at what age did your child outgrow?
Months

_____
(Months)

If yes, was your child's EE diagnosed by a doctor?

¿Fue diagnosticado por un doctor?

◯ Yes
◯ No
◯ Don't know

How old was your child when first diagnosed by a doctor?
Year(s)
¿Cuándo fue diagnosticado?
Años

_____
(Years / Años)

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

¿Cuándo fue diagnosticado?
Meses

_____
(months / Meses)

23. Has your child ever had GERD (Gastroesophageal Reflux Disease)?

¿Ha tenido reflujo de ácida?

◯ No
◯ Yes, only when she/he was a baby, but outgrew
◯ Yes, he/she has it now
◯ Don't know

If outgrown, at what age?
Year(s)

_____
(years)

If outgrown, at what age?
Months

_____
(Months)

If yes, was your child's GERD diagnosed by a doctor?

¿Fue diagnosticado por un doctor?

◯ Yes
◯ No
◯ Don't know

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

¿Cuándo fue diagnosticado?
Años

_____
(years)

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

¿Cuándo fue diagnosticado?
Meses

_____
(months / Meses)

24. What is your child's food allergy status (meaning any food)? ¿Ha tenido... alergias a algunas comidas? ¿Ahora tiene?	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never

If NEVER skip to PEDIATRIC SLEEP QUESTIONNAIRE

24b. Allergy to Dairy products / Cheese / Milk? Leche, queso, productos lactos	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Allergy to Egg? Huevos	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Allergy to Peanuts? Cacahuete/ maní (Incluyendo crema/mantequilla de maní)	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Allergy to Tree Nuts Nueces de árbol	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Allergy to Fish? Pescado	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Allergy to Shellfish? Mariscos	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Allergy to Wheat? Productos de trigo	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Allergy to Soy/Tofu? Soja/tofu	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never

Allergy to Seeds? Semillas	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Specify Other Food Allergy #1:	_____ (name of other food #1 child is allergic to)
Other Food Allergy #1	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Specify Other Food Allergy #2:	_____ (name of other food #2 child is allergic to)
Other Food Allergy #2	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Specify Other Food Allergy #3:	_____ (name of other food #3 child is allergic to)
Other Food Allergy #3	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Specify Other Food Allergy #4:	_____ (name of other food #4 child is allergic to)
Other Food Allergy #4	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never
Specify Other Food Allergy #5:	_____ (name of other food #5 child is allergic to)
Other Food Allergy #5	◯ Current ◯ Outgrown since last visit ◯ Food was never introduced due to positive skin test or RAST ◯ Never

Specify Other Food Allergy #6:

_____
(name of other food #6 child is allergic to)

Other Food Allergy #6

- ◯ Current
- ◯ Outgrown since last visit
- ◯ Food was never introduced due to positive skin test or RAST
- ◯ Never

25a. Has your child been breast fed since the last visit?

¿Sido alimentado con leche materna...en el último año?

- ◯ Yes
- ◯ No

Skip to question 26 if child has not been breast fed since the last visit

25b. Since the last visit, has your child ever experienced allergic symptoms to any food that was passed exclusively through breast milk?

¿En el año pasado ha experimentado... sin toma alérgica a los alimentos pasados a través de la leche materna?

- ◯ Yes
- ◯ No
- ◯ Don't know

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:
Other food #1 _____

If other, list other foods:
Other food #2 _____

If other, list other foods:
Other food #3 _____

If other, list other foods:
Other food #4 _____

If other, list other foods:
Other food #5 _____

If other, list other foods:
Other food #6 _____

26. Has your child experienced any of the following symptoms from ingestion since the last visit?

¿Ha experimentado su hijo alguno de los siguientes síntomas por ingestión en el último año?

26a. Any mouth symptoms

Síntomas de boca

◯ Yes
◯ No
◯ Don't know

26a. Specific symptoms of food allergy (through ingestion):
a. MOUTH (Boca)
Cow's Milk/Dairy Products/Cheese

	Check box if yes
Lips Itching/Tingling / Picazón en los labios	☐
Lips Swelling / Labios hinchados	☐
Tongue Itching/Tingling / Picazón la lengua	☐
Tongue Swelling / Lengua hinchada	☐

26 a. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Egg

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Tongue Swelling	☐

26a. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Peanut

	Check box if yes
Lips Itching/Tinging	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Tongue Swelling	☐

26a. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Tree Nuts

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Tongue Swelling	☐

26a. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Fish

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Tongue Swelling	☐

26a. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Shellfish

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Tongue Swelling	☐

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Wheat

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Tongue Swelling	☐

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Soy/Tofu

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐

Tongue Itching/Tingling ☐
Tongue Swelling ☐

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Seeds

Check box if yes

Lips Itching/Tingling ☐
Lips Swelling ☐
Tongue Itching/Tingling ☐
Tongue Swelling ☐

26a. Name of Other Food Allergy #1 _____

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Other Food Allergy #1

Check box if yes

Lips Itching/Tingling ☐
Lips Swelling ☐
Tongue Itching/Tingling ☐
Tongue Swelling ☐

26a. Name of Other Food Allergy #2 _____

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Other Food Allergy #2

Check box if yes

Lips Itching/Tingling ☐
Lips Swelling ☐
Tongue Itching/Tingling ☐
Tongue Swelling ☐

26a. Name of Other Food Allergy #3 _____

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Other Food Allergy #3

	Check box if yes
Lips Itching/Tingling	○
Lips Swelling	○
Tongue Itching/Tingling	○
Tongue Swelling	○

26a. Name of Other Food Allergy #4 _____

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Other Food Allergy #4

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Tongue Swelling	☐

26a. Name of Other Food Allergy #5 _____

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Other Food Allergy #5

	Check box if yes
Lips Itching/Tingling	☐
Lips Swelling	☐
Tongue Itching/Tingling	☐
Toungue Swelling	☐

26a. Name of Other Food Allergy #6 _____

26. Specific symptoms of food allergy (through ingestion):
a. MOUTH
Other Food Allergy #6

	Check box if yes
Lips Itching/Tingling	○

Lips Swelling	◯
Tongue Itching/Tingling	◯
Tongue Swelling	◯

26 b/c. Eye or nose symptoms Síntomas de ojos/ nariz	◯ Yes ◯ No ◯ Don't know

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Cow's Milk/Dairy Products/Cheese

	Check box if yes
Red/Watery/Itchy Eye / Ojo rojo/pica	☐
Swollen Eye / Ojo hinchado	☐
Stuffy/Runny Nose / Congestión nasal	☐
Sneezing / Estornudo	☐
Itchy Nose / Picazón en la nariz	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Egg

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Peanut

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Tree Nuts

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Fish

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Shellfish

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Wheat

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Soy/Tofu

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Seeds

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26b/c. Name of Other Food Allergy #1

_____

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Other Food Allergy #1

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26b/c. Name of Other Food Allergy #2

_____

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Other Food Allergy #2

	Check box if yes
Red/Watery/Itchy Eye	☐

Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26b/c. Name of Other Food Allergy #3 _____

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Other Food Allergy #3

	Check box if yes
Red/Watery/Itchy Eye	○
Swollen Eye	○
Stuffy/Runny Nose	○
Sneezing	○
Itchy Nose	○

26b/c. Name of Other Food Allergy #4 _____

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Other Food Allergy #4

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26b/c. Name of Other Food Allergy #5 _____

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Other Food Allergy #5

	Check box if yes
Red/Watery/Itchy Eye	○
Swollen Eye	○
Stuffy/Runny Nose	○

Sneezing	◯
Itchy Nose	◯

26b/c. Name of Other Food Allergy #6 _____

26. Specific symptoms of food allergy (through ingestion):
b/c. EYE/NOSE
Other Food Allergy #6

	Check box if yes
Red/Watery/Itchy Eye	☐
Swollen Eye	☐
Stuffy/Runny Nose	☐
Sneezing	☐
Itchy Nose	☐

26d. Throat symptoms
Síntomas de la garganta

◯ Yes
◯ No
◯ Don't know

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Cow's Milk/Dairy Products/Cheese

	Check box if yes
Itching and/or tightness in the throat / Picazón u opresión en la garganta	☐
Hoarseness/change of voice / Voz ronco	☐
Choking/Difficulty Swallowing / Dificultad para deglutir	☐
Throat Clearing / Limpiado de la garganta	☐

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Egg

	Check box if yes
Itching and/or tightness in the throat	◯
Hoarseness/change of voice	◯
Choking/Difficulty Swallowing	◯

Throat Clearing	◯

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Peanut

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty swallowing	☐
Throat Clearing	☐

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Tree Nuts

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Fish

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Shellfish

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Wheat

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Soy/Tofu

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Seeds

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26d. Name of Other Food Allergy #1

_____

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Other Food Allergy #1

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26d. Name of Other Food Allergy #2

_____

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Other Food Allergy #2

	Check box if yes
Itching and/or tightness in the throat	○
Hoarseness/change of voice	○
Choking/Difficulty Swallowing	○
Throat Clearing	○

26d. Name of Other Food Allergy #3

_____

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Other Food Allergy #3

	Check box if yes
Itching and/or tightness in the throat	○
Hoarseness/change of voice	○
Choking/Difficulty Swallowing	○
Throat Clearing	○

26d. Name of Other Food Allergy #4

_____

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Other Food Allergy #4

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26d. Name of Other Food Allergy #5

_____

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Other Food Allergy #5

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26d. Name of Other Food Allergy #6 _____

26. Specific symptoms of food allergy (through ingestion):
d. THROAT
Other Food Allergy #6

	Check box if yes
Itching and/or tightness in the throat	☐
Hoarseness/change of voice	☐
Choking/Difficulty Swallowing	☐
Throat Clearing	☐

26e. Skin symptoms
Síntomas de piel

◯ Yes
◯ No
◯ Don't know

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Cow's Milk/Dairy Products/Cheese

	Check box if yes
Itching / Pica	☐
Hives / Urticaria	☐
Swelling of the face and/or extremeties / Hinchazón de la cara o extremidades	☐
Redness of the skin / Piel rojo	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Egg

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Peanut

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Treenut

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Fish

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Shellfish

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Wheat

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Soy/Tofu

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Seeds

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26e. Name of Other Food Allergy #1 _____

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Other Food Allergy #1

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26e. Name of Other Food Allergy #2

_____

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Other Food Allergy #2

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremeties	☐
Redness of the skin	☐

26e. Name of Other Food Allergy #3

_____

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Other Food Allergy #3

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremities	☐
Redness of the skin	☐

26e. Name of Other Food Allergy #4

_____

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Other Food Allergy #4

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremities	☐
Redness of the skin	☐

26e. Name of Other Food Allergy #5

_____

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Other Food Allergy #5

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremities	☐
Redness of the skin	☐

26e. Name of Other Food Allergy #6

_____

26. Specific symptoms of food allergy (through ingestion):
e. SKIN
Other Food Allergy #6

	Check box if yes
Itching	☐
Hives	☐
Swelling of the face and/or extremities	☐
Redness of the skin	☐

26f. Lung Symptoms

Síntomas de Pulmón

◯ Yes
◯ No
◯ Don't know

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Cow's Milk/Dairy Products/Cheese

	Check box if yes
Shortness of breath / Falta de aliento	☐
Repetitive coughing / Tos repetitiva	☐
Wheezing / Aliento ruidoso	☐
Chest Tightness/Opresión en el pecho	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Egg

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Peanut

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Treenut

	Check box if yes
Shortness of Breath	☐
Repetitive Coughing	☐
Wheezing	☐
Chest Tightness	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Fish

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Shellfish

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Wheat

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Soy/Tofu

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Seeds

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐

Wheezing ☐
Chest Tightness ☐

26f. Name of Other Food Allergy #1

_____

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Other Food Allergy #1

Check box if yes

Shortness of breath ☐
Repetitive coughing ☐
Wheezing ☐
Chest Tightness ☐

26f. Name of Other Food Allergy #2

_____

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Other Food Allergy #2

Check box if yes

Shortness of breath ☐
Repetitive coughing ☐
Wheezing ☐
Chest Tighness ☐

26f. Name of Other Food Allergy #3

_____

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Other Food Allergy #3

Check box if yes

Shortness of breath ☐
Repetitive coughing ☐
Wheezing ☐
Chest Tightness ☐

26f. Name of Other Food Allergy #4

_____

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Other Food Allergy #4

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26f. Name of Other Food Allergy #5 _____

26. Specific symptoms of food allergy (through ingestion):
f. LUNG
Other Food Allergy #5

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26f. Name of Other Food Allergy #6 _____

34. Specific symptoms of food allergy (through ingestion):
f. LUNG
Other Food Allergy #6

	Check box if yes
Shortness of breath	☐
Repetitive coughing	☐
Wheezing	☐
Chest Tightness	☐

26g. Gut symptoms
Síntomas de tripa / intestino

◯ Yes
◯ No
◯ Don't know

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Cow's Milk/Dairy Products/Cheese

Check box if yes

Stomach cramps/pain / Dolor de estómago	☐
Nausea / Náusea	☐
Vomiting / Vómito	☐
Diarrhea / Diarrea	☐
Bloating (swelling, gassy feeling) / Estómago hinchado	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Egg

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Peanut

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Tree Nuts

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Fish

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Shellfish

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Wheat

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Blaoting (swelling, gassy feeling)	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Soy/Tofu

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Seeds

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26g. Name of Other Food Allergy #1

_____

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Other Food Allergy #1

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26g. Name of Other Food Allergy #2

_____

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Other Food Allergy #2

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26g. Name of Other Food Allergy #3

_____

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Other Food Allergy #3

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26g. Name of Other Food Allergy #4 _____

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Other Food Allergy #4

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26g. Name of Other Food Allergy #5 _____

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Other Food Allergy #5

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26g. Name of Other Food Allergy #6 _____

26. Specific symptoms of food allergy (through ingestion):
g. GUT
Other Food Allergy #6

	Check box if yes
Stomach cramps/pain	☐
Nausea	☐
Vomiting	☐
Diarrhea	☐
Bloating (swelling, gassy feeling)	☐

26h. Cardiovascular symptoms
Síntomas de cardiovascular

◯ Yes
◯ No
◯ Don't know

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Cow's Milk/Dairy Products/Cheese

	Check box if yes
Pale or turn blue / Piel pálida o azul	☐
Dizzy/Light-headed / Marceo	☐
Passing out/Fainting / Desmogo	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Egg

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Peanut

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Treenut

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Fish

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Shellfish

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Wheat

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Soy/Tofu

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Seeds

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26h. Name of Other Food Allergy #1 _____

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Other Food Allergy #1

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26h. Name of Other Food Allergy #2 _____

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Other Food Allergy #2

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26h. Name of Other Food Allergy #3 _____

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Other Food Allergy #3

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26h. Name of Other Food Allergy #4 _____

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Other Food Allergy #4

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26h. Name of Other Food Allergy #5

_____

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Other Food Allergy #5

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

26h. Name of Other Food Allergy #6

_____

26. Specific symptoms of food allergy (through ingestion):
h. CARDIOVACULAR
Other Food Allergy #6

	Check box if yes
Pale or turn blue	☐
Dizzy/Light-headed	☐
Passing out/Fainting	☐

27. Since the last visit, has your child ever experienced a severe allergic reaction that affect the throat, lungs, and/or cardiovascular system?

◯ Yes
◯ No
◯ Don't know

¿En el último año, ha experimentado una reacción alérgica grave que afecto la garganta, los pulmones o corazón?

IF NO SKIP TO QUESTION 28

If yes, to what foods? (select all that apply

	Yes, Doctor diagnosed	No, not doctor diagnosed
Cow's Mild/Dairy Products/Cheese	◯	◯
Egg	◯	◯
Peanut	◯	◯
Tree Nuts	◯	◯
Fish	◯	◯
Shellfish	◯	◯
Wheat	◯	◯
Soy/Tofu	◯	◯
Seeds	◯	◯
Other 1	◯	◯
Other 2	◯	◯
Other 3	◯	◯
Other 4	◯	◯
Other 5	◯	◯
Other 6	◯	◯

Number of episodes since last visit
Cow's Milk/Dairy Products/Cheese _____

Number of episodes since last visit
Eggs _____

Number of episodes since last visit
Peanut _____

Number of episodes since last visit
Tree Nuts _____

Number of episodes since last visit
Fish _____

Number of episodes since last visit
Shellfish _____

Number of episodes since last visit
Wheat _____

Number of episodes since last visit
Soy/tofu _____

Number of episodes since last visit
Seeds _____

IF other, specify:
Other 1 _____

Number of episodes since last visit
Other 1 _____

IF other, specify:
Other 2 _____

Number of episodes since last visit
Other 2 _____

IF other, specify:
Other 3 _____

Number of episodes since last visit
Other 3 _____

IF other, specify:
Other 4 _____

Number of episodes since last visit
Other 4 _____

IF other, specify:
Other 5 _____

Number of episodes since last visit
Other 5 _____

IF other, specify:
Other 6 _____

Number of episodes since last visit
Other 6 _____

28. For food that you child had an allergic reaction to since the last visit, how long does it usually take form eating the food to the onset of the allergic symptoms.?

¿Después de comer la comida, cuánto tiempo toma para los síntomas a aparecer?

28. How long does it usually take from eating the food to the onset of the allergic symptoms for COW'S MILK/DAIRY PRODUCTS/CHEESE?
(Time until onset in DAYS)

¿Después de comer la comida, cuánto tiempo toma para los síntomas a aparecer?

_____
(number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for COW'S MILK/DAIRY PRODUCTS/CHEESE?
(Time until onset in HOURS)

¿Después de comer la comida, cuánto tiempo toma para los síntomas a aparecer?

_____
(number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for COW'S MILK/DAIRY PRODUCTS/CHEESE? (Time until onset in MINUTES)

¿Después de comer la comida, cuánto tiempo toma para los síntomas a aparecer?

_____ (number of minutes)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for EGGS? (Time until onset in DAYS)

_____ (number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for EGGS? (Time until onset in HOURS)

_____ (number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for EGGS? (Time until onset in MINUTES)

_____ (number of minutes)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for PEANUTS? (Time until onset in DAYS)

_____ (number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for PEANUTS? (Time until onset in HOURS)

_____ (number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for PEANUTS? (Time until onset in MINUTES)

_____ (number of minutes)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for TREE NUTS? (Time until onset in DAYS)

_____ (number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for TREE NUTS? (Time until onset in HOURS)

_____ (number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for TREE NUTS? (Time until onset in MINUTES)

_____ (number of minutes)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for FISH? (Time until onset in DAYS)

_____ (number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for FISH? (Time until onset in HOURS)

_____ (number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for FISH? (Time until onset in MINUTES)

_____ (number of minutes)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for SHELLFISH? (Time until onset in DAYS)	_____ (number of days)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SHELLFISH? (Time until onset in HOURS)	_____ (number of hours)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SHELLFISH? (Time until onset in MINUTES)	_____ (number of minutes)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for WHEAT? (Time until onset in DAYS)	_____ (number of days)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for WHEAT? (Time until onset in HOURS)	_____ (number of hours)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for WHEAT? (Time until onset in MINUTES)	_____ (number of minutes)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SOY/TOFU? (Time until onset in DAYS)	_____ (number of days)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SOY/TOFU? (Time until onset in HOURS)	_____ (number of hours)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SOY/TOFU? (Time until onset in MINUTES)	_____ (number of minutes)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SEEDS? (Time until onset in DAYS)	_____ (number of days)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SEEDS? (Time until onset in HOURS)	_____ (number of hours)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for SEEDS? (Time until onset in MINUTES)	_____ (number of minutes)
28. Name of Other Food Allergy #1	_____
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #1? (Time until onset in DAYS)	_____ (number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #1? (Time until onset in HOURS)	_____ (number of hours)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #1? (Time until onset in MINUTES)	_____ (number of minutes)
28. Name of Other Food Allergy #2	_____
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #2? (Time until onset in DAYS)	_____ (number of days)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #2? (Time until onset in HOURS)	_____ (number of hours)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #2? (Time until onset in MINUTES)	_____ (number of minutes)
28. Name of Other Food Allergy #3	_____
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #3? (Time until onset in DAYS)	_____ (number of days)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #3? (Time until onset in HOURS)	_____ (number of hours)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #3? (Time until onset in MINUTES)	_____ (number of minutes)
28. Name of Other Food Allergy #4	_____
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #4? (Time until onset in DAYS)	_____ (number of days)
28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #4? (Time until onset in HOURS)	_____ (number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #4?
(Time until onset in MINUTES)

_____ (number of minutes)

28. Name of Other Food Allergy #5

_____

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #5?
(Time until onset in DAYS)

_____ (number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #5?
(Time until onset in HOURS)

_____ (number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #5?
(Time until onset in MINUTES)

_____ (number of minutes)

28. Name of Other Food Allergy #6

_____

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #6?
(Time until onset in DAYS)

_____ (number of days)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #6?
(Time until onset in HOURS)

_____ (number of hours)

28. How long does it usually take from eating the food to the onset of the allergic symptoms for OTHER FOOD ALLERGY #6?
(Time until onset in MINUTES)

_____ (number of minutes)

29. Since the last visit, has your child ever had an allergic reaction that improved completely and then came back?

¿En el último año, ha tenido ... una reacción alérgica que mejoró completamente y luego regreso?

29. Since the last visit, has your child ever had an allergic reaction that improved completely and then came back?

◯ Yes
◯ No

29. If yes, timing to onset of recurrent symptoms:
Cow's Milk/Dairy Products/Cheese
Days

_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Cow's Milk/Dairy Products/Cheese
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Cow's Milk/Dairy Products/Cheese
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Eggs
Days
_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Eggs
Hours
_____ (hours)

29. If yes, timing to onset of recurrent symptoms:
Eggs
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Peanut
Days
_____ (days)

29. If yes, timing to onset of recurrent symptoms:
Peanut
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Peanut
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Tree nuts
Days
_____ (days)

29. If yes, timing to onset of recurrent symptoms:
Tree nuts
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Tree nuts
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Fish
Days
_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Fish
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Fish
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Shellfish
Days _____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Shellfish
Hours _____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Shellfish
Minutes _____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Wheat
Days _____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Wheat
Hours _____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Wheat
Minutes _____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Soy/Tofu
Days _____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Soy/Tofu
Hours _____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Soy/Tofu
Minutes _____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Seeds
Days _____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Seeds
Hours _____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Seeds
Minutes _____ (Min)

29. If yes, timing to onset of recurrent symptoms:
Other 1
Days _____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Other 1
Hours _____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Other 1
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Other 2
Days
_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Other 2
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Other 2
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Other 3
Days
_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Other 3
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Other 3
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Other 4
Days
_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Other 4
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Other 4
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Other 5
Days
_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Other 5
Hours
_____ (Hours)

29. If yes, timing to onset of recurrent symptoms:
Other 5
Minutes
_____ (Minutes)

29. If yes, timing to onset of recurrent symptoms:
Other 6
Days
_____ (Days)

29. If yes, timing to onset of recurrent symptoms:
Other 6
Hours

_____
(Hours)

29. If yes, timing to onset of recurrent symptoms:
Other 6
Minutes

_____
(Minutes)

Pediatric Sleep Questionnaire

A47. Does the time at which your child goes to bed change a lot from day to day?

¿La hora en que... duerme cambia mucho cada día o normalmente duerme a la misma hora cada día?

◯ Yes
◯ No
◯ Don't know

A48. Does the time at which your child gets up from bed change a lot from day to day?

¿La hora en que... levante cambia mucho cada día o se levante a la misma hora cada día?

◯ Yes
◯ No
◯ Don't know

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

¿A que hora duerme... normalmente durante la semana?

_____
(24hr)

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

¿A que hora duerme... normalmente durante la fin de semana?

_____
(24hr)

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

¿A que hora se levanta ... normalmente la semana?

_____
(24 hr)

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

¿A que hora se levanta... normalmente durante la fin de semana?

_____
(24 hr)

A.53 How many hours of sleep does your child usually get on (weekday) school nights?
Hours

_____
(Hours)

A.53 How many hours of sleep does your child usually get on (weekday) school nights?
Minutes

_____
(Minutes)

A.54 How many hours of sleep does your child usually get on (weekend) non-school nights?
Hours

_____
(Hours)

A.54 How many hours of sleep does your child usually get on (weekend) non-school nights?
Minutes

_____
(Minutes)

If the child is < 2 years old skip to question B10

B7. Does your child wake up with headaches in the morning?

¿Normalmente, tiene...dolor de cabeza en la mañana?

◯ Yes
◯ No
◯ Don't know

B8. Does your child get a headache at least once a month, on average?

¿Tiene dolor de cabeza al menos una vez por mes?

◯ Yes
◯ No
◯ Don't know

B10. Does your child still have tonsils and/or adenoids?

¿Tiene... sus amígdalas o adenoides o han sido removidos? (por una cirugía)

◯ Yes
◯ No
◯ Don't know

If not, when were they removed?
years

_____
(years)

If not, when were they removed?
Months

_____
(Months)

B11. Has your child ever had a condition causing difficulty with breathing?

¿Ha tenido... un problema que causa dificultad para respirar?

◯ Yes
◯ No
◯ Don't know

If so, please describe

_____

30. On an average day, how many hours and minutes does your child watch Tv?

◯ Don't know

30. On an average day, how many hours and minutes does your child watch TV?
Hours

¿Cuántas horas por día mira televisión?
Horas

_____
(Hours/ horas)

30. On an average day, how many hours and minutes does your child watch TV?

¿Cuántas horas por día mira televisión?

_____
(Minutes)

31. On an average day, how many hours and minutes does your child spend playing video games or sitting in front of the computer? Include both time spent on the computer at home and at school.

◯ Don't know

31. On an average day, how many hours and minutes does your child spend playing video games or sitting in front of the computer? Include both time spent on the computer at home and at school.
Hours

¿Cuántas horas por día está... en la computadora?

_____
(Hours)

31. On an average day, how many hours and minutes does your child spend playing video games or sitting in front of the computer? Include both time spent on the computer at home and at school.
Minutes

¿Cuántas horas por día está... en la computadora?

_____
(Minutes)

32. If your child goes to school, in an average week when your child is in school, how many days does your child go to physical education (PE) classes?

◯ Don't know
◯ Doesn't attend school

32. If your child goes to school, in an average week when your child is in school, how many days does your child go to physical education (PE) classes?
Days

¿En la escuela, va... a clase de gimnasia?
¿Cuántas días por semana?

_____
(Days)

33. Since the last visit, did your child play on any sports teams or participate in other organized physical activities? Some examples would include dance classes, YMCA swim classes, weekend park district, church or school basketball teams, or other teams or activities run by schools or local community centers.

¿En el último año, participó... en algunos deportes?

◯ Yes
◯ No
◯ Don't know

34. On an average day, how many hours and minutes does your child spend in active play? Some examples of active play include running around, playing catch, basketball and bicycling. (PROMPT: If respondent indicates that answer would vary based on the time of year, ask them to average out their child's activity. For example, if the answer in the summer would be 8 hours a day, and in the winter 4 hours, the answer should be hours. You may need to help them with the math.
Hours

¿Cuántas horas por día está corriendo, jugando, haciendo muy activo(a)?

_____
(Hours)

34. On an average day, how many hours and minutes does your child spend in active play? Some examples of active play include running around, playing catch, basketball and bicycling. (PROMPT: If respondent indicates that answer would vary based on the time of year, ask them to average out their child's activity. For example, if the answer in the summer would be 8 hours a day, and in the winter 4 hours, the answer should be hours. You may need to help them with the math.
Minutes

¿Cuántas horas por día está corriendo, jugando, haciendo muy activo(a)?

_____
(Minutes)

34. On an average day, how many hours and minutes does your child spend in active play? Some examples of active play include running around, playing catch, basketball and bicycling. (PROMPT: If respondent indicates that answer would vary based on the time of year, ask them to average out their child's activity. For example, if the answer in the summer would be 8 hours a day, and in the winter 4 hours, the answer should be hours. You may need to help them with the math.
Hours

◯ Don't know
(Hours)

35. About how physically active is you child compared to other children his/her age? Would you say about the same, a lot less, a little less, a little more, a lot more active?

¿Ud. Cree que, comparado a otros niños de la misma edad, que... es más activo, o menos activos que otros niños? ¿Mucho más (o menos) o poco más (menos)?

◯ 1. A lot less active
◯ 2. A little less active
◯ 3. Same
◯ 4. A little more active
◯ 5. A lot more active

36. Do you live close enough to your child's school that he/she could walk or bike to school?

¿Ud. Vive cerca de la escuela para que puede caminar o montar la bicicleta a escuela?

◯ Yes
◯ No
◯ Don't know
◯ Not applicable

37. How many days a week does your child bike to school?

◯ Don't know

37. How many days a week does your child bike to school?
Days

¿Cuántas días por semana monta su bicicleta para ir a la escuela?

_____
(days)

38. How many days a week does your child walk to school?

◯ Don't Know

38. How many days a week does your child walk to school?
Days

¿Cuántas días por semana camina para ir a la escuela?

_____
(Days)

Section II. Family History

39. What is your present marital status?

¿Mamá Ud. esta...?
Casada
Viuda
Divorciada
Separada
Soltera

- ◯ Married
- ◯ Widowed
- ◯ Divorced
- ◯ Separated
- ◯ Single

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

¿Qué grado de escuela Ud. terminó?

- ◯ No school
- ◯ 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)

41. Are you currently working for pay?

¿Ud. Está trabajando?

- ◯ Yes
- ◯ No
- ◯ Retired

42. What is your occupation/job title?

¿Cuál es su ocupación?

_____

41. 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
- ◯ Don't know

42. Will you answer some questions about your child's biological father?

¿Puedo preguntar sobre el padre?

- ◯ Yes
- ◯ No

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

¿Y por el padre que grado de escuela terminó el?

- ◯ 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)
- ◯ Don't know

44. Is he currently working for pay?

¿Y él está trabajando?

- ◯ Yes
- ◯ No
- ◯ Retired
- ◯ Don't know

What is his occupation/ Job title
Don't know

- ◯ Don't know

45. What is his occupation/job title?

¿Cuál es su ocupación?

_____

46. 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
- ◯ Don't know

Section III. Home Environment

47. What was your total household income last year, before taxes? (INCLUDES PUBLIC ASSISTANCE)

¿Cuál fue su ingreso familiar el año pasado antes de impuestos?

- ◯ < $5,000
- ◯ $5,000-9,999
- ◯ $10,000-14,999
- ◯ $15,000-19,999
- ◯ $20,000-24,999
- ◯ $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

48. Here are some questions about your current home:

a) How long have you lived in your current home? (TIME IN YEARS)

¿Cuántos años ha vivido Ud. en su Casa?

_____

a) How long have you lived in your current home? (TIME IN MONTHS)

_____

b) What type of housing is your home?

¿Qué tipo de casa?
aparatamento

- ◯ Single family
- ◯ Duplex
- ◯ Row House
- ◯ Condo/Apartment
- ◯ Trailer Home
- ◯ Shelter

c) # of bedrooms

¿Cuántas habitaciones tiene en la casa?

_____

d) # of bathrooms

¿Cuántos baños?

_____

e) # of people who permanently live in your home

¿Cuántas personas viven allí?

_____

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

¿Qué usa Ud. para calentar la casa?
Aceite
Electricidad
Gas

- ◯ Oil
- ◯ Electricity
- ◯ Gas

If Others, specify:

_____
(other type of fuel used for heating the home)

g) What type of stove do you use for cooking? ¿Y para cocinar? Gas Electricidad	◯ Gas ◯ Electric
If Others, specify:	_____ (other type of fuel used for cooking)
h) Do you have any wall to wall carpet in your home? ¿Hay alfombra de pared a pared en alguna parte de la casa?	◯ Yes ◯ No
If yes, specify location: Sala Sala de estar Comendar Cocina Habitaciones Sótano Baño	☐ 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? ¿Cuántos años tiene desde su casa ha sido consumado?	◯ 10 years or less ◯ 11-25 years ◯ 26-50 years ◯ 51-75 years ◯ Greater than 75 years old ◯ Don't know
49. Do you (mother of the child) currently smoke cigarettes, cigars, or pipes? ¿Ud. fuma? (¿Ha fumado?)	◯ Yes ◯ No
If yes, what do/did you smoke? Cigarrillos Cigarros Pipa	◯ Cigarettes ◯ Cigars ◯ Pipes
If yes to Q 49, Do you smoke inside the home? ¿Fuma en la casa?	◯ Yes ◯ No
How many (cigarettes, cigars, pipes) do you smoke PER DAY (Regardless of indoor or outdoor) ¿Cuántos cigarrillos fuma por día? En la casa o a fuera	_____
50a. Can I ask you about your child's biological father's smoking status?	◯ Yes ◯ No

50b. Does your child's father currently smoke cigarettes, cigars, or pipes?

¿Y el padre de ... fuma?

◯ Yes
◯ No
◯ Don't Know

If yes, what does/did he smoke?

Cigarrillos
Cigarros
Pipa

◯ Cigarettes
◯ Cigars
◯ Pipes

If yes to Q 50b,
Does he smoke inside the home?

¿Fuma él en la casa?

◯ Yes
◯ No

How many (cigarettes, cigars, pipes) does he smoke PER DAY (Regardless of indoor or outdoor)?

¿Cuántos cigarrillos fuma por día?

_____
(per day)

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

¿Hay otras personas en la casa que fuman?

◯ Yes
◯ No

How many people?

¿Cuántas personas?

_____
(# of people)

How many of them smoke inside the home?

¿Cuántas personas fuman en la casa?

_____

52. Total numbers of cigarettes smoked inside your home per day (NOT INCLUDING AMOUNT SMOKED by yourself and the father of your child)?

¿Cuántos cigarrillos fuman por día en la casa?

_____

53. Do you currently have any pets in your home?

¿Tiene Ud. mascotas o animales en la casa?

◯ Yes
◯ No

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

	Yes	No
Cat / Gato	◯	◯
Dog / Pero	◯	◯
Reptiles / Reptil	◯	◯
Rabbit / Conejo	◯	◯

Fish / Pez	◯	◯
Guinea Pig	◯	◯
Birds / Pájaro	◯	◯
Others	◯	◯

How many cats? _____

How many dogs? _____

How many reptiles? _____

How many rabbits? _____

How many fish? _____

How many guinea pigs? _____

How many birds? _____

If others, specify:
Type other 1 _____

How many others?
First other _____

If others, specify:
Type other 2 _____

How many others?
Second other _____

If others, specify:
Type other 3 _____

How many others?
Third other _____

54. Does the house you live in have any cockroaches?

¿Hay cucarachas en la casa?

◯ Yes
◯ No
◯ Unsure

55. Does the house you live in have any mice/rats?

¿Hay ratones en las casa?

◯ Yes
◯ No

56. Does the house you live in have any visible mold, mildew, water damage, leakage or seepage?

¿Hay moho o daños por agua en la casa?

◯ Yes
◯ No

56. Do you currently live in a farming environment?

¿Ud. no vive en una granja, verdad?

◯ Yes
◯ No