Appendix F. Tucson Epidemiologic Study of Obstructive Lung Diseases

*3 Month Asthma Questionnaire F-1
6, 12, 24, 36 Month Questionnaire F-19
Prenatal Questionnaire F-76
60 Month Questionnaire F-136

*3 Month Asthma Questionnaire

Background Information (To be filled out BEFORE Interview)

1. Name of Child: First: …… Last:……
2. Interviewer Initials: ___ ___ ___
3. Months since birth : (DOB __ __/__ __/__ __ __ __) Months……
4. Time Interview Began: (*Military Time*):Hour……Min……..
5. Name of respondent: First: ……Last : ……
6. Relationship of respondent to the child: (Ask over phone and check one)

Biologic mother	1	☐
Biologic father	2	☐
Adoptive mother	3	☐
Adoptive father	4	☐
Stepmother	5	☐
Stepfather	6	☐
Grandmother	7	☐
Grandfather	8	☐
Legal Guardian	9	☐
Other adult	10	☐ (specify relationship) _____

Child's Medical History/Asthma Symptoms O.

I would like to ask you some questions about how (insert name of child)_____ has been doing since our last conversation 3 months back. I will begin with questions about your child's health care:

1. Who is your child's primary (main) health care provider ?

Doctor:	1	☐
Nurse	2	☐
Physician Assistant	3	☐
Other	4	☐ (specify): ……..

2. What is the name, address and phone number of your child's health care provider?

Name: _____

Address: _____

_____

_____

Phone #: ( )_____

3. In the past 3 month how many times has your child seen this provider?

_____ time (s)

Since we last spoke, has you child had any of the following symptoms:

Symptom	A. In the past 3 months has your child had: Yes = 01 No = 02 DK = 888 NR = 999	B. If yes, How many times did your child have (Insert Symptom) ? (List # times)	C. For how many days (on average) Did your child have (Insert Symptom) ? (List # days)	D. Within the last 2 weeks has your child had (Insert Symptom) Yes = 01 No = 02 DK=888 NR=999	E. Did your child see a doctor for this symptom? Yes = 01 No = 02 DK=888 NR=999	F. If Q. E yes how many times? (Insert Number of Times Below)	G. If yes, was the doctor seen different from your regular health care provider? Yes = 01 No = 02 DK=888 NR=999 (If yes, Insert name and address of the doctor)	**(IF the Child has had the Symptom, Continue Questions in the Table on the Next Page. If NOT, SKIP to Q. 12)**
4. Runny or stuffed nose?								
5. Difficulty feeding?								
6. Ear Infection?								
7. Cough?								
REV-7A. Cough without a cold, or cough that continued after a cold ended?								
8. Barking or croupy cough?								
9. Difficulty breathing?								
10. Wheezing or whistling in the chest?								
REV-10A. Wheezing without a cold?								
11. Sore Throat								

Symptoms Cont.

Symptoms	H. Did your child go to the emergency room for this symptom? 1=Yes 2=No	I. If Q.H yes, how many times ? (Insert Number of Times Below)	J. [If the child has been to the emergency room,] which emergency room? 1=Harlem Hosp. 2= CMPC 3=Other (Please Specify) _____	K. [If the child has been to the ER,] What was the date(s) of the emergency room visit? (Indicate date(s) below)	L. Has your child been in the hospital for this symptom? 1=Yes 2=No	M. If Q. L yes, how many times? (Insert Number of Times Below)	N. If the child has been in the hospital, which hospital? 1=Harlem Hosp. 2= CMPC 3=Other (Please Specify) _____	O. If the child has been in the hospital, What was the date(s) of admision?	P. Did he/shesstay over-night? 1=Yes 2=No
4. Runny or stuffed nose?									
5. Difficulty feeding?									
6. Ear Infection?									
7. Cough?									
REV-7A. Cough without a cold, or cough that continued after a cold ended?									
8. Barking or croupy cough?									
9. Difficulty breathing?									
10. Wheezing or whistling in the chest?									
REV-10A. Wheezing without a cold?									
11. Sore Throat									

Note: Please make sure to record an answer in the box for questions REV-11A, 11B, 11C, and 11D.
DK=88
NR=99

REV – 11A.	All together, how many times during the past three months has your child been to the ER for ANY symptoms?	☐☐
REV- 11Ai	How many of these times for the BREATHING problems (7 – 10) above?	☐☐
REV – 11B.	All together, how many times during the past three months has your child been to the doctor's office for ANY symptoms?	☐☐
REV- 11Bi	How many of these times for the BREATHING problems (7 – 10) above?	☐☐
REV – 11C.	All together, how many times during the past three months has your child been hospitalized for ANY symptoms?	☐☐
REV- 11Ci	How many of these times for the BREATHING problems (7 – 10) above?	☐☐
REV – 11D.	All together, how many times during the past three months has your child been hospitalized overnight for ANY symptoms?	☐☐
REV- 11Di	How many of these times for the BREATHING problems (7 – 10) above?	☐☐

12. In the last 3 months, on how many nights during a typical week (7 nights) was your sleep interrupted because your child has trouble breathing?

    _____ nights

13. In the past three months, have you or your baby's father lost work time because of your child's breathing problems?
    Include time you were not able to do your daily work even if you are not employed outside of the home.

Yes	01
No	02
DK	888
NR	999

Since we last spoke, which was about three months ago, have you been told by a doctor or a nurse that (insert name of child) had any of the following problems:

Medical Problem	A. Has your child had: Yes = 1 No = 2 DK = 888 NR = 999	B. If yes, Was he/she hospitalized for this? Yes = 01 No = 02 DK=888 NR=999	C. Which hospital Was he/she in? (List name and location of hospital) 1=Harlem Hospital 2=CPMC 3=Other (Please Specify _____)	What was the date of your child's admission? (List Month/Day/ Year)	D. Could you give us your child's medical record number? (List MRN if it is given)
14. Pneumonia					
15. Bronchiolitus					
16. Bronchitis					
17. Croup					
18. Sinus trouble					
19. Pulmonary Tuberculosis					
20. Other Infections					
REV-20A. Specify					
21. Any other illnesses/ Accidents					
REV-21A. Specify					

22. Does your child ever get attacks of runny or itchy eyes other than from colds?

Yes	01
No	02
DK	888
NR	999

23. Does your child ever get attacks of sneezing or runny nose other than from colds?

Yes	01
No	02
DK	888
NR	999

24. Has your doctor ever said that your child has asthma?

Yes	(Ask A-C)	01
No	(Ask REV-24A)	02
DK		888
NR		999

REV-24A. Has your doctor ever said that your child MIGHT HAVE asthma or asthma symptoms?

Yes	(Ask A-C)	01
No		02
DK		888
NR		999

A. Which best describes your child's level of symptoms in the last 3 months?

The child has had asthma and needed medication on a regular basis, and also had one or more attacks requiring additional treatment.	01
The child has had asthma and needed medication on a routine basis, but did not have any attacks while on medication.	02
The child has had some asthma, needing medication only for occasional attacks	03
The child has had some asthma, but did not take any medicine for it	04
The child has not been troubled by asthma	05
DK	888
NR	999

B. At what age did your child's asthma start? _____ Age in Months

C. Does your child take medicine for his/her asthma at this time?

Yes	(Ask D)	01
No	(SKIP to F)	02
DK		888
NR		999

D. If yes, What is the name of the medicine used for his/her asthma? What Dose? How often does he/she take the medicine?
How is the medicine given? (As a pill (P), capsule (c), liquid (L), inhaler pump (I), or nebulizer machine (N) ?

Medication Name	Dosage Taken (Amount taken each time)	Frequency (Number of times per day)	Form/Route (pills,caps,liquid,MDI,Neb)
1)			P C L I N
2)			P C L I N
3)			P C L I N
4)			P C L I N

E. In the past 3 months has your child taken any asthma medication on a daily basis (i.e. every day for more than 2 weeks)?

Yes	01
No	02
DK	888
NR	999

F. Has he/she been hospitalized overnight for asthma in the last 3 months?

Yes (Ask G-H)	01
No	02
DK	888
NR	999

G. Specify Hospital _____

H. Date of Admission: Month_____ Day_____ Year_____

25. Has he/she been hospitalized overnight for the asthmatic or wheezy bronchitis in the last 3 months?

Yes	(Ask A-B)	01
No	(SKIP to C)	02
DK		888
NR		999

A. Specify Hospital _____

B. Date of Admission: Month_____ Day_____ Year_____

C. Does he/she currently take medicine for his/her asthmatic or wheezy bronchitis?

Yes	01
No	02
DK	888
NR	999

26. Has your doctor ever said that your child has eczema?

Yes	(Ask A-D)	01
No	(SKIP to 27)	02
DK		888
NR		999

A. Does he/she currently take medicine on the skin or by mouth for eczema?

Yes	01
No	02
DK	888
NR	999

B. Has he/she been hospitalized overnight for eczema in the last 3 months?

Yes	(Ask C-D)	01
No		02
DK		888
NR		999

C. Specify Hospital _____

D. Date of Admission: Month_____ Day_____ Year_____

27. Some parents have told us they find other remedies helpful for breathing problems such as soups, teas, oils, and salves that they make at home or buy from a store. In the past 3 months have you used any home remedies for your child's breathing problems?

Yes	(Ask A)	01
No		02
DK		888
NR		999

A. If, yes list names of remedies and how they are used (taken by mouth, rubbed, inhaled by patient)?

Name of Remedy	Route of Administration (Oral, topical, inhaled)	Frequency (Number of times per day)
1)		
2)		
3)		
4)		

REV-27A.
List all OTHER medicines that your child used during the past 3 months? What Dose? How often does he/she take the medicine?
How is the medicine given? (As a pill (P), capsule (c), liquid (L), inhaler pump (I), or nebulizer machine (N)?

Medication Name	Dosage Taken (Amount taken each time)	Frequency (Number of times per day)	Form/Route (pills,caps,liquid,MDI,Neb)
1)			P C L I N
2)			P C L I N
3)			P C L I N
4)			P C L I N

REV-28. Please tell me if your child has been given any of the following medications during the past three months: (Circle Yes = 1 or No = 0)

		Yes	No	DK	If Yes Dose	If Yes: Frequency
1)	proventil, ventolin, albuterol	1	0	8	_____	_____
2)	salmeterol, serevent	1	0	8	_____	_____
3)	flovent, beclovent, vanceril, aerobid, azmacort	1	0	8	_____	_____
4)	intal, cromolyn, tilade, nedocromil	1	0	8	_____	_____
5)	theophylline, slobid, theodur, uniphyl	1	0	8	_____	_____
6)	prednisone, prelone, pediapred	1	0	8	_____	_____
7)	singulare	1	0	8	_____	_____

Infant Diet P.

1. Was your baby breast fed at all (after delivery/ since our last phone contact)?

Yes	(Ask 6)	01
No	(Skip to 12)	02
DK		888
NR		999

2. Is your baby currently being breast fed?

Yes	(Skip to 1)	01
No	(Ask 12)	02
DK		888
NR		999

3. How old was your baby when you completely stopped breast feeding?

_____ Weeks (OR _____ Days)

4. Is your baby currently taking formula regularly?

Yes	01
No	02
DK	888
NR	999

5. Has the baby been given any foods other than breast milk or formula, even if only in tiny amounts?

Yes	(Ask A)	01
No	(SKIP A)	02
DK		888
NR		999

A. At what age did you start feeding solid foods to your baby? _____ Months

Maternal-Paternal Allergies/Asthma Q.

1. Have you ever been diagnosed with asthma?

Yes	01
No	02
DK	888
NR	999

2. If yes, have you ever been hospitalized or visited the emergency room for your asthma?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. How many times _____

3. Have you ever been diagnosed with hay fever?

Yes (Ask A-C)	01
No	02
DK	888
NR	999

A. When were you diagnosed? ___ ___/ ___ ___ ___ ___
(mo) (yr)

B. How often do you have symptoms? _____ Times per month

C. What causes your symptoms? _____

4. Have you ever been diagnosed with atopic dermatitis or eczema (a specific type of scaly skin rash)?

Yes (Ask A-C)	01
No	02
DK	888
NR	999

A. When were you diagnosed? ___ ___/ ___ ___ ___ ___
(mo) (yr)

B. How often do you have symptoms? _____ Times per month

C. What triggers your symptoms? _____

5. Do you have any allergies?

Yes (Ask A-M)	01
No	02
DK	888
NR	999

A-M. What are you allergic to?

Codes 1=Yes 2=No

A.	Dust		_____
B.	Cats		_____
C.	Dogs		_____
D.	Trees		_____
E.	Grass		_____
F.	Weeds		_____
G.	Molds		_____
H.	Certain Drugs	Specify_____	_____
I.	Certain Foods	Specify_____	_____
J.	Cockroaches		_____
K.	Mice		_____
L.	Rats	1	_____
M.	Other	Specify _____	_____

6. Does anyone in your family have a history of asthma or allergies? (Probe: A biological relative)

Yes (Ask A)	01
No	02
DK	888
NR	999

A. Who in your family has a history of asthma or allergies? _____

7. Has your baby's father ever been diagnosed with asthma?

Yes	01
No	02
DK	888
NR	999

8. If yes, has your baby's father ever been hospitalized or visited the emergency room for his asthma?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. How many times _____

9. Has your baby's father ever been diagnosed with hay fever?

Yes (Ask A-C)	01
No	02
DK	888
NR	999

A. When was he diagnosed? ___ ___/ ___ ___ ___ ___
(mo) (yr)

B. How often does he have symptoms? _____ Times per month

C. What causes his symptoms? _____

10. Has your baby's father been diagnosed with atopic dermatitis or eczema (a specific type of scaly skin rash)?

Yes (Ask A-C)	01
No	02
DK	888
NR	999

A. When was he diagnosed? ___ ___/ ___ ___ ___ ___
(mo) (yr)

B. How often does he have symptoms? _____ Times per month

C. What triggers his symptoms? _____

11. Does your baby's father have any allergies?

Yes (Ask A-M)	01
No	02
DK	888
NR	999

A-M. What is he allergic to?

Codes
1=Yes
2=No

A.	Dust		_____
B.	Cats		_____
C.	Dogs		_____
D.	Trees		_____
E.	Grass		_____
F.	Weeds		_____
G.	Molds		_____
H.	Certain Drugs	Specify_____	_____
I.	Certain Foods	Specify_____	_____
J.	Cockroaches		_____
K.	Mice		_____
L.	Rats	1	_____
M.	Other	Specify _____	_____

12. Does anyone in your baby's father's family have a history of asthma or allergies?

Yes	(Ask A)	01
No		02
DK		888
NR		999

A. Who in your baby's father's family has a history of asthma or allergies? _____

Maternal-Immunizations/Stings T.

1. Have you ever been immunized for tetanus? (Probe: Had a shot for tetanus?)

Yes	(Ask A)	01
No		02
DK		888
NR		999

A. Have you been immunized for tetanus within the last 10 years?

Yes	01
No	02
DK	888
NR	999

2. Have you ever been immunized for mumps? (Probe: Had a shot for mumps?)

Yes	01
No	02
DK	888
NR	999

3. Have you ever had mumps?

Yes	01
No	02
DK	888
NR	999

4. Have you ever been stung by a bee?

Yes (Ask A-B)	01
No	02
DK	888
NR	999

A. When was the last time you were stung by a bee? ___ ___ / ___ ___ ___ ___

B. Did you have a severe reaction to the bee sting?

Yes	(Ask C)	01
No		02
DK		888
NR		999

C. Please describe your reaction to the bee sting.

_____

_____

5. Have you been stung by other insects such as wasps or hornets?

Yes (Ask A-C)	01
No	02
DK	888
NR	999

A. What was the insect that stung you?

Wasp	01	01
Hornet	02	02
Other _____ (Please Specify)		03
DK		888
NR		999

B. When was the last time you were stung by this insect? ___ ___ / ___ ___ ___ ___

C. Did you have a severe reaction to the insect sting?

Yes (Ask D)	01
No	02
DK	888
NR	999

D. Please describe your reaction to the insect sting.

_____
_____

6. To your knowledge, are there any crickets near your home, or near where you lived in the past?

Yes	01
No	02
DK	888
NR	999

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

6, 12, 24, 36 Month Questionnaire

____ 6 Month Questionnaire
____ 12 Month Questionnaire
____ 24 Month Questionnaire
____ 36 Month Questionnaire
____ 60 Month Questionnaire

Hello, my name is_____ I want to start by thanking you for your help with this survey. I want to let you know that all of your answers to these questions are completely confidential. If you feel uncomfortable answering any of these questions, that's fine. However, we would appreciate you being as honest as possible in your answers. We are going to be asking you about changes in the information you gave us during the last interview, so some of the questions will be the same as the questions we asked you in the previous interview. Do you have any questions before we begin? Thank you for helping us with this important project.

FOR INTERVIEWER USE ONLY

Mother's medical record number ☐☐☐☐☐☐☐

Infant's medical record number ☐☐☐☐☐☐☐

Interviewer Initials ☐☐☐

Length of interview Start_____ End_____ ☐☐☐ minutes

Language of interview
English 01
Spanish 02
Other _____ 03

Baby's Date of Birth? ☐☐/☐☐/☐☐☐☐

Baby's Weight _____ kg

Baby's Height _____ cm

Baby's Head Circumference _____ cm

Mother's Head Circumference _____ cm

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Demographics A.

3A. Have you started going to school or graduated from any schools since our last full interview (NOTE to Interviewer–
at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)?

Yes	(Ask B)	01
No		02
DK		888
NR		999

B. What degree have you obtained or what type of school are you attending?_____
_____

6. Are you currently. . .

Married,	01
Living with the same partner for 7 years or more,	02
Widowed,	03
Divorced,	04
Separated, or	05
Never married	6
DK	88
NR	99

8. From all sources in Jan-Dec of last year, what was your annual household income?
(PROBE: Were there any other sources of income, help from family or friends? About how much?)

Less than 10,000	01
10,001 - 20,000	02
20,001 - 30,000	03
30,001 - 40,000	04
40,001 - 50,000	05
50,001 - 60,000	06
60,001 - 70,000	07
70,001 - 80,000	08
80,001 - 90,000	09
More than 90,000	10
DK	888
NR	999

9. How many people were supported by that income? ☐☐

DK = 888
NR = 999

10. Think about where you live, the food you eat, and the things you can afford to do and buy. How do you feel about your overall living condition? Would you say. . .

Very satisfied,	01
Somewhat satisfied,	02
Neither satisfied or dissatisfied,	03
Somewhat dissatisfied, or	04
Very dissatisfied?	05
DK	888
NR	999

11. In the last 6 months, has there been a time when you and your family needed food but couldn't afford to buy it?

Yes	01
No	02
DK	888
NR	999

12. In the last 6 months, has there been a time when you couldn't afford a place to stay, or when you couldn't pay the rent?

Yes	01
No	02
DK	888
NR	999

13. In the last 6 months, has your gas or electricity been turned off because you couldn't afford to pay the bill?

Yes	01
No	02
DK	888
NR	999

14. In the last 6 months, have you needed to buy any type of clothing for yourself or your family but didn't buy it because you couldn't afford to pay for it?

Yes	01
No	02
DK	888
NR	999

15. In the last 6 months, has there been a time when you or a member of your family needed medicine or medical care but didn't get the treatment because you couldn't afford it?

Yes	01
No	02
DK	888
NR	999

16. Do you currently receive Medicaid?

Yes	01
No	02
DK	888
NR	999

17. Do you currently receive any type of public assistance?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. Please specify type of public assistance_____

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Child's Medical History/Asthma Symptoms O.

I would like to ask you some questions about how (insert name of child)_____ has been doing since our last conversation 3 months back. I will begin with questions about your child's health care:

26. Who is your child's primary (main) health care provider ?

Doctor:	1	☐
Nurse	2	☐
Physician Assistant	3	☐
Other	4	☐ (specify): ……..

27. What is the name, address and phone number of your child's health care provider?

Name: _____

Address: _____

_____

_____

Phone #: ( )_____

28. In the past 3 month how many times has your child seen this provider?

_____ time (s)

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Since we last spoke, has you child had any of the following symptoms:

Symptom	A. In the past 3 months has your child had: Yes = 01 No = 02 DK = 888 NR = 999	C. If yes, How many times did your child have (Insert Symptom) ? (List # times)	C. For how many days (on average) Did your child have (Insert Symptom) ? (List # days)	D. Within the last 2 weeks has your child had (Insert Symptom) Yes = 01 No = 02 DK=888 NR=999	E. Did your child see a doctor for this symptom? Yes = 01 No = 02 DK=888 NR=999	F. If Q. E yes how many times? (Insert Number of Times Below)	G. If yes, was the doctor seen different from your regular health care provider? Yes = 01 No = 02 DK=888 NR=999 (If yes, Insert name and address of the doctor)	**(IF the Child has had the Symptom, Continue Questions in the Table on the Next Page. If NOT, SKIP to Q. 12)**
29. Runny or stuffed nose?								
30. Difficulty feeding?								
31. Ear Infection?								
32. Cough?								
REV-7A. Cough without a cold, or cough that continued after a cold ended?								
33. Barking or croupy cough?								
34. Difficulty breathing?								
35. Wheezing or whistling in the chest?								
REV-10A. Wheezing without a cold?								
36. Sore Throat								

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Symptoms Cont.

Symptoms	H. Did your child go to the emergency room for this symptom? 1=Yes 2=No	I. If Q.H yes, how many times ? (Insert Number of Times Below)	J. [If the child has been to the emergency room,] which emergency room? 1=Harlem Hosp. 2= CMPC 3=Other (Please Specify) _____	K. [If the child has been to the ER,] What was the date(s) of the emergency room visit? (Indicate date(s) below)	L. Has your child been in the hospital for this symptom? 1=Yes 2=No	M. If Q. L yes, how many times? (Insert Number of Times Below)	N. If the child has been in the hospital, which hospital? 1=Harlem Hosp. 2= CMPC 3=Other (Please Specify) _____	O. If the child has been in the hospital, What was the date(s) of admision?	P. Did he/shesstay over-night? 1=Yes 2=No
11. Runny or stuffed nose?									
12. Difficulty feeding?									
13. Ear Infection?									
14. Cough?									
REV-7A. Cough without a cold, or cough that continued after a cold ended?									
15. Barking or croupy cough?									
16. Difficulty breathing?									
17. Wheezing or whistling in the chest?									
REV-10A. Wheezing without a cold?									
11. Sore Throat									

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Note: Please make sure to record an answer in the boxes for questions REV-11A, 11B, 11C, and 11D.
DK=88
NR=99

REV – 11A. All together, how many times during the past three months has your child been to the ER for ANY symptoms? ☐☐

REV- 11Ai How many of these times for the BREATHING problems (7 – 10) above? ☐☐

REV – 11B. All together, how many times during the past three months has your child been to the doctor's office for ANY symptoms? ☐☐

REV- 11Bi How many of these times for the BREATHING problems (7 – 10) above? ☐☐

REV – 11C. All together, how many times during the past three months has your child been hospitalized for ANY symptoms? ☐☐

REV- 11Ci How many of these times for the BREATHING problems (7 – 10) above? ☐☐

REV – 11D. All together, how many times during the past three months has your child been hospitalized overnight for ANY symptoms? ☐☐

REV- 11Di How many of these times for the BREATHING problems (7 – 10) above? ☐☐

37. In the last 3 months, on how many nights during a typical week (7 nights) was your sleep interrupted because your child has trouble breathing?

_____ nights

38. In the past three months, have you or your baby's father lost work time because of your child's breathing problems?
Include time you were not able to do your daily work even if you are not employed outside of the home.

Yes	01
No	02
DK	888
NR	999

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Since we last spoke, which was about three months ago, have you been told by a doctor or a nurse that (insert name of child) had any of the following problems:

Medical Problem	A. Has your child had: Yes = 1 No = 2 DK = 888 NR = 999	E. If yes, Was he/she hospitalized for this? Yes = 01 No = 02 DK=888 NR=999	F. Which hospital Was he/she in? (List name and location of hospital) 1=Harlem Hospital 2=CPMC 3=Other (Please Specify _____)	G. What was the date of your child's admission? (List Month/Day/ Year)	H. Could you give us your child's medical record number? (List MRN if it is given)
39. Pneumonia					
40. Bronchiolitus					
41. Bronchitis					
42. Croup					
43. Sinus trouble					
44. Pulmonary Tuberculosis					
45. Other Infections					
REV-20A. Specify					
46. Any other illnesses/ Accidents					
REV-21A. Specify					

47. Does your child ever get attacks of runny or itchy eyes other than from colds?

Yes	01
No	02
DK	888
NR	999

48. Does your child ever get attacks of sneezing or runny nose other than from colds?

Yes	01
No	02
DK	888
NR	999

49. Has your doctor ever said that your child has asthma?

Yes	(Ask A-C)	01
No	(Ask REV-24A)	02
DK		888
NR		999

REV-24A. Has your doctor ever said that your child MIGHT HAVE asthma or asthma symptoms?

Yes	(Ask A-C)	01
No		02
DK		888
NR		999

B. Which best describes your child's level of symptoms in the last 3 months?

The child has had asthma and needed medication on a regular basis, and also had one or more attacks requiring additional treatment.	01
The child has had asthma and needed medication on a routine basis, but did not have any attacks while on medication.	02
The child has had some asthma, needing medication only for occasional attacks	03
The child has had some asthma, but did not take any medicine for it	04
The child has not been troubled by asthma	05
DK	888
NR	999

B. At what age did your child's asthma start? _____ Age in Months

C. Does your child take medicine for his/her asthma at this time?

Yes	(Ask D)	01
No	(SKIP to F)	02
DK		888
NR		999

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

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D. If yes, What is the name of the medicine used for his/her asthma? What Dose? How often does he/she take the medicine? How is the medicine given? (As a pill (P), capsule (c), liquid (L), inhaler pump (I), or nebulizer machine (N) ?

Medication Name	Dosage Taken (Amount taken each time)	Frequency (Number of times per day)	Form/Route (pills,caps,liquid,MDI,Neb)
1)			P C L I N
2)			P C L I N
3)			P C L I N
4)			P C L I N

E. In the past 3 months has your child taken any asthma medication on a daily basis (i.e. every day for more than 2 weeks)?

Yes	01
No	02
DK	888
NR	999

F. Has he/she been hospitalized overnight for asthma in the last 3 months?

Yes (Ask G-H)	01
No	02
DK	888
NR	999

G. Specify Hospital _____

H. Date of Admission: Month_____ Day_____ Year_____

50. Has he/she been hospitalized overnight for the asthmatic or wheezy bronchitis in the last 3 months?

Yes (Ask A-B)	01
No (SKIP to C)	02
DK	888
NR	999

A. Specify Hospital _____

B. Date of Admission: Month_____ Day_____ Year_____

C. Does he/she currently take medicine for his/her asthmatic or wheezy bronchitis?

Yes	01
No	02
DK	888
NR	999

29. Did you give your baby any other prescription medicine since our last full interview (NOTE to Interviewer– at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)?

Yes	(Ask A - E)	01
No		02
DK		888
NR		999

A. What prescription drugs your baby has been given.

[RECORD ANSWERS IN TABLE BELOW]

B. At what age was your baby started on [**INSERT MEDICATION**]?

[RECORD ANSWERS IN TABLE BELOW]

C. At **(INSERT AGE)**, how long was your baby on [**INSERT MEDICATION**]?

[RECORD ANSWERS IN TABLE BELOW]

D. At **(INSERT AGE**), how many mg of **[INSERT MEDICATION**] a day did you give your baby? (PROBE: How many pills a day did you give your baby?)

[RECORD ANSWERS IN TABLE BELOW]

E. Why **(INSERT REASON**), was your baby given **[INSERT MEDICATION**]

[RECORD ANSWERS IN TABLE BELOW]

A. Medication Name	**B. Age**	**C. mg/day**	**D. Duration**	**E. Reason**
1)				
2)				
3)				

30. Did you give your baby any non-prescription medication since our last full interview (NOTE to Interviewer– at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)? (PROBE: Have you given your baby any over the counter drugs?)

Yes	(Ask A - D)	01
No		02
DK		888
NR		999

A. What non-prescription drugs your baby has been given.

[RECORD ANSWERS IN TABLE BELOW]

B. At what age was your baby started on [**INSERT MEDICATION**]?

[RECORD ANSWERS IN TABLE BELOW]

C. At **(INSERT AGE)**, how long was your baby on [**INSERT MEDICATION**]?

[RECORD ANSWERS IN TABLE BELOW]

D. At **(INSERT AGE**), how many mg of **(INSERT MEDICATION**) a day did you give your baby? (PROBE: How many pills a day did you give your baby?)

[RECORD ANSWERS IN TABLE BELOW]

A. Medication Name	**B. Age**	**C. mg/day**	**D. Duration**
1)			
2)			
3)			

26. Has your doctor ever said that your child has eczema?

Yes	(Ask A-D)	01
No	(SKIP to 27)	02
DK		888
NR		999

C. Does he/she currently take medicine on the skin or by mouth for eczema?

Yes	01
No	02
DK	888
NR	999

D. Has he/she been hospitalized overnight for eczema in the last 3 months?

Yes	(Ask C-D)	01
No		02
DK		888
NR		999

C. Specify Hospital _____

D. Date of Admission: Month_____ Day_____ Year_____

28. Some parents have told us they find other remedies helpful for breathing problems such as soups, teas, oils, and salves that they
make at home or buy from a store. In the past 3 months have you used any home remedies for your child's breathing problems?

Yes	(Ask A)	01
No		02
DK		888
NR		999

A. If, yes list names of remedies and how they are used (taken by mouth, rubbed, inhaled by patient)?

Name of Remedy	Route of Administration (Oral, topical, inhaled)	Frequency (Number of times per day)
1)		
2)		
3)		
4)		

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

REV-28. Please tell me if your child has been given any of the following medications during the past three months:
(Circle Yes = 1 or No = 0)

		Yes	No	DK	If Yes Dose	If Yes: Frequency
1)	proventil, ventolin, albuterol	1	0	8	_____	_____
2)	salmeterol, serevent	1	0	8	_____	_____
3)	flovent, beclovent, vanceril, aerobid, azmacort	1	0	8	_____	_____
4)	intal, cromolyn, tilade, nedocromil	1	0	8	_____	_____
5)	theophylline, slobid, theodur, uniphyl	1	0	8	_____	_____
6)	prednisone, prelone, pediapred	1	0	8	_____	_____
7)	singulare	1	0	8	_____	_____

31. Has your baby been referred by a doctor for any special services? (Probe: Therapist, Specialist)?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. If yes, What Services? (Probe for detail)_____

_____

32. Do any of your child's relatives have asthma?

Yes (Ask A-K)	01
No	02
DK	888
NR	999

A-K. If yes, which relative(s)?

Codes:
Yes=01
No= 02
DK=888
NR=999

A. _____Mother

B. _____Maternal Grandmother

C. _____Maternal Grandfather

D. _____Father

E. _____Paternal Grandmother

F. _____Paternal Grandfather

G. _____Sisters Number with Asthma_____

H. _____Brothers Number with Asthma_____

I. _____Aunt(s)

J. _____Uncle(s)

K. _____Cousin(s)

33. Do any of your child's relatives have allergies?

Yes	(Ask A-K)	01
No		02
DK		888
NR		999

A-K. If yes, which relative(s)?

Codes:
Yes=01
No= 02
DK=888
NR=999

A. _____Mother

B. _____Maternal Grandmother

C. _____Maternal Grandfather

D. _____Father

E. _____Paternal Grandmother

F. _____Paternal Grandfather

G. _____Sisters Number with Allergies_____

H. _____Brothers Number with Allergies_____

I. _____Aunt(s)

J. _____Uncle(s)

K. _____Cousin(s)

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Employment C.

1A. Has your employment status changed since our last full interview (NOTE to Interviewer– at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)? (Probe: Did you leave your job? Get a new job?).

Yes		01
No	(SKIP to Environmental Exposures)	02
DK		888
NR		999

2. What type of work have you been doing?

Sales	01
Restaurant/Fast Food	02
Telemarketing	03
School Employee	04
Health Care	05
Factory	06
Office Work	07
Other (Specify_____)	08

3. For any jobs you have held since our last visit, please tell me the type of business, your position and dates of your employment, and your employer's address.

Job 1: Type of business_____

Your position_____

Dates of employment_____

Employer's Address_____

Job 2: Type of business_____

Your position_____

Dates of employment_____

Employer's Address_____

Job 3: Type of business_____

Your position_____

Dates of employment_____

Employer's Address _____

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

4. At each job, what is the average number of hours you (work/worked) a week?

Job 1		Job 2		Job 3	
☐☐		☐☐	☐☐		
INAP	777	INAP	777	INAP	777
DK	888	DK	888	DK	888
NR	999	NR	999	NR	999

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Environmental Exposures D.

Now I am going to ask you about your baby's environmental exposures since our last full interview (NOTE to Interviewer–
at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)?

A. Has your baby been exposed to **[INSERT EXPOSURE]** ?

[RECORD ANSWER IN TABLE BELOW]

If Yes, **ASK**:

B. Was your baby's exposure direct (did your baby have contact with (i.e. touch, inhale) the substance)?

[RECORD ANSWER IN TABLE BELOW]

C. On average, since our last full interview how often is your baby exposed to **[INSERT EXPOSURE]** ? Would you say. . .

[RECORD ANSWER IN TABLE BELOW]

D. At what age(s) was your baby first exposed to **[INSERT EXPOSURE] ?**.

[RECORD ANSWER IN TABLE BELOW]

EXPOSURE	A. Exposure Since our last visit Yes = 1 No = 2 DK = 888 NR = 999	A. Direct Exposure Yes = 01 No = 02 i.e.) It touched the baby's skin	C. Frequency Daily = 1 2-3/ week = 2 1/ week = 3 1/ month = 4 <1/ month = 5	D. List age baby was exposed (In Months)
1. Coal products from hot asphalt or tar roofing material				
2. Mercury				
3. Paint or paint products				
Pesticides (herbicides) from:				
9. agriculture				
10. gardening/landscaping				
11. spraying for insects in your home				
12. Wood stoves, fireplace				

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Smoking E.

1. Have you smoked cigarettes since our last full interview (NOTE to Interviewer– at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)?

Yes	(Ask 2)	01
No	(SKIP 10)	02
DK		888
NR		999

A. How many cigarettes do you smoke a day? ☐☐

INAP = 777
DK = 888
NR = 999

10**. Since our last visit**, has a household member or regular visitor to your house smoked cigarettes, pipes, marijuana, or cigars in your home? (PROBE: These people may include family, friends, housekeepers, babysitters or roommates).

Yes	(ASK A-D)	01
No		02
DK		888
NR		999

A. Can you please tell me the number of smokers in your home, and by home, we mean the place where you spend the most time?

☐☐

B. In your home **since our last full interview**, how many months in a row was your baby exposed to **(INSERT TOBACCO)** smoke in the air from other people smoking?
[RECORD ANSWER IN TABLE BELOW]

C. In your home since our last full interview - about how many hours a day is your baby exposed to smoke from **[INSERT TOBACCO]** ? (PROBE: About how many hours each day is your baby exposed to your own or someone else's smoke?)

D. In your home **since our last full interview**, how many **(INSERT TOBACCO)** per day was your baby exposed to?
[RECORD ANSWER IN TABLE BELOW]

	B.Months Exp.	C. Hrs/Day	D. Cig/Day
11) Cigarette			
12) Marijuana			
13) Pipe			
14) Cigar			

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

20**. Since our last full interview**, outside of your house, has your baby been exposed to smoke from cigarettes, pipes, marijuana, or cigars (NOTE to Interviewer re. last full interview–at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)?

Yes	(ASK A-D)	01
No		02
DK		888
NR		999

21-24. Outside of your home, since our last full interview (NOTE to Interviewer–at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview), about how many hours a day is your baby exposed to smoke from **[INSERT TOBACCO]** ? (PROBE: About how many hours is your baby exposed to cigarette smoke?)

A. Where, outside of your home, is your child exposed to **[INSERT TOBACCO].**

[RECORD ANSWER IN TABLE BELOW]

B. Outside of your home **since our last full interview**, how many consecutive months was your baby exposed to **(INSERT PRODUCT)** smoke?

[RECORD ANSWER IN TABLE BELOW]

C. Outside of your home since our last visit - about how many hours a day is your baby exposed to smoke from **[INSERT PRODUCT]** ? (PROBE: About how many hours is your baby exposed to cigarette smoke?)

[RECORD ANSWER IN TABLE BELOW]

D.

	A. Place of Exposure (i.e. Relatives home)	B. Months Exp.	C. Hrs/Day	D. Cig/Day
21) Cigarette				
22) Marijuana				
23) Pipe				
24) Cigar				

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Residence F.

48. Have you moved to a different residence since our last full interview (NOTE to Interviewer– at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview)?

Yes	(ASK 1- 10)	01
No	(SKIP to 12)	02
INAP		777
DK		888
NR		999

CHECK TO SEE IF RESPONDENT HAS MOVED
SINCE THE LAST INTERVIEW

If NO, SKIP to Q. 12

1-10.

A) Please tell me your address including the street, city, state, zip code and country ?
[RECORD ANSWER IN TABLE BELOW]

B) Is this a house or apt?
[RECORD ANSWER IN TABLE BELOW]

C) What are the dates during which you lived at this residence?
[RECORD ANSWER IN TABLE BELOW]

D) Would you consider this area predominantly urban, suburban, or rural ?
[RECORD ANSWER IN TABLE BELOW]

Repeat Questions A - D until all residences since last full interview are listed. Begin with the remarks: "Please tell me. . .)

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Residence	A. Street	B. City	C. State Code (Postal)	D. Zip Code	E. Country USA=1 DR =2 Other = 3 (List other below in Q. 11A)	F. House/ Apt. H = 01 A = 02	G. Dates: From: _ _ /_ _ _ _	H. To: _ _ /_ _ _ _	I. Area Urban=1 Suburb=2 Rural=3 DK=888 NR=999
1.Current									
2.Previous									
3.Previous									
4.Previous									
5.Previous									
6. Previous									
7. Previous									
8. Previous									
9. Previous									
10. Previous									

*if outside the U.S. do not ask street

12. In a typical week, how many nights a week does your baby spend at your current address? Would you say:

6 -7 days		01
4 -5 days		02
2 -3 days	(ASK A-B)	03
0 -1 day	(ASK A-B)	04
DK		888
NR		999

A. What is the address where your baby stays 4-7 nights a week?

Address City State Zip☐☐☐☐☐

_____

B. In a typical week, how many nights does your baby sleep at this address? ☐

C. How many months has your baby been sleeping at this address? ☐☐mos.

INAP = 777
DK = 888
NR = 999

49. Does your child frequently spend time at another place like a relative's house, a babysitter's home, or a daycare center?

Yes	(ASK A-E)	01
No		02
DK		888
NR		999

A-B. On average, how many days per week and hours per day does your child go to this place? (Probe: Relatives house or Babysitter's house)

A. _____ Days per Week

B. _____Hours per Day

C. How would you describe the place where your child goes? (Probe: Aunt's house, daycare in a home, daycare not in a home) _____

_____

D-E. About how many other children are at this place who are:

D. Less than 2 years _____
E. Older than 2 years _____

50. Has your baby spent a total of one month or more outside of Northern Manhattan and/or the South Bronx?

Yes	(ASK A)	01
No		02
DK		888
NR		999

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

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A. Where, outside of this area, has your baby been for a total of one month or more and how much time has he/she spent there?

Place 1 _____ Number of Months _____

Place 2 _____ Number of Months _____

Place 3 _____ Number of Months _____

Place 4 _____ Number of Months _____

Place 5 _____ Number of Months _____

Place 6 _____ Number of Months _____

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

CHECK TO SEE IF RESPONDENT HAS MOVED
SINCE THE LAST INTERVIEW

If NO, SKIP to Q.20

13. For the purposes of this study, let's refer to the address where your baby spends most of his/her time as your home. Which of the following best describes your home? Is it a.....

single family house, like a town house?	(Ask A)	01
2 or 3 family house?	(Ask A)	02
building for 4-6 families, like a brownstone?	(Ask A)	03
100% residential apartment building?	(Ask A)	04
combined residential and commercial building? Or	(Ask A)	05
a temporary shelter or commune?		06
DK		888
NR		999

A. Do you . . .

own,	01
rent, (pay ½ or more of rent)	02
or live with family or friends?	03
DK	888
NR	999

14. Does your home have a basement?

Yes	01
No	02
INAP	777
DK	888
NR	999

15. Excluding a basement and/or attic, how many floors are in your building? ☐☐floors

DK=888
NR=99

16. Excluding the basement, what floor do you live on? (Note to Interviewer: Number basement as "0" and floors above consecutively).

☐☐ fl

DK	888
NR	999

17. How high are the ceilings in your home?

☐☐ft☐☐in

DK	888
NR	999

18. Excluding bathrooms and kitchens, how many rooms are there in your home?

☐☐rooms

DK	888
NR	999

[Note to Interviewer: Remember to refer to the place where the baby spends most of his/her time for the remaining Residential Questions]

19. Does your residence have a communal kitchen? (PROBE: Do you share a kitchen with other families, that is separate from your immediate living space?)

Yes	01
No	02
DK	888
NR	999

20. During the time that has passed since our last full interview (NOTE to Interviewer at 6 months/Prenatal Interview; at 12 months/6month Interview; at 24 months/12 month Interview), what room in your house has your baby spent the most time in?

Living room	01
Kitchen	02
Bedroom	03
Bathroom	04
Other (specify)_____	05
DK	888
NR	999

21. Is there a window in this room?

Yes	(ASK A)	01
No		02
DK		888
NR		999

A. Do the windows in this room face the .....

CODES: **1=YES 2 = NO**

1. Street, (ASK B) _____
2. Alley, or _____
3. Courtyard? _____

B. Is the truck or bus traffic on the street…

Light (occasional vehicles passing by)	01
Medium (many vehicles passing by)	02
Heavy (a continuous flow of traffic)	03
INAP	777
DK	888
NR	999

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

51. Where does your child usually sleep at night?

Living room	01
Kitchen	02
Child's Bedroom	03
Parent's Bedroom	04
Family Room/TV Room	05
Bathroom	06
Other (specify)_____	07
DK	888
NR	999

24. Do you notice any paint chips or dust from paint in your home?

Yes	01
No	02
DK	888
NR	999

25.Since our last visit, please tell me if you notice any [INSERT PROBLEM] in your home.

PROBLEM	
A. Rodents	
B. Roaches	
C. Other Insect Pests (i.e. ants, fleas, waterbugs, silverfish, bedbugs, bees.)	
D. Leaky pipes	
E. Mold	
F. Holes in ceilings/walls	

Codes

Yes	1
No	2
DK	8
NR	9

[Note to Interviewer: Remember to refer to the place where the baby spends most of his/her time for the remaining Residential Questions]

26. How often do you see cockroaches in your home?

Never	01
Rarely	02
Weekly	03
Daily	04
DK	888
NR	999

27. How often do you see mice in your home?

Never	01
Rarely	02
Weekly	03
Daily	04
DK	888
NR	999

28. How often do you see rats in your home?

Never	01
Rarely	02
Weekly	03
Daily	04
DK	888
NR	999

29. Have you had an exterminator (i.e. anyone other than your super) spray chemicals or any other material in your home to get rid of insects or animal pests? (Probe: Did someone/an exterminator from a company come to your home to spray for pests?)

Yes (Ask 31-38)	01
No	02
DK	888
NR	999

30. Have you, your super, or anyone else (not an exterminator) used any pest control measures (pesticides, traps, etc.) to control pests (insects, rodents) in your household?

Yes (Ask 31-38)	01
No	02
DK	888
NR	999

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

31 – 38.**[RECORD ANSWERS IN TABLE BELOW]**

A. What kind of traps or pesticides have been used?

B. What pests are they used for?

C. What brand or type of traps or pesticide (i.e. spray or powder) are used?

D. How often do you use these pest control measures? For how long have they been used?

[RECORD ANSWERS IN TABLE BELOW]

	A. Type Yes = 1 No = 2 DK = 8 NR = 9	B. Pest(s) Used For Roaches = 1 Mice or Rats = 2 Ants = 3 Roaches/Mice or Rats = 4 Roaches/Ants = 5 Mice or Rats/Ants = 6 All Three = 7	C. Brand(s) or Type(s) Used	D. Frequency/Duration of Use: > 1 Time /Week =1 1 Time /Week =2 1-3 Times / Month = 3 Once a month =4 < Once a month =5
31. Sticky traps				
32. Bait traps (e.g. Combat)				
33. Boric Acid				
34. Gel				
35. Spray by an exterminator				
36. Can Sprays				
37. The Bomb				
38. Other (specify)_____				

39. Can you give me any additional information about your pest control (rodents /roaches), (e.g., brand name, foreign products, description of original methods, etc.) ? _____.

40. Is there any water damage in your home that has not been fixed ? (signs such as scaled off paint, swollen panels, wet spots etc)

Yes	01
No	02
DK	888
NR	999

41. Do you ever add moisture to the air in your household (Probe: a humidifier or pans of water on the radiator)?

Yes (Ask A)	01
No (SKIP to 42)	02
DK	888
NR	999

A. What method (s) do you use?

Cool Mist Humidifier	01
Hot Mist Humidifier	02
Pans of Water on Radiators	03
Boiling Water on Stove	04
DK	888
NR	999

42. Has your home/apartment been renovated or had any repairs done since our last visit?

Yes (Ask Q. 43)	01
No	02
DK	888
NR	999

43. What type of repairs/renovations occurred in your home? (ASK A-G)

Codes
Yes=1
N0=2

A. Leaky pipes _____
B. Holes/Cracks in the Ceiling/Wall _____
C. Refinishing Floors _____
D. Painting _____
E. Construction (Specify_____) _____
F. Other (Specify_____) _____

G. Please describe the type of repairs/renovations and give the dates that they occurred.

TYPE OF REPAIR/RENOVATION	DATE
_____	_____
_____	_____
_____	_____

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

44. Now I'd like to ask some questions about the heating in your home. What is the main type of heating fuel in your home?

Gas	01
Electric	02
Fuel oil	03
Coal	04
Wood	05
Other (SPECIFY) _____	06
DK	888
NR	999

A. How is your home heated?

Radiator (steam or hot water)	01
Forced hot air vents	02
Other Please Specify_____	03

45. During the winter, do you use [INSERT HEATER]at least once a month to heat your home?

[RECORD ANSWERS IN TABLE BELOW]

A. In your home, how many (INSERT HEATER TYPE) do you use?

B. In the colder months, how many days a week do you use your (INSERT HEATER)?

	A. Utilize		B. # heaters in home		C. days/week in use	
	Yes (Ask B-C)	No	DK	NR		
a) a fireplace	1	2	8	9		
b) a woodstove/oven	1	2	8	9		
c) a coal stove/oven	1	2	8	9		
d) a kerosene heater	1	2	8	9		
e) an electric baseboard/ space heater	1	2	8	9		

IF RESPONDENT HAS A FIREPLACE ASK 46 IF NOT SKIP TO 47

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

46. Do you mostly burn. . . (read a-d) in your fireplace?

a)	Wood	01
b)	Coal	02
c)	Newspaper	03
d)	Garbage	04
e)	INAP	777
f)	DK	888
g)	NR	999

[Note to Interviewer: Remember to refer to the place where the baby spends most of his/her time for the remaining Residential Questions]

47. Do you currently live in the same building or within 2 blocks of:

	Insert Code Below Yes=1 No=2 DK=8 NR=9
a) a dry cleaning shop	
b) a photo developing shop	
c) an industrial plant (Probe: factory)	
d) a bus depot	
e) a sewage treatment plant	
f) a restaurant	
g) an incinerator	
h) a car repair shop	
i) other (please specify) _____	

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Cooking/Related Appliances G.

Codes
INAP= 777
DK=888
NR=999

I'd like you to tell me about the cooking appliances you use in your home. Do you have (Ask 1 - 9) in your home?

	A. In Home				Number of Times Used Per Week				Minutes of use per meal			
	Yes	No	DK	NR	B. Breakfast	C. Lunch	D. Dinner	E. Other	F. Breakfast	G. Lunch	H. Dinner	I. Other
1) an electric stove	01 Ask A-B	O2	888	999								
2) an electric oven	01 Ask A-B	O2	888	999								
3) a gas stove	01 Ask A-B	O2	888	999								
4) a gas oven	01 Ask A-B	O2	888	999								

Date __ __ /__ __ / __ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Codes
INAP= 777
DK=888
NR=999

I'd like you to tell me about the cooking appliances you use in your home. Do you have (Ask 1 - 9) in your home?

	A. In Home				Number of Times Used Per Week				Minutes of use per meal			
	Yes	No	DK	NR	B. Breakfast	C. Lunch	D. Dinner	E. Other	F. Breakfast	G. Lunch	H. Dinner	I. Other
5) a wood stove	01 Ask A-B	O2	888	999								
6) a wood oven	01 Ask A-B	O2	888	999								
7) a coal burning stove`	01 Ask A-B	O2	888	999								
8) a coal burning oven	01 Ask A-B	O2	888	999								
9) a charcoal grill	01 Ask A-B	O2	888	999								

10. Does your gas range or oven have a continuously burning pilot light?

Yes	01
No	02
INAP	777
DK	888
NR	999

11. Since our last visit, has anyone else, besides you, cooked in your house?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. In the last six months, how many hours a week did someone else spend cooking in your house?

☐☐ hrs.

DK	888
NR	999

12. Is there an exhaust fan over or near the cooking stove?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. Would you say you use the exhaust fan. . .

always or almost always while the oven/stove is on,	01
at least half the time while the oven/stove is on,	02
only when the kitchen is smoky or to get rid of odors, or	03
rarely or never?	04
INAP	777
DK	888
NR	999

13. Is the cooking oven separate from the stove?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. Is there an exhaust fan over or near the oven?

Yes (ASK B)	01
No	02
INAP	777
DK	888
NR	999

B. Would you say you use the exhaust fan. . ..

always or almost always while the oven/stove is on,	01
at least half the time while the oven/stove is on,	02
only when the kitchen is smoky or to get rid of odors, or	03
rarely or never?	04
INAP	777
DK	888
NR	999

14. Since our last visit, how often did you use the range or oven to heat your home? Would you say. . .

More than once a week,	01
2 - 4 times per month,	02
Once a month or less,	03
Only in case of power failure, or	04
Never	05
DK	888
NR	999

15. Do you use an electric air cleaner in your home?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. Since our last visit, how many times have you used it?

☐☐/month

INAP	777
DK	888

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

16. Do you burn candles in your home?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. Since our last visit, how many times have you burned candles?

☐☐/month

INAP	777
DK	888
NR	999

17. Do you burn incense or similar products in your home?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. Since our last visit, how many times have you burned incense?

☐☐/month

INAP	777
DK	888
NR	999

19. Do you ever use an air freshener in your home?

Yes (ASK A -D)	01
No	02
DK	888
NR	999

A. In what rooms do you use an air freshener?_____

B. About how many months during the year do keep/use an air freshener in your home? _____

C. What brand and type of air fresheners do you use (regularly)? _____

D. Does anyone in your home get ill, or have breathing problems, because of air fresheners?

Yes (ASK E)	01
No	02
DK	888
NR	999

E. Who in your family has such a reaction to air fresheners? _____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Activities H.

1. In a typical week, since our last visit, how many hours a day does your baby spend outdoors? Would you say your baby spends…

1-2 hrs,	01
3-4 hrs,	02
5-6 hrs, or	03
7 or more hrs outdoors?	04
INAP	05
DK	88
NR	99

2. In a typical week, since our last visit, how many hours per day does your baby spend inside your home? Would you say your baby spends. . .

1-2 hrs,	01
3-4 hrs,	02
5-6 hrs, or	03
7 or more hrs in your home?	04
INAP	05
DK	88
NR	99

5. Do you have a pet?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. What kind of pet is it? (NOTE to Interviewer If anything other than one, single dog or one cat (i.e. 4 cats) circle "Other" and describe pet situation in shaded area).

Dog	01
Cat	02
Other (Specify) _____	03
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Infant Diet P.

Now I am going to ask you some questions about your baby's diet.

1. Is your baby currently taking formula regularly?

Yes	(ASK 2)	01
No	(Skip to 3)	02
DK		888
NR		999

2. On average, how many times a day do you feed formula to your baby, (Probe: the whole 24 hours of the day)?

1 – 3	01
4 – 5	02
6 – 7	03
8 – 9	04
10 – 12	05
> 12	06
DK	888
NR	999

3. Thinking about the past 7 days, on how many days was your baby given infant formula at least once?

Number of days ☐ (If "0", SKIP to Question 5)

4. On average, how many ounces of formula does your baby drink at each formula feeding?

_____ ounces

5. How frequently does your baby cough or choke during feedings?

Never	01
Sometimes	02
Many Feedings (Often)	03
DK	888
NR	999

6. Is your baby currently being breast fed?

Yes	(Skip to 8)	01
No	(Ask 7)	02
DK		888
NR		999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

7. Was your baby breast fed at all (after delivery/ since our last phone contact)?

Yes	(Skip to 10)	01
No	(Skip to 13)	02
DK		888
NR		999

8. [IF STILL BREAST-FEEDING] How many times a day do you breast feed your baby, on average, that is in the whole 24 hours of the day?

1 – 3	01
4 – 5	02
6 – 7	03
8 – 9	04
10 – 12	05
> 12	06
DK	888
NR	999

9. About how many minutes does an average breast feeding last?

_____ Minutes

IF THE MOTHER IS STILL BREAST-FEEDING, SKIP TO Q. 13

10. [IF NO LONGER BREAST-FEEDING] What is the date that you started to wean your baby? (Probe: when you start cutting down on breast feeding) ___ ___/___ ___ ___ ___

A. How many times a days were you breast feeding when you started to wean your baby?

_____ Times per day

11. How long did it take you to stop breast feeding completely, once you decided to stop?

Less than 1 week	01
1 to 2 weeks	02
3 to 4 weeks	03
DK	888
NR	999

12. How old was your baby when you completely stopped breast feeding?

_____ Weeks

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

13-28. In the time your baby has been fed formula, have you switched the brand of formula you fed your baby? [DO NOT COUNT CHANGE FROM HOSPITAL BRAND]

Yes	(Ask A and B)	01
No	(SKIP to C)	02
DK		888
NR		999

A. What brand or brands of formula did you use before?
[RECORD ANSWERS IN TABLE BELOW]

B. Indicate Duration of use for brands used before.
[RECORD ANSWERS IN TABLE BELOW]

C. What brand or brands of formula are you using now?
[RECORD ANSWERS IN TABLE BELOW]

D. Indicate Duration of use for brands used now.
[RECORD ANSWERS IN TABLE BELOW]

13-28.

BRAND(S) USED	A. Please Mark the Brand(s) used **Before** **1 = Yes** **2 = No**	B. List Duration of Brands used **Before** **(In Weeks)**	C. Please Mark the Brand(s) used **Now** **1 = Yes** **2 = No**	D. List Duration of Brands used **Now** **(In Weeks)**
13. Alimentum				
14. Enfamil				
15. Follow-up Carnation				
16.Gerber Baby Formula				
17. Good nature				
18. Good Start				
19. Isomil				
20. I-Soyalac				
21. Nursoy				
22. Nutramigen				
23. Pregestimil				
24. Prosobee				
25. Similac				
26. SMA				
27. Soylac				
28. Other (SPECIFY)				

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

1. Has the baby been given any foods other than breast milk or formula, even if only in tiny amounts?

Yes	(Ask 30-33)	01
No	(SKIP to 34)	02
DK		888
NR		999

30. Does your baby ever have any of the following: fruits, vegetables, fruit or vegetable juices, or mashed or jarred fruit or vegetable meals, even if only in small amounts?

Yes (Ask 31)	01
No (SKIP to 32)	02
DK	888
NR	999

31. Which of the following has your child eaten (or drank) at least once a week on average for the past month? Has your child had…..

A. Juices or juice drinks (like carrot or apple juice, Hi-C, etc)?

Yes (Ask B)	01
No (SKIP to C)	02
DK	888
NR	999

B. Which juices or juice drinks has your child had at least once a week? [get brands, types, etc.] About how often does he/she have this? What is the usual amount eaten?

Juice_____ Frequency_____ Amount_____

Juice_____ Frequency_____ Amount_____

Juice_____ Frequency_____ Amount_____

Juice_____ Frequency_____ Amount_____

Juice_____ Frequency_____ Amount_____

Juice_____ Frequency_____ Amount_____

Has your child had….

C. mashed, chopped, cooked or raw fruit?

Yes (Ask D)	01
No (SKIP to E)	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

D. Which fruits has your child had at least once a week?

About how often does he/she have this? What is the usual amount eaten?

Fruit_____ Frequency_____ Amount_____

Fruit_____ Frequency_____ Amount_____

Fruit_____ Frequency_____ Amount_____

Fruit_____ Frequency_____ Amount_____

Fruit_____ Frequency_____ Amount_____

Fruit_____ Frequency_____ Amount_____

E. …. mashed, chopped, cooked or raw vegetables?

Yes (Ask F)	01
No (SKIP to 32)	02
DK	888
NR	999

F. Which vegetables has your child had at least once a week?

About how often does he/she have this? What is the usual amount eaten?

Vegetable_____ Frequency_____ Amount_____

Vegetable_____ Frequency_____ Amount_____

Vegetable_____ Frequency_____ Amount_____

Vegetable_____ Frequency_____ Amount_____

Vegetable_____ Frequency_____ Amount_____

Vegetable_____ Frequency_____ Amount_____

32. Does your child eat fish regularly, such as mackerel (areque), cod (bacalao), conch (lambi), tuna, salmon, bluefish, catfish, snapper, kingfish or any other ocean fish, whether fresh, frozen or canned?

Yes (Ask A)	01
No (SKIP to 33)	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

A. Which fish has your child had at least once a week?
About how often does he/she have this? What is the usual amount eaten?

Fish_____ Frequency_____ Amount_____

Fish_____ Frequency_____ Amount_____

Fish_____ Frequency_____ Amount_____

Fish_____ Frequency_____ Amount_____

Fish_____ Frequency_____ Amount_____

Fish_____ Frequency_____ Amount_____

33. Does your child eat any fish or shellfish (i.e. crabs) caught by people who fish in the Hudson River?

Yes (Ask A)	01
No (SKIP to 34)	02
DK	888
NR	999

A. Which river fish does your child eat?
About how often does he/she have it? What is the usual amount eaten?

Fish_____ Frequency_____ Amount_____

Fish_____ Frequency_____ Amount_____

34. Is the baby on a special diet now?

Yes (Ask A - B)	01
No (SKIP to 35)	02
DK	888
NR	999

_____

A. How long has the baby been on this diet?

_____

B. What is the reason for this diet?

1. Allergy (specify type of diet)

Yes	01
No	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

		Given on Final Version Y/N
2. Weight Reduction (specify type of diet)	Yes	01
	No	02
_____	DK	888
	NR	999
3. Religious (specify type of diet)	Yes	01
	No	02
_____	DK	888
	NR	999
4. Other (specify reason and type of diet)	Yes	01
	No	02
_____	DK	888
	NR	999

35. Has the baby been given over-the-counter products such as Scott's Emulsion, Bush or herbal teas, Gripe Water or other similar products?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. What particular products was the baby given?

_____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Infant Vitamins S.

1. Do you give your baby vitamin or mineral supplements of any kind?

Yes	(Ask 2)	01
No	(Skip to Demoralization Q. 1)	02
DK		888
NR		999

2. Does the baby get multivitamin drops or pills? [Note pills may be unlikely in an infant under two, and they are not recommended, but we might ask in case they're crushed into food or such]

Yes	(Ask A-D)	01
No	(Skip to Q. 3)	02
DK		888
NR		999

A. Which vitamins/supplements do you give your baby?

[RECORD ANSWER IN TABLE BELOW]

B. What kind or brand do you use? [PROBE FOR DETAIL]

[RECORD ANSWER IN TABLE BELOW]

C. On average, how many times per week or month do you give them to the baby ?

[RECORD ANSWER IN TABLE BELOW]

D. On average, how much liquid (or how many pills) do you give each time?

[RECORD ANSWERS IN TABLE BELOW]

E. For how long have you been giving this to the baby ?

[RECORD ANSWER IN TABLE BELOW]

F. What is the dosage of the vitamins you give to your baby?

[RECORD ANSWER IN TABLE BELOW]

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

3. Do you give the baby any other vitamin or mineral supplements such as cod liver oils, tonics etc.?

Yes	(Ask A-D)	01
No	(Skip to Q. 4)	02
DK		888
NR		999

A. Which vitamins/supplements do you give your baby?

[RECORD ANSWER IN TABLE BELOW]

B. What kind or brand do you use? [PROBE FOR DETAIL]

[RECORD ANSWER IN TABLE BELOW]

C. On average, how many times per week or month do you give them to the baby ?

[RECORD ANSWER IN TABLE BELOW]

D. On average, how much liquid (or how many pills) do you give each time?

[RECORD ANSWERS IN TABLE BELOW]

E. For how long have you been giving this to the baby ?

[RECORD ANSWER IN TABLE BELOW]

F. What is the dosage of the vitamins you give to your baby?

[RECORD ANSWER IN TABLE BELOW]

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

4. Do you give the baby any other supplements or tonics?

[REPEAT UNTIL ALL HAVE BEEN COVERED]

A. Vitamins/ Supplements Given	B. Brand or Type	C. Frequency of Use (days per wk, per mo)	D. Number of Pills Given	E. Months or Years Given	F. Dosage

Demoralization L.

Now we are going to ask you some questions about your feelings and your state of mind.during the past year.

1. During the past year, how often have you felt you were bothered by all different kinds of ailments in different parts of your body….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

2. During the past year, how often have you been bothered by feelings of sadness or depression – feeling blue….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

3. In general, how satisfied have you been with yourself in the last year….

very satisfied	0
somewhat satisfied	1
somewhat dissatisfied	3
very dissatisfied	4

4. During the past year, how often have you had attacks of sudden fear or panic….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

5. During the past year, how often have you felt confident….

very often	0
fairly often	1
sometimes	2
almost never	3
never?	4

6. During the past year, how often have you felt lonely….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

7. During the past year, how often have you been bothered by feelings of restlessness….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

8. During the past year, how often have you felt useless….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

9. During the past year, how often have you feared going crazy; losing your mind….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

10. During the past year, how often have you felt anxious….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

11. During the past year, how often have you feared something terrible would happen to you….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

12. During the past year, how often have you felt confused and had trouble thinking….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

13. During the past year, how often have you had trouble concentrating or keeping your mind on what you are doing….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

14. During the past year, how often have you felt that nothing turns out for you the way you want it to – would you say.

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

15. During the past year, how often have you felt completely hopeless about everything….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

16. During the past year, how often have you felt completely helpless….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

17. During the past year, how often have you had times when you couldn't help wondering if anything was worthwhile anymore….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

18. During the past year, how often have you been bothered by cold sweats….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

19. During the past year, how often have you had trouble with headaches or pains in the head….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

20. During the past year, how often has your appetite been poor….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

21. In general, if you had to compare yourself with the average woman your age , what grade would you give yourself for the past year….

excellent	0
good	1
average	2
below average	3
a lot below average?	4

Do you:

You are the kind of person….	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
22. who feels she has much to be proud of….	0	1	2	3	4
23. who is the worrying type – you know, a worrier….	4	3	2	1	0
24. who feels that she is a failure generally, in life….	4	3	2	1	0

25. When you have gotten angry in the last year, how often have you felt uncomfortable, like getting headaches, stomach pains, cold sweats and things like that….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

26. During the past year, how often have you feared being left all alone or abandoned….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

27. During the past year, how often have you been bothered by nervousness, being fidgety or tense….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Stress Questions R.

1. In the last month, how often have you felt that you were unable to control the important things in your life?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

2. In the last month, how often have you felt confident about your ability to handle personal problems?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

3. In the last month, how often have you felt that things are going your way?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Now we are going to ask you a few questions about your eating behaviors and house cleaning.

Cleaning N.

1. Where do people in your household usually eat meals? (Circle One)

Kitchen	1
Living room	2
Bedroom	3
Dining room	4
Other (Specify)_____	5

2. Are there any other areas where people in your household eat or snack?

Yes (Ask A)	01
No	02
DK	888
NR	999

A-E. What areas? (Circle all that apply)

	Yes	No
A. Kitchen	1	2
B. Living room	1	2
C Bedroom	1	2
D. Dining room	1	2
E. Other (Specify) _____	1	2

House cleaning questions

3. Which of these methods are ever used to clean the floors of your home?

	Never	**1-3 times /month**	**1 time per week**	**More than 1/week**
a. Vacuum	1	2	3	4
b. Dust mop or dry mop	1	2	3	4
c. Damp mop (no water spilled on floor)	1	2	3	4
d. Wet mop (involves pouring water on floor)	1	2	3	4
e. Broom	1	2	3	4
f. Other (Specify_____)	1	2	3	4

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

4. Do you own a vacuum cleaner?

Yes	(SKIP to 6)	01
No	(ASK 5)	02
DK		888
NR		999

5. Is there a vacuum in the building that you can use?

Yes	01
No	02
DK	888
NR	999

6. How often are the following conditions found in your home overnight?

	Never	**1-3 times /month**	**1 time per week**	**More than 1/week**	**INAP**
a. Food waste in an uncovered garbage can	1	2	3	4	777
b. Uncovered food in cupboards	1	2	3	4	777
c. Dirty dishes in the sink or on the countertop	1	2	3	4	777
d. Food spills or scraps on countertops, table, or stove	1	2	3	4	777
e. Un-rinsed bottles or cans	1	2	3	4	777
f. Pet food	1	2	3	4	777
g. Cat litter/feces	1	2	3	4	777
h. Dirty diapers	1	2	3	4	777

7. How frequently is your baby in the room with you when you are vacuuming, sweeping, or dusting?

Never	01
Seldom	02
Sometimes	03
Usually	04
DK	05
NR	06

WELL, we've come to the end of the interview. THANK YOU AGAIN for your participation and in helping us with this important study.

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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Prenatal Questionnaire

Hello, my name is_____ I want to start by thanking you for your help with this survey. I want to let you know that all of your answers to these questions are completely confidential. I will be asking you questions about your education, income, places you lived, your diet during pregnancy, chemicals you might have been exposed to and drugs or medication you might have taken during your pregnancy. If you feel uncomfortable answering any of these questions, that's fine. However, we would appreciate you being as honest as possible in your

For INTERVIEWER USE ONLY

Mother's medical record number		☐☐☐☐☐☐☐
Interviewer Initials		☐☐☐
Length of interview		☐☐☐ minutes
Language of interview		
English	01	
Spanish	02	
Other _____	03	
Prenatal Clinic		
CPMC Clinics	01	
Harlem Hospital Clinic	02	
_____		
Patient's due date?		☐☐/☐☐/☐☐☐☐

answers. Do you have any questions before we begin? Thank you for helping us with this important project.

Demographics A.

1. What is your date of birth? ☐☐/☐☐/☐☐☐☐

   DK 888
   NR 999

2. What is your height? (in inches) ☐☐

   DK 888
   NR 999

3. How many years of school have you completed? ☐☐

   DK 888
   NR 999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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4. What is the highest degree you have earned? (Probe: Did you receive your GED?)

Less than High School	01
Some High School	02
High School Diploma	03
GED	04
Some College Classes	05
2 Year College Degree	06
4 Year College Degree	07
4 + Years of College	08

5. Are you currently attending school?

Yes	01
No	02
DK	888
NR	999

6. Are you currently. . .

Married,	01
Living with the same partner for 7 years or more,	02
Widowed,	03
Divorced,	04
Separated, or	05
Never married	06
DK	888
NR	999

7. Now I'm going to ask questions about your household. Can you please tell me if you have a

	YES	NO	DK	NR
Freezer ?	01	02	888	999
Radio/Stereo?	01	02	888	999
TV?	01	02	888	999
Telephone?	01	02	888	999
VCR?	01	02	888	999
Car?	01	02	888	999
Computer?	01	02	888	999

8. From all sources in Jan-Dec of last year, what was your annual household income?
(PROBE: Were there any other sources of income, help from family or friends? About how much?)

Less than 10,000	01
10,001 - 20,000	02
20,001 - 30,000	03
30,001 - 40,000	04
40,001 - 50,000	05
50,001 - 60,000	06
60,001 - 70,000	07
70,001 - 80,000	08
80,001 - 90,000	09
More than 90,000	10
DK	888
NR	999

9. How many people were supported by that income? ☐☐
DK = 888
NR = 999

10. Think about where you live, the food you eat, and the things you can afford to do and buy. How do you feel about your overall living condition? Would you say. . .

Very satisfied,	01
Somewhat satisfied,	02
Neither satisfied nor dissatisfied,	03
Somewhat dissatisfied, or	04
Very dissatisfied?	05
DK	888
NR	999

11. In the last 6 months, has there been a time when you and your family needed food but couldn't afford to buy it?

Yes	01
No	02
DK	888
NR	999

12. In the last 6 months, has there been a time when you couldn't afford a place to stay, or when you couldn't pay the rent?

Yes	01
No	02
DK	888
NR	999

13. In the last 6 months, has your gas or electricity been turned off because you couldn't afford to pay the bill?

Yes	01
No	02
DK	888
NR	999

14. In the last 6 months, have you needed to buy any type of clothing for yourself or your family but didn't buy it because you couldn't afford to pay for it?

Yes	01
No	02
DK	888
NR	999

15. In the last 6 months, has there been a time when you or a member of your family needed medicine or medical care but didn't get the treatment because you couldn't afford it?

Yes	01
No	02
DK	888
NR	999

16. Do you currently receive Medicaid?

Yes	01
No	02
DK	888
NR	999

17. Do you currently receive any type of public assistance?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. Please specify type of public assistance_____

18. What is your ethnic background?

Puerto Rican	01
Mexican/Mexican American	02
Dominican/Dominican American	03
Other Hispanic/ Other Hispanic American	04
African American	05
African	06
Caribbean/Caribbean American	07
Other (SPECIFY) _____	08
DK	888
NR	999

19. In what country were you born?

U.S. (Not Puerto Rico)	01
Puerto Rico	02
Dominican Republic	03
Mexico	04
South America (SPECIFY)_____	05
Caribbean (SPECIFY)_____	06
Africa (SPECIFY)_____	07
Europe (SPECIFY)_____	08
Other (SPECIFY)_____	09
DK	888
NR	999

20. What is your mother's ethnic background?
(PROBE: What's your best guess?)

Puerto Rican	01
Mexican/Mexican American	02
Dominican/Dominican American	03
Other Hispanic/ Other Hispanic American	04
African American	05
African	06
Caribbean/Caribbean American	07
Other (SPECIFY) _____	08
DK	888
NR	999

21. What is your father's ethnic background?
(PROBE: What's your best guess?)

Puerto Rican	01
Mexican/Mexican American	02
Dominican/Dominican American	03
Other Hispanic/ Other Hispanic American	04
African American	05
African	06
Caribbean/Caribbean American	07
Other (SPECIFY) _____	08
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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22. What is your baby's father's ethnic background?
(PROBE: What's your best guess?)

Puerto Rican	01
Mexican/Mexican American	02
Dominican/Dominican American	03
Other Hispanic/ Other Hispanic American	04
African American	05
African	06
Caribbean/Caribbean American	07
Other (SPECIFY) _____	08
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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Medical History B

During your pregnancy, have you been diagnosed with . . .**[INSERT ILLNESS]. . .**

A-C. In Which Trimester did it occur?

D. Have you ever been diagnosed with (insert illness) (Probe: Before this Pregnancy)

ILLNESS	Yes Ask A-D	No Ask D	DK	NR	A. 1st Tri 01=Yes 02=No 888=DK 999=NR	B. 2nd Tri 01=Yes 02=No 888=DK 999=NR	C. 3rd Tri 01=Yes 02=No 888=DK 999=NR	D. Ever Had 01=Yes 02=NO 888=DK 999=NR
1 = high blood pressure/hypertension? (That is, BP > 160/95 and includes pregnancy induced hypertension, pre-eclampsia, toxemia and super-imposed hypertension)	01	02	888	999				
2 = diabetes?	01	02	888	999				
3 = anemia?	01	02	888	999				
4= asthma?	01	02	888	999				
5 = epilepsy?	01	02	888	999				
6 =any STD like herpes, syphilis, chlamydia.?	01	02	888	999				
7 = HIV/AIDS?	01	02	888	999				
8 = urinary tract infection or kidney infection:	01	02	888	999				
9. Other SPECIFY_____	01	02	888	999				
10.=Other SPECIFY_____	01	02	888	999				

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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11. Have you taken any prescription medicine during your pregnancy?

Yes	Ask 12-	19	01
No			02
DK			888
NR			999

12-17. Please tell me what prescription drugs you've taken during this pregnancy.

[RECORD ANSWERS IN TABLE BELOW]

C. In your **(INSERT TRIMESTER**), how long were you on [**INSERT MEDICATION**]?

[RECORD ANSWERS IN TABLE BELOW]

D. In your **(INSERT TRIMESTER**), how many mg of **(INSERT MEDICATION**) did you take a day? (PROBE: How many pills did you take a day?)

[RECORD ANSWERS IN TABLE BELOW]

Medication Name	**Yes=01 No=02**	***TRIMESTER 1***		***TRIMESTER 2***		***TRIMESTER 3***	
12. Antibiotics Specify_____		**A. Duration (In Days)**	**B. mg/day**	**B. Duration (In Days)**	**D. mg/day**	**E. Duration (In Days)**	**F. mg/day**
13. Decongestant Specify_____							
14. Pain Killer Specify_____							
15. Other Specify_____							
16. Other Specify_____							
17. Other Specify_____							

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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18. Have you taken any non-prescription medicine during your pregnancy?
(PROBE: Have you taken any over the counter drugs?)

Yes	Ask 21-27	01
No		02
DK		888
NR		999

19- 25. Please tell me what non-prescription drugs you've taken during this pregnancy.
[RECORD ANSWERS IN TABLE BELOW]

A. In your **(INSERT TRIMESTER**), how long were you on [**INSERT MEDICATION**]?

[RECORD ANSWERS IN TABLE BELOW]

B. In your **(INSERT TRIMESTER**), how many mg of **(INSERT MEDICATION**) did you take a day? (PROBE: How many pills did you take a day?
[RECORD ANSWERS IN TABLE BELOW]

Medication Name	**Yes=01 No=02**	***TRIMESTER 1***		***TRIMESTER 2***		***TRIMESTER 3***	
19. Tylenol (Acetaminophen)		**A. Duration (In Days)**	**B. mg/day**	**C. Duration (In Days)**	**D. mg/day**	**E. Duration (In Days)**	**F. mg/day**
20. Advil/Motrin (Ibuprofen)							
21. Cough Medicine Specify_____							
22. Cold Medicine Specify_____							
23. Aspirin Specify_____							
24. Other Specify_____							
25. Other Specify_____							

26. Now I'm going to ask you some questions regarding your current and past pregnancies. Excluding this pregnancy, how many times have you been pregnant? (Probe: No matter what happened with the pregnancy) **(IF 0, SKIP TO Q. 37)**

☐☐

DK = 888
NR = 999

27 – 36. [**RECORD ANSWERS IN TABLE BELOW]**

A. What was the result of your **(INSERT PREGNANCY #)** pregnancy? (PROBE: Did you have twins? Did you have a single baby? Was the baby born still born?)

B. On what date did your **(INSERT PREGNANCY #)** pregnancy end? (PROBE: What was your __(1st, 2nd, etc.) __ child's birthday? What date did you or your doctor end this pregnancy?)

C. How many weeks did this pregnancy last?

D. What was the baby's sex?

E – F. What was the baby's birth weight?

G. Is the child living?

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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*Use the following codes for birth outcome.

01= a live single birth
02= a live multiple birth
03= a stillbirth (Ask A-C ONLY)
04= a spontaneous abortion (< 20 weeks) (Ask A-C ONLY)
05= an elective abortion (Ask A-C ONLY)
06= ectopic pregnancy (Ask A-C ONLY)
07= a molar pregnancy (Ask A-C ONLY)

Question # / Pregnancy #	A. Outcome *	B. D.O.B. or Termination - - / - - / - - - -	C. Weeks pregnancy lasted	D. Baby's sex Female = 01 Male = 02	E. Baby's weight (Pounds)	F. Baby's weight (Ounces)	G Is child still alive Yes = 01 No = 02
27.) / 1							
28.) / 2							
29.) / 3							
30.) / 4							
31.) / 5							
32.) / 6							
33.) / 7							
34.) / 8							
35.) / 9							
36.) / 10							

37. What was your weight at the beginning of this (current) pregnancy? (in lbs)
(Probe Just before you became pregnant)

☐☐☐ lbs
DK = 888
NR = 999

38. What is your current weight? (in lbs) ☐☐☐ lbs
DK = 888
NR = 999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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39. Thus far, have you had any complications with this pregnancy?

Yes	(ASK 40)	01
No	(Read Complications in 40)	02
DK		888
NR		999

[NOTE TO INTERVIEWER: Read through the possible complications EVEN IF the woman says she has had no complications]

40. What complications have you had with this pregnancy?

Codes 01= Yes 02= No 888= DK 999=NR

A.	Preeclampsia, eclampsia, toxemia	___
B.	Severe Morning Sickness (Repeated vomiting with weight loss)	___
C.	Abdominal Cramps	___
D.	Vaginal Bleeding	___
E.	Vaginal Infections (Other than STDs)	___
F.	Swollen Feet	___
G.	Severe Headaches	___
H.	Diarrhea	___
I.	Constipation	___
J.	Hemorrhoids	___
K.	Other (Specify_____)	___

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Employment C.

1. During any part of your pregnancy, have you been employed (Probe: Had any type of job)?

Yes		01
No	(SKIP to Section D)	02
DK		888
NR		999

2. What type of work have you done during pregnancy?

Sales	01
Restaurant/Fast Food	02
Telemarketing	03
School Employee	04
Health Care	05
Factory	06
Office Work	07
Other (Specify_____)	08

3. For any jobs you have held during this pregnancy, please tell me the type of business, your position and dates of your employment, and your employer's address.

Job 1: Type of business_____

Your position_____

Dates of employment_____

Employer's Address_____

Job 2: Type of business_____

Your position_____

Dates of employment_____

Employer's Address_____

Job 3: Type of business_____

Your position_____

Dates of employment_____

Employer's Address _____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

4. At each job, what is the average number of hours you (work/worked) a week?

A. Job 1		B. Job 2		C. Job 3	
☐☐		☐☐		☐☐	
INAP	777	INAP	777	INAP	777
DK	888	DK	888	DK	888
NR	999	NR	999	NR	999

5. When commuting to work, how much time (in minutes) do you spend on average? (Probe:For Going One Way) (Please fill out all that apply).

A. Walking or biking _____ minutes
B. On a motorcycle / scooter / moped _____ minutes
C. In a car / taxi _____ minutes
D. In a bus / tram _____ minutes
E. In a train / subway _____ minutes

6. Now I'd like you to describe how active your workday (is/was) at your most recent job. (Probe: This question just refers to physical work. It's not a measure of your productivity)
Would you describe your workday as (Choose One). . .

Highly active - that means you are on your feet all day and constantly moving and/or lifting objects,	01
Active - that means you are on your feet all day but are in a stationary position or you spend about half your day moving around or on your feet, or	02
Sedentary - that means you sit at a desk virtually all day	03
INAP	777
DK	888
NR	999

---

7. During your pregnancy, have there been any non-routine work events, like leaks or spills in your workplace?

Yes	(Ask A-C)	01
No		02
DK		888
NR		999

A. What chemical spilled?

_____

B. Were you directly exposed to the chemical spill?
(PROBE: Did you either inhale, ingest or touch the chemical?)

Yes	01
No	02
INAP	777
DK	888
NR	999

C. How many hours were you exposed to the chemical? ☐☐.☐ hrs
(PROBE: How many minutes were you exposed?)

INAP = 777
DK = 888
NR = 999

8. During your pregnancy, were you required to wear protective clothing or a respirator?

Yes	Please Specify_____	01
No		02
INAP		777
DK		888
NR		999

9. During your pregnancy, how often did you wear protective equipment on the job? Would you say. . .

Always,	01
Sometimes,	02
Rarely, or	03
Never?	04
INAP	777
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Environmental Exposures D.

Now I am going to ask you about other environmental exposures during your pregnancy. Please think about the **current pregnancy**, either at work or at home.

A. Have you been exposed to **[INSERT EXPOSURE FROM TABLE BELOW]** ?
[RECORD ANSWER IN TABLE BELOW]

If Yes, **ASK**:

B. Was your exposure direct?
(PROBE: Did you handle [INSERT EXPOSURE]?)

C. How often are you exposed to **[INSERT EXPOSURE]** ? Would you say. . .

D. Did the exposure to **[INSERT CHEMICAL]** occur while you were at work?

E. In what trimester(s) were you exposed to **[INSERT EXPOSURE] ?**.

If NO, ASK:
F. Before your current pregnancy, have you **ever** been exposed to **[INSERT EXPOSURE**]?

G. When was the date of your last exposure?

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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EXPOSURE	A. Exposure During Pregnancy Yes= 01 No = 02 DK = 888 NR = 999	B. Direct Exposure Yes = 01 No = 02 i.e. Doing it yourself or direct contact with the substance	C. Frequency Daily = 1 2-3/ week = 2 1/ week = 3 1/ month = 4 <1/ month = 5 1 or 2 times during pregnancy = 6	D. At work Yes = 01 No = 02	E. List trimester(s) you were exposed 1st = 1 2nd =2 3rd = 3 1st & 2nd =4 1st & 3rd =5 2nd & 3rd =6 All = 7 None = 8	F. Ever Exposed Yes = 01 No = 02 DK = 888 NR = 999	G. Date of Last exposure _ _/_ _ /_ _ _ _ DK=888 NR=999
1. Coal products from hot asphalt or tar roofing material							
2. Carbon black from copying or printing machines							
3. Clothing Dyes							
Hair Products							
4. hair dyes							
5. relaxers							
6. permanent solutions							
7. Mercury							
8. Paint or paint products							
Pesticides (herbicides) from:							
9. agriculture							
10. gardening/landscaping							
11. spraying for insects							

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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12. During this pregnancy, as part of a ritual, or on someone's advice, or just because you craved it, have you eaten, inhaled or rubbed on your body any of the following items: freezer ice, laundry starch, mercury, and clay?

Yes	(ASK 14-18)	01
No	(No skip to Section E)	02
DK		888
NR		999

Items	A. First Trimester (Probe: First 3 Months of Pregnancy) Yes = 1 No = 2	B. Second Trimester (Probe: Second 3 Months of Pregnancy) Yes = 1 No = 2	C. Third Trimester (Probe: Last 3 Months of Pregnancy) Yes = 1 No = 2
13. Freezer Ice			
14. Clay			
15. Laundry Starch			
16. Mercury Dust			
17. Other (Specify) _____			

DK = 888
NR = 999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Smoking History/ Exposure E

1. Now I'd like to ask you about your smoking history. Do you smoke?

Yes	(Ask A-B)	01
No	Ask B	02
DK		888
NR		999

A. How many cigarettes do you smoke a day?

☐☐

INAP = 777
DK = 888
NR = 999

B. Are you currently using the Nicorette gum, patch, or other pharmaceutical device to help you stop smoking?

Yes	01
No	02
DK	888
NR	999

2. During your entire lifetime, have you ever smoked at least one cigarette a day for at least a 6 month period?

Yes		01
No	(SKIP TO Q. 9)	02
DK		888
NR		999

3. How old were you when you first started smoking at least one cigarette a day?

☐☐yrs old

INAP = 777
DK = 888
NR = 999

4. How many years, all together, did you smoke at least one cigarette a day?
(NOTE: Round to nearest year, if smoked < 1 year record as 1 year)

☐☐yrs

INAP = 777
DK = 888
NR = 999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

5. During the period when you smoked at least one cigarette a day, on average, how many cigarettes did you smoke a day? (PROBE: 20 cigarettes = 1 pack)

☐☐/day
INAP = 777
DK = 888
NR = 999

6. When was your last cigarette? ☐☐/☐☐/☐☐☐☐
INAP=777
DK = 888
NR = 999

7. Since the start of your pregnancy, have you . . .

decreased the amount of cigarettes you smoke,	(ASK A-B)	01
or stopped altogether?	(ASK A-B)	02
NO		03
INAP		777
DK		888
NR _____		999

A. Why did you want to decrease or stop smoking cigarettes?

Pregnant	01
Illness	02
Costs too much money	03
Knew of dangers	04
OTHER (SPECIFY)_____	05
INAP	777
DK	888
NR	999

B. After the birth of your child, do you think you'll start smoking cigarettes again?

Yes	01
No	02
INAP	777
DK	888
NR	999

8. During previous pregnancies, did you smoke cigarettes?

Yes	01
No	02
INAP	777
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

9. During your entire lifetime, have you ever smoked **[INSERT PRODUCT]** for a period of at least 6 months?

RECORD ANSWERS IN TABLE BELOW

A. How many years have you smoked (INSERT PRODUCT)

B. On average, how many (INSERT PRODUCT) did you smoke a week?

C. Have you smoked any (INSER PRODUCT) during your pregnancy?

Tobacco	Yes **Ask A-B**	No	INAP	DK	NR	A. Yrs Smoked	B. # / Week	C. During Pregnancy 1= Yes 2= No
a) Cigar	**01**	**02**	**777**	**888**	**999**			
b) Pipe	**01**	**02**	**777**	**888**	**999**			
c) Mari-juana	01	**02**	**777**	**888**	**999**			

10. **Presently**, does a household member or regular visitor to your home smoke cigarettes, pipes, marijuana, or cigars in your home? (PROBE: These people may include family, friends, housekeepers, babysitters or roommates).

Yes	(ASK A-G)	01
No	(ASK E-G)	02
DK		888
NR		999

E. Can you please tell me the number of smokers in your home, and by home, we mean the place where you spend the most time?

☐☐

F. In your home **during your pregnancy**, how many consecutive months were you exposed to someone else's **(INSERT TOBACCO)** smoke?

[RECORD ANSWER IN TABLE BELOW]

G. In your home during your pregnancy- about how many hours a day are you exposed to smoke in the air from other people smoking **[INSERT TOBACCO]** ? (PROBE: About how many hours are you exposed to someone else's smoke?)

H. In your home **during your pregnancy**, how many **(INSERT TOBACCO)** per day were you exposed to?

[RECORD ANSWER IN TABLE BELOW]

I. In your home **during the last two years**, how many consecutive months were you exposed to someone else's **(INSERT TOBACCO)** smoke?

J. In your home during the last two years - about how many hours a day are you exposed to smoke in the air from other people smoking **[INSERT TOBACCO]** ? (PROBE: About how many hours are you exposed to someone else's smoke?)

K. In your home **during the last two years**, how many **(INSERT TOBACCO)** per day were you exposed to?

	During Pregnancy			Last Two Years		
	B. Months Exp.	C. Hrs/Day	D. Cig/Day	E. Months Exp.	F. Hrs/Day	G. Cig/Day
11) Cigarette						
12) marijuana						
13) Pipe						
14) Cigar						

15. During your pregnancy, has anyone in your workplace smoked in your presence?

Yes	(ASK A-G)	01
No	(ASK E-G)	02
INAP		777
DK		888
NR		999

A. Can you please tell me the number of smokers in your workplace, and we mean the number of people who smoke in the workplace?

☐☐

B. In your **WORKPLACE during your pregnancy-** about how many hours a day are you exposed to smoke in the air from other people smoking **[INSERT TOBACCO]** ? (PROBE: About how many hours are you exposed to someone else's smoke?)

[RECORD ANSWER IN TABLE BELOW]

C. In your WORKPLACE during your pregnancy, how many consecutive months were you exposed to someone else's **(INSERT TOBACCO)** smoke?

D. In your **WORKPLACE during your pregnancy**, how many **(INSERT TOBACCO)** per day were you exposed to?

[RECORD ANSWER IN TABLE BELOW]

E. In your **WORKPLACE during the last two years -** about how many hours a day are you exposed to smoke in the air from other people smoking **[INSERT TOBACCO]** ? (PROBE: About how many hours are you exposed to someone else's smoke?)

F. In your WORKPLACE during the last two years, how many consecutive months were you exposed to someone else's **(INSERT TOBACCO)** smoke?

G. In your **WORKPLACE during the last two years**, how many **(INSERT TOBACCO)** per day were you exposed to?

	During Pregnancy			Last Two Years		
	B. Months Exp.	C. Hrs/Day	D. Cig/Day	E. Months Exp.	F. Hrs/Day	G. Cig/Day
16) Cigarette						
17) Marijuana						
18) Pipe						
19) Cigar						

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Residence F.

1-10. Now I'm going to ask you some questions about each place you have lived in over your entire lifetime. Starting with your current residence, "Please tell me. . .

[RECORD ANSWERS IN TABLE BELOW]

A-E) your (previous) address? Please include the street, city, state, zip code and country."

F) is this a house or apt?

G-H) the dates during which you lived at this residence."

I) if you would consider this area predominantly urban, suburban, or rural."

Repeat Questions A - G until history is completed. Begin with the remarks: "Please tell me. . .)

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Residence	A. Street	B. City	C. State Code (Postal)	D. Zip Code	E. Country USA=1 DR =2 Other = 3 (List other below in Q. 11A)	F. House/ Apt. H = 01 A = 02	G. Dates: From: __ __/__ __ __ __	H. To: __ __/__ __ __ __	I. Area Urban=1 Suburb=2 Rural=3 DK=888 NR=999
1.Current									
2.Previous									
3.Previous									
4.Previous									
5.Previous									
6.Previous									
7.Previous									
8.Previous									
9.Previous									
10.Previous									

*if outside the U.S. do not ask street

11. How many years have you lived in mainland U.S.A? ☐☐ yrs.

A. Other Country Lived in _____

12. In a typical week, during this pregnancy, how many nights a week do you spend at your current address? Would you say:

6 -7 days		01
4 -5 days		02
2 -3 days	(ASK A-C)	03
0 -1 day	(ASK A-C)	04
DK		888
NR		999

[IF DIFFERENT FROM CURRENT ADDRESS]

A. What is the address where you spend most of your time?

Address	City	State	Zip (Be sure to get)
			☐☐☐☐☐

B. In a typical week, how many nights are you sleeping at this address? ☐ nights

C. How many months have you been sleeping at this address? ☐☐mos.

INAP = 777
DK = 888
NR = 999

[Note to Interviewer: Refer to the place where the woman spends most of her time for the remaining Residential Questions]

13. For the purposes of this study, let's refer to this place as your home. Which of the following best describes your home? Is it a.....

single family house, like a town house?	(Ask A)	01
2 or 3 family house?	(Ask A)	02
building for 4-6 families, like a brownstone?	(Ask A)	03
100% residential apartment building?	(Ask A)	04
combined residential and commercial building? Or	(Ask A)	05
a temporary shelter or commune?		06
DK		888
NR		999

A. Do you . . .

own,	01
rent, (pay ½ or more of rent)	02
or live with family or friends?	03
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

14. Does your home have a basement?

Yes	01
No	02
INAP	777
DK	888
NR	999

15. Excluding a basement and/or attic, how many floors are in your building? ☐☐floors

DK=888
NR=999

16. Excluding the basement, what floor do you live on? (Note to Interviewer: Number Basement as "0" and floors above consecutively),

☐☐ fl

DK	888
NR	999

17. How high are the ceilings in your home? ☐☐ft☐☐in

DK	888
NR	999

18. Excluding bathrooms and kitchens, how many rooms are there in your home?

☐☐rooms

DK	888
NR	999

[Note to Interviewer: Remember to refer to the place where the woman spends most of her time for the remaining Residential Questions]

19. Does your residence have a communal kitchen? (PROBE: Do you share a kitchen with other families, that is separate from your immediate living space?)

Yes	01
No	02
DK	888
NR	999

20. During this trimester, what room in your house have you spent the most time in (i.e. Third Trimester)?

Living room	01
Kitchen	02
Bedroom	03
Bathroom	04
Other (specify)_____	05
DK	888
NR	999

21. Is there a window in this room?

Yes	(ASK A)	01
No		02
DK		888
NR		999

A. Do the windows in this room face the ..... **CODES**: **1=YES 2 = NO**

1. Street,	(ASK B)	_____
2. Alley, or		_____
3. Courtyard?		_____

B. Is the truck or bus traffic on the street…

Light (occasional vehicles passing by)	01
Medium (many vehicles passing by)	02
Heavy (a continuous flow of traffic)	03
INAP	777
DK	888
NR	999

22. In the warmer months, do you use an air conditioner in your home?

Yes	(ASK A)	01
No	(ASK A)	02
DK		888
NR		999

C. In the warmer months, would you say you leave your window open....

Never,	01
Rarely,	02
Sometimes, or	03
Almost all the time?	04
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

23. In the warmer months, do you use fans to cool your house?

Yes	(ASK A-D)	01
No		02
DK		888
NR		999

A-D. What type/s of fan/s do you use? Do you use a…

	Codes Yes = 1 No = 2
A. Ceiling Fan	____
B. Oscillating/ Table Fan (Probe: Moves back and forth)	____
C. Window Fan (Ask E)	____
D. Other (SPECIFY)_____	____

E. Do you position the window fan so that air blows. . .

In,	01
Out, or	02
Both in and out	03
DK	888
NR	999

24. Do you ever notice paint chips or dust from paint in your home?

Yes	01
No	02
DK	888
NR	999

25. During your pregnancy, please tell me if you notice any [INSERT PROBLEM] in your home.

PROBLEM	
A. Rodents	
B. Roaches	
C. Other Insect Pests (i.e. ants, fleas, waterbugs, silverfish, bedbugs, bees.)	
D. Leaky pipes	
E. Mold	
F. Holes in ceilings/walls	

Codes

Yes	1
No	2
DK	8
NR	9

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

[Note to Interviewer: Remember to refer to the place where the woman spends most of her time for the remaining Residential Questions]

31. How often have you seen cockroaches in your home?

Never	01
Rarely	02
Weekly	03
Daily	04
DK	888
NR	999

32. How often have you seen mice in your home?

Never	01
Rarely	02
Weekly	03
Daily	04
DK	888
NR	999

33. How often have you seen rats in your home?

Never	01
Rarely	02
Weekly	03
Daily	04
DK	888
NR	999

34. Have you had an exterminator (i.e. anyone other than your super) spray chemicals or any other material in your home to get rid of insects or animal pests? (Probe: Did someone/an exterminator from a company come to your home to spray for pests?)

Yes (Ask 31-38)	01
No	02
DK	888
NR	999

35. Have you, your super, or anyone else (not an exterminator) used any pest control measures (pesticides, traps, etc.) to control pests (insects, rodents) in your household?

Yes (Ask 31-38)	01
No	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

31 – 38. **[RECORD ANSWERS IN TABLE BELOW]**

A. What kind of traps or pesticides have been used?

B. What pests are they used for?

C. What brand or type of traps or pesticide (i.e. spray or powder) are used?

D. How often have these pest control measures been used? For how long have they been used?

[RECORD ANSWERS IN TABLE BELOW]

	B. Type Yes = 1 No = 2 DK = 8 NR = 9	B. Pest(s) Used For Roaches = 1 Mice = 2 Rats = 3 Ants = 4 Other = 5 (Specify)	C. Brand(s) or Type(s) Used	D. Frequency/Duration of Use: > 1 Time /Week =1 1 Time /Week =2 1-3 Times / Month = 3 Once a month =4 < Once a month =5
31. Sticky traps				
32. Bait traps (e.g. Combat)				
33. Boric Acid				
34. Gel				
35. Spray by an exterminator				
36. Can Sprays				
37. The Bomb				
38. Other (specify)_____				

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

38.1-38.8 **[RECORD ANSWERS IN TABLE BELOW]**

Now, I would like to ask you some questions about use of pest control measures during each trimester of pregnancy

A. Have the following types of traps or pesticides been used?

A.1 During the 1st trimester
A.2 During the 2nd trimester
A.3 During the 3rd trimester

B. How often have these pest control measures been used? For how long have they been used?

B.1 During the 1st trimester
B.2 During the 2nd trimester
B.3 During the 3rd trimester

C. What was the date of the last use (probe for approximate date if exact date is not know).

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

[RECORD ANSWERS IN TABLE BELOW]

	A-C. Type **Yes = 1** **No = 2** **DK = 8** **NR = 9**			**D-F. Frequency/Duration of Use:** **> 1 Time /Week =1** **1 Time /Week =2** **1-3 Times / Month = 3** **Once a month =4** **< Once a month =5**			**G. Date of last use** _ _/_ _/_ _ _ _
	A. 1st trimester	**B. 2nd trimester**	**C. 3rd trimester**	**D. 1st trimester**	**E. 2nd trimester**	**F. 3rd trimester**	
38.1. Sticky traps							_ _/_ _/_ _ _ _
38.2. Bait traps (e.g. Combat)							_ _/_ _/_ _ _ _
38.3. Boric Acid							_ _/_ _/_ _ _ _
38.4. Gel							_ _/_ _/_ _ _ _
38.5. Spray by an exterminator							_ _/_ _/_ _ _ _
38.6. Can Sprays							_ _/_ _/_ _ _ _
38.7. The Bomb							_ _/_ _/_ _ _ _
38.8. Other (specify)_____							_ _/_ _/_ _ _ _

39.. Can you give me any additional information about your pest control (rodents /roaches), (e.g., brand name, foreign products, description of original methods, etc.) ? _____

40. Is there any water damage in your home that has not been fixed ? (signs such as scaled off paint, swollen panels, wet spots etc)

Yes	01
No	02
DK	888
NR	999

41. Do you ever add moisture to the air in your household (Probe: a humidifier or pans of water on the radiator)?

Yes (Ask A)	01
No (SKIP to 42)	02
DK	888
NR	999

A. What method (s) do you use?

Cool Mist Humidifier	01
Hot Mist Humidifier	02
Pans of Water on Radiators	03
Boiling Water on Stove	04
DK	888
NR	999

42. Has your home/apartment been renovated or had any repairs done in the last two years?

Yes (Ask Q. 43)	01
No	02
DK	888
NR	999

44. What type of repairs/renovations occurred in your home? (ASK A-G)

Codes
Yes=1
N0=2

A. Leaky pipes _____
B. Holes/Cracks in the Ceiling/Wall _____
C. Refinishing Floors _____
D. Painting _____
E. Construction (Specify_____) _____
F. Other (Specify_____) _____

G. Please describe the type of repairs/renovations and give the dates that they occurred.

TYPE OF REPAIR/RENOVATION	DATE
_____	_____
_____	_____
_____	_____

44. Now I'd like to ask some questions about the heating in your home. What is the main type of heating fuel in your home?

Gas	01
Electric	02
Fuel oil	03
Coal	05
Wood	06
Other Please Specify _____	07
DK	888
NR	999

B. How is your home heated?

Radiator (steam or hot water)	01
Forced hot air vents	02
Other Please Specify_____	03

45. During the winter, do you use [INSERT HEATER]at least once a month to heat your home?

[RECORD ANSWERS IN TABLE BELOW]

D. In your home, how many (INSERT HEATER TYPE) do you use?

E. In the colder months, how many days a week do you use your (INSERT HEATER)?

	A. Utilize				B. # heaters in home	C. days/week in use
	Yes (Ask B-C)	No	DK	NR		
a) a fireplace	1	2	8	9		
b) a woodstove/oven	1	2	8	9		
c) a coal stove/oven	1	2	8	9		
d) a kerosene heater	1	2	8	9		
e) an electric baseboard/ space heater	1	2	8	9		

IF RESPONDENT HAS A FIREPLACE ASK 46 IF NOT SKIP TO 47

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

46. Do you mostly burn. . . (read a-d) in your fireplace?

a)	Wood	01
b)	Coal	02
c)	Newspaper	03
h)	Garbage	04
i)	INAP	777
j)	DK	888
k)	NR	999

[Note to Interviewer: Remember to refer to the place where the woman spends most of her time for the remaining Residential Questions]

47. Now I'd like to ask questions about your neighborhood. Do you currently live in the same building or within 2 blocks of:

	Insert Code Below Yes = 1 No = 2 DK = 8 NR = 9
a) a dry cleaning shop	
b) a photo developing shop	
c) an industrial plant	
d) a bus depot	
e) a sewage treatment plant	
f) restaurant	
g) an incinerator (Probe: Burn garbage and see black smoke)	
h) car repair garage	
i) other (please specify) _____	

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Cooking/Related Appliances G.

Codes
INAP= 777
DK=888
NR=999

I'd like you to tell me about the cooking appliances you use in your home. Do you have (Ask 1 - 9) in your home?

	A. In Home				Number of Times Used Per Week				Minutes of use per meal			
	Yes	No	DK	NR	B. Breakfast	C. Lunch	D. Dinner	E. Other	F. Breakfast	G. Lunch	H. Dinner	I. Other
1) an electric stove	01 Ask A-B	O2	888	999								
2) an electric oven	01 Ask A-B	O2	888	999								
3) a gas stove	01 Ask A-B	O2	888	999								
4) a gas oven	01 Ask A-B	O2	888	999								

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Codes
INAP= 777
DK=888
NR=999

I'd like you to tell me about the cooking appliances you use in your home. Do you have (Ask 1 - 9) in your home?

	A. In Home				Number of Times Used Per Week				Minutes of use per meal			
	Yes	No	DK	NR	B. Breakfast	C. Lunch	D. Dinner	E. Other	F. Breakfast	G. Lunch	H. Dinner	I. Other
5) a wood stove	01 Ask A-B	O2	888	999								
6) a wood oven	01 Ask A-B	O2	888	999								
7) a coal burning stove`	01 Ask A-B	O2	888	999								
8) a coal burning oven	01 Ask A-B	O2	888	999								
9) a charcoal grill	01 Ask A-B	O2	888	999								

10. Does your gas range or oven have a continuously burning pilot light?

Yes	01
No	02
INAP	777
DK	888
NR	999

11. In the past week, has anyone else, besides you, cooked in your house?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. In the last week, how many hours did someone else spend cooking in your house?

☐☐ hrs.

DK	888
NR	999

12. Is there an exhaust fan over or near the cooking stove?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. Would you say you use the exhaust fan. . .

always or almost always while the oven/stove is on,	01
at least half the time while the oven/stove is on,	02
only when the kitchen is smoky or to get rid of odors, or	03
rarely or never?	04
INAP	777
DK	888
NR	999

13. Is the cooking oven separate from the stove?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. Is there an exhaust fan over or near the oven?

Yes (ASK B)	01
No	02
INAP	777
DK	888
NR	999

B. Would you say you use the exhaust fan. (SHOW CARD). ..

always or almost always while the oven/stove is on,	01
at least half the time while the oven/stove is on,	02
only when the kitchen is smoky or to get rid of odors, or	03
rarely or never?	04
INAP	777
DK	888
NR	999

14. During the cooler months, how often do you use the range or oven to heat your home? Would you say. . .

More than once a week,	01
2 - 4 times per month,	02
Once a month or less,	03
Only in case of power failure, or	04
Never	05
DK	888
NR	999

15. Do you use an electric air cleaner in your home?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. In the past month, how many times have you used it?

☐☐/month

INAP	777
DK	888

16. Do you burn candles in your home?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. In the past month, how many times have you burned candles?

☐☐/month

INAP	777
DK	888
NR	999

17. Do you burn incense or similar products in your home?

Yes (ASK A)	01
No	02
DK	888
NR	999

A. In the past month, how many times have you burned incense?

☐☐/month

INAP	777
DK	888
NR	999

18. Do you store any of the following items in any part of your home? (READ LIST and Circle Answers)

	Yes	No	DK	NR
A. Kerosene	01	02	888	999
B. Gasoline	01	02	888	999
C. Gas-powered lawn mower	01	02	888	999
D. Paint thinner	01	02	888	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Activities H

1. Now I'd like to ask you some questions about your day-to-day activities. In a typical week, during this pregnancy, how many hours a day do you spend outdoors? Would you say you spend…

1-2 hrs,	01
3-4 hrs,	02
5-6 hrs, or	03
7 or more hrs outdoors?	04
INAP	77
DK	88
NR	99

2. In a typical week during this pregnancy, how many waking hours per day do you spend inside your home? Would you say you spend. . .

1-2 hrs,	01
3-4 hrs,	02
5-6 hrs, or	03
7 or more hrs in your home?	04
INAP	77
DK	88
NR	99

3. In a typical week, during this pregnancy, how many hours a day do you spend in transit? Would you say you spend…

1-2 hrs	01
3-4 hrs	02
5-6 hrs	03
7 or more hours in transit?	04
DK	88
NR	99

4. During this pregnancy, please tell me your 3 most common means of transportation. Start by telling me what mode of transport you take the most, then the 2nd most, and finally, your 3rd most.

CODES	
Subway	01
Bus	02
Drive	03
Walk/bike	04
Taxi/gypsy cab	05
Other (SPECIFY)_____	06

A. Most Common _____ (Insert Code here) B. 2nd Most _____ (Insert Code here) C. 3rd Most_____ (Insert Code here)

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

5. Do you have a pet?

Yes	(ASK A)	01
No		02
DK		888
NR		999

B. What kind of pet is it? (NOTE to Interviewer If anything other than one, single dog or one cat (i.e. 4 cats) circle "Other" and describe pet situation in shaded area).

Dog	01
Cat	02
Other (Specify) _____	03
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Non-alcoholic Drinks I.

A. Now I'd like to ask some questions about your diet. Let's begin with nonalcoholic drinks.
From the start of this pregnancy through today, have you drank (Ask 1-5)…(PROBE: Not even once?)

List ForQuestion A		For use in each trimester.	
Yes	1	Less than 1/day	1
No	2	1-2/day	2
DK	8	3-4/day	3
NR	9	5 or more/day	4
		INAP	7
		DK	8
		NR	9

B – D. In your [INSERT TRIMESTER], how many cups did you drink a day? Would you say [INSERT FREQUENCY]?

	A.)	Use in each Trimester		
		B) 1st Tri	C) 2nd Tri	D) 3rd Tri
1) caffeinated coffee				
2) non-herbal hot tea (i.e. Lipton)				
3) non-herbal iced tea (i.e. Lipton)				
4) caffeinated soda (including diet)				
5) hot chocolate				

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Alcoholic Drinks J.

Now I'd like to ask some questions about alcoholic drinks

1. Thinking about the year prior to your pregnancy, did you often go out or meet with friends on the weekends?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. During these outings with friends, was it common for you to have a few drinks of alcohol?

Yes	01
No	02
DK	888
NR	999

2. On an average weekend in the year prior to your pregnancy, about how many drinks would you have a night?

_____/night

DK	888
NR	999

3. In the year prior to your pregnancy, how many drinks could you hold before you felt sleepy or like you were going to pass out?

_____ # of Drinks

DK	888
NR	999

4. In the year prior to your pregnancy, have you ever awakened, in the morning, after drinking the night before, and found that you couldn't remember part of the evening before?

Yes	01
No	02
DK	888
NR	999

5. Now I'd like you to think about weekdays. On an average weekday in the year prior to your pregnancy, either after work, or just to relax how many drinks would you have a day?

_____/day

DK	888
NR	999

6. In the year prior to your pregnancy, did you ever crave a drink early in the morning?

Yes	01
No	02
DK	888
NR	999

7. Have you ever been criticized about your drinking?

Yes	01
No	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

8 – 10. A. From the start of this pregnancy through today, have you drank (INSERT ALCOHOL)…

List ForQuestion A

Yes	1
No	2
DK	8
NR	9

For questions that the respondent answers yes, Ask B-D.

B - D. In your [INSERT TRIMESTER], how many drinks of (INSERT ALCOHOL) did you have a day? Would you say [INSERT FREQUENCY] . . .

For our purposes one drink of alcohol means:
One 12 oz. container of Beer or Wine Cooler or,
A 5 oz. glass of Wine or,
One 2 oz. shot of Hard Alcohol, or one mixed drink.

Frequency Codes

Less than 1/Day	1
1-2/Day	2
3-4/Day	3
5 or more/Day	4

ALCOHOL	A.		Use in each Trimester B. TRI 1	C. TRI 2	D. TRI 3
8) wine					
9) beer					
10) hard liquor					

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Food K.

11) During your pregnancy, how often , if ever, have you eaten [INSERT FOOD]. . .

FOOD	Never	Rarely < 1/month	1-2/ month	1-2/week	>2/week	Daily	DK	NR
1) smoked meats, including poultry, beef and pork? (PROBE: Things like beef jerky, smoked turkey, etc.)	01	02	03	04	05	06	888	999
2) smoked nuts?	01	02	03	04	05	06	888	999
3) smoked fish (e.g. lox)?	01	02	03	04	05	06	888	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

12) During your pregnancy how many times have you eaten **[INSERT MEAT]** that was **[INSERT COOKING METHOD]**.

Would you say…

Never	01
Rarely (1/month or less)	02
2-3/month	03
1/week	04
2-4/week	05
Daily	06
DK	888
NR	999

	MEAT					
Cooking Method	4. Poultry	5. Hamburger	6. Steak	7. Pork (not including sausage/bacon)	8. Sausage or bacon	9. Fish
A. Fried						
B. Broiled						
C. Barbecued/ Charcoal Broiled						
D. Cooked so that it is browned or blackened on the outside (by any cooking method)						

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

13) During the last two weeks how many times have you eaten **[INSERT MEAT]** that was cooked **[INSERT COOKING METHOD]**.

Would you say…	
Never	01
1/week	02
2-4/week	03
Daily	04
DK	888
NR	999

Cooking Method	***MEAT***					
	10. Poultry	11. Hamburger	12. Steak	13. Pork (not including sausage/bacon)	14. Sausage or bacon	15. Fish
A. Fried						
B. Broiled						
C. Barbecued/ Charcoal Broiled						
D. Cooked so that it is browned or blackened on the outside (by any cooking method)						

16. Do you eat any fish or shellfish (i.e. crabs) caught by people who fish in the Hudson River?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. Which river fish do you eat?

Fluke	01
Shad	02
Striped Bass	03
Crabs	04
Blackfish	05
Whiting	06
Other specify_____	07

B. About how often do you have this fish? What is the usual amount eaten?

Fish_____ Frequency_____ Amount_____

Fish_____ Frequency_____ Amount_____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Demoralization L.

Now we are going to ask you some questions about your feelings and your state of mind.during the past year.

1. During the past year, how often have you felt you were bothered by all different kinds of ailments in different parts of your body….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

2. During the past year, how often have you been bothered by feelings of sadness or depression – feeling blue….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

3. In general, how satisfied have you been with yourself in the last year….

very satisfied	0
somewhat satisfied	1
somewhat dissatisfied	3
very dissatisfied	4

4. During the past year, how often have you had attacks of sudden fear or panic….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

5. During the past year, how often have you felt confident….

very often	0
fairly often	1
sometimes	2
almost never	3
never?	4

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

During the past year, how often have you felt lonely….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

6. During the past year, how often have you been bothered by feelings of restlessness….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

7. During the past year, how often have you felt useless….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

8. During the past year, how often have you feared going crazy; losing your mind….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

9. During the past year, how often have you felt anxious….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

10. During the past year, how often have you feared something terrible would happen to you….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

11. During the past year, how often have you felt confused and had trouble thinking….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

12. During the past year, how often have you had trouble concentrating or keeping your mind on what you are doing….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

13. During the past year, how often have you felt that nothing turns out for you the way you want it to – would you say.

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

14. During the past year, how often have you felt completely hopeless about everything….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

15. During the past year, how often have you felt completely helpless….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

16. During the past year, how often have you had times when you couldn't help wondering if anything was worthwhile anymore….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

17. During the past year, how often have you been bothered by cold sweats….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

18. During the past year, how often have you had trouble with headaches or pains in the head….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

19. During the past year, how often has your appetite been poor….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

20. In general, if you had to compare yourself with the average woman your age , what grade would you give yourself for the past year….

excellent	0
good	1
average	2
below average	3
a lot below average?	4

Do you:

You are the kind of person….	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
21. who feels she has much to be proud of….	0	1	2	3	4
22. who is the worrying type – you know, a worrier….	4	3	2	1	0
23. who feels that she is a failure generally, in life….	4	3	2	1	0

24. When you have gotten angry in the last year, how often have you felt uncomfortable, like getting headaches, stomach pains, cold sweats and things like that….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

25. During the past year, how often have you feared being left all alone or abandoned….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

26. During the past year, how often have you been bothered by nervousness, being fidgety or tense….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Vitamins M.

Now we are going to ask you some questions about your vitamin use.

1. During this pregnancy, have you taken vitamin or mineral supplements of any kind, including prenatal vitamins?

Yes	(Ask 2)	01
No	(Skip 2 – 5)	02
DK		888
NR		999

2. During this pregnancy have you taken a prenatal vitamin?

Yes	(Ask A-F, SKIP Q 3)	01
No	(Ask Q 3)	02
DK		888
NR		999

[RECORD ANSWER IN TABLE BELOW FOR A - F]

A. What prenatal vitamins have you taken?

B. What kind or brand of prenatal vitamin? [PROBE FOR DETAIL]

C. On average, how many times per week or month do you take them?

D. On average, how many do you take each day?

E. For how long have you been taking them?

F. Do you know how much of the vitamin or mineral is in them?

3. During this pregnancy have you taken a multivitamin?

Yes	(Ask A-F)	01
No		02
DK		888
NR		999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

[RECORD ANSWERS IN TABLE BELOW FOR A – F]

A. What multivitamin are you taking?

B. What kind or brand of multivitamin? [PROBE FOR DETAIL]

C. On average, how many times per week or month do you take them?

D. On average, how many do you take each day?

E. For how long have you been taking them?

F. Do you know how much of the vitamin or mineral is in them?

4. During this pregnancy, have you taken any other vitamins or minerals?

Yes	(Ask A-F and 5)	01
No	(SKIP 5)	02
DK		888
NR		999

[RECORD ANSWER IN TABLE BELOW FOR A - F]

A. What other vitamins or minerals have you taken?

B. What kind or brand of multivitamin? [PROBE FOR DETAIL]

C. On average, how many times per week or month do you take them?

D. On average, how many do you take each day?

E. For how long have you been taking them?

F. Do you know how much of the vitamin or mineral is in them?

5. During this pregnancy have you taken any other supplements? [REPEAT UNTIL ALL HAVE BEEN COVERED]

Yes	(Ask A-F)	01
No	(SKIP TO Cleaning Q. 1)	02
DK		888
NR		999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Table for Questions 1-5

A. Vitamins Taken	B. Brand or Type	C. Frequency of Use (days per wk, per mo.)	D. Number of Pills Taken per Day	E. Weeks or Months or Years Taken	F. Dosage

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Now we are going to ask you a few questions about your eating behaviors and house cleaning.

Cleaning N.

1. Where do people in your household usually eat meals? (Circle One)

Kitchen	1
Living room	2
Bedroom	3
Dining room	4
Other (Specify)_____	5

2. Are there any other areas where people in your household eat or snack?

Yes (Ask A)	01
No	02
DK	888
NR	999

A-E. What areas? (Circle all that apply)

	Yes	No
A. Kitchen	1	2
B. Living room	1	2
C Bedroom	1	2
D. Dining room		2
E. Other (Specify) _____	1	2

House cleaning questions

3. Which of these methods are ever used to clean the floors of your home?

	Never	**1-3 times /month**	**1 time per week**	**More than 1/week**
a. Vacuum	1	2	3	4
b. Dust mop or dry mop	1	2	3	4
c. Damp mop (no water spilled on floor)	1	2	3	4
d. Wet mop (involves pouring water on floor)	1	2	3	4
e. Broom	1	2	3	4
f. Other (Specify_____)	1	2	3	4

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

1. Do you own a vacuum cleaner?

Yes	(SKIP to 6)	01
No	(ASK 5)	02
DK		888
NR		999

5. Is there a vacuum in the building that you can use?

Yes	01
No	02
DK	888
NR	999

6. How often are the following conditions found in your home overnight?

	Never	**1-3 times /month**	**1 time per week**	**More than 1/week**	**INAP**
a. Food waste in an uncovered garbage can	1	2	3	4	777
b. Uncovered food in cupboards	1	2	3	4	777
c. Dirty dishes in the sink or on the countertop	1	2	3	4	777
d. Food spills or scraps on countertops, table, or stove	1	2	3	4	777
e. Un-rinsed bottles or cans	1	2	3	4	777
f. Pet food	1	2	3	4	777
g. Cat litter/feces	1	2	3	4	777
h. Dirty diapers	1	2	3	4	777

WELL, we've come to the end of the interview. THANK YOU AGAIN for your participation and in helping us with this important study.

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

60 Month Questionnaire

Hello, my name is_____ I want to start by thanking you for your help with this survey. I want to let you know that all of your answers to these questions are completely confidential. If you feel uncomfortable answering any of these questions, that's fine. However, we would appreciate you being as honest as possible in your answers. We are going to be asking you about changes in the information you gave us during the last interview, so some of the questions will be the same as the questions we asked you in the previous interview. Do you have any questions before we begin? Thank you for helping us with this important project.

FOR INTERVIEWER USE ONLY

Mother's medical record number ☐☐☐☐☐☐☐

Infant's medical record number ☐☐☐☐☐☐☐

Interviewer Initials ☐☐☐

Length of interview Start_____ End_____ ☐☐☐ minutes

Language of interview

English	01
Spanish	02
Other _____	03

Baby's Date of Birth? ☐☐/☐☐/☐☐☐☐

Baby's Weight _____ kg

Baby's Height _____ cm

Baby's Head Circumference _____ cm

Mother's Head Circumference _____ cm

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Demographics A.

1. Have you started going to school or graduated from any schools since our last full interview (NOTE to Interviewer–
at 36 months)?

Yes	(Ask B)	01
No		02
DK		888
NR		999

1b.What degree have you obtained or what type of school are you attending?

_____

2. Are you currently. . .

Married,	01
Living with the same partner for 7 years or more,	02
Widowed,	03
Divorced,	04
Separated, or	05
Never married	06
DK	888
NR	999

3. From all sources in Jan-Dec of last year, what was your annual household income?
(PROBE: Were there any other sources of income, help from family or friends? About how much?)

Less than 10,000	01
10,001 - 20,000	02
20,001 - 30,000	03
30,001 - 40,000	04
40,001 - 50,000	05
50,001 - 60,000	06
60,001 - 70,000	07
70,001 - 80,000	08
80,001 - 90,000	09
More than 90,000	10
DK	888
NR	999

4. How many people were supported by that income? ☐☐

DK = 888
NR = 999

5. Think about where you live, the food you eat, and the things you can afford to do and buy. How do you feel about your overall living condition? Would you say. . .

Very satisfied,	01
Somewhat satisfied,	02
Neither satisfied or dissatisfied,	03
Somewhat dissatisfied, or	04
Very dissatisfied?	05
DK	888
NR	999

6. In the last year, has there been a time when you and your family needed food but couldn't afford to buy it?

Yes	01
No	02
DK	888
NR	999

7. In the last year, has there been a time when you couldn't afford a place to stay, or when you couldn't pay the rent?

Yes	01
No	02
DK	888
NR	999

8. In the last year, has your gas or electricity been turned off because you couldn't afford to pay the bill?

Yes	01
No	02
DK	888
NR	999

9. In the last year, have you needed to buy any type of clothing for yourself or your family but didn't buy it because you couldn't afford to pay for it?

Yes	01
No	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

10. In the last year, has there been a time when you or a member of your family needed medicine or medical care but didn't get the treatment because you couldn't afford it?

Yes	01
No	02
DK	888
NR	999

11. Do you currently receive Medicaid?

Yes	01
No	02
DK	888
NR	999

12. Do you currently receive any type of public assistance?

Yes (Ask A)	01
No	02
DK	888
NR	999

A. Please specify type of public assistance_____

(Place responses -circle the number- in chart below.)

13. How many (total) children have you given birth to? (Circle the number in chart below).
14. How many of these children live with you (in your home/apt)?
15. How many people live in your home/apt?
16. How many other children *not yours* live in your home/apt?
17. How many other adults live in your home/apt?

13. How many children have you given birth to- total?	14. How many of your children live in *your home/apt*?	15. Total number of people living in home/apt?	16. How many OTHER *children- not yours-* live in your home/ apt?	17. How many *other adults* live in your home/apt?
	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9
10	10	10	10	10
11	11	11	11	11

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Child's Medical History/Asthma Symptoms B.

I would like to ask you some questions about how (insert name of child) _____ has been doing since our last conversation 3 months back. I will begin with questions about your child's health care:

51. Who is your child's primary (main) health care provider?

Doctor:	1	☐
Nurse	2	☐
Physician Assistant	3	☐
Other	4	☐ (specify): ……..

52. What is the name, address and phone number of your child's health care provider?

Name: _____

Address: _____

_____

_____

Phone #: ( ) _____

53. In the past 3 month how many times has your child seen this provider?

_____ time (s)

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Since we last spoke, has you child had any of the following symptoms:

Symptom	A. In the past 3 months has your child had: Yes = 01 No = 02 DK = 888 NR = 999	D. If yes, How many times did your child have (Insert Symptom) ? (List # times)	C. For how many days (on average) Did your child have (Insert Symptom) ? (List # days)	D. Within the last 2 weeks has your child had (Insert Symptom) Yes = 01 No = 02 DK=888 NR=999	E. Did your child see a doctor for this symptom? Yes = 01 No = 02 DK=888 NR=999	F. If Q. E yes how many times? (Insert Number of Times Below)	G. If yes, was the doctor seen different from your regular health care provider? Yes = 01 No = 02 DK=888 NR=999 (If yes, Insert name and address of the doctor)	**(IF the Child has had the Symptom, Continue Questions in the Table on the Next Page. If NOT, SKIP to Q. 12)**
54. Runny or stuffed nose?								
55. Ear Infection?								
56. Cough?								
REV-7A. Cough without a cold, or cough that continued after a cold ended?								
57. Barking or croupy cough?								
58. **Asthma**?								
59. Wheezing or whistling in the chest?								
REV-10A. Wheezing without a cold?								
60. Sore Throat								

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Symptoms Cont.

Symptoms	H. Did your child go to the emergency room for this symptom? 1=Yes 2=No	I. If Q.H yes, how many times ? (Insert Number of Times Below)	J. [If the child has been to the emergency room,] which emergency room? 1=Harlem Hosp. 2= CMPC 3=Other (Please Specify) _____	K. [If the child has been to the ER,] What was the date(s) of the emergency room visit? (Indicate date(s) below)	L. Has your child been in the hospital for this symptom? 1=Yes 2=No	M. If Q. L yes, how many times? (Insert Number of Times Below)	N. If the child has been in the hospital, which hospital? 1=Harlem Hosp. 2= CMPC 3=Other (Please Specify) _____	O. If the child has been in the hospital, What was the date(s) of admision?	P. Did he/shesstay over-night? 1=Yes 2=No
18. Runny or stuffed nose?									
19. Ear Infection?									
20. Cough?									
REV-7A. Cough without a cold, or cough that continued after a cold ended?									
21. Barking or croupy cough?									
22. **Asthma**?									
23. Wheezing or whistling in the chest?									
REV-10A. Wheezing without a cold?									
11. Sore Throat									

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Note: Please make sure to record an answer in the boxes for questions REV-11A, 11B, 11C, and 11D.

DK=88
NR=99

REV – 11A. All together, how many times during the past three months has your child been to the ER for ANY symptoms? ☐☐

REV- 11Ai How many of these times for asthma (7 – 10) above? ☐☐

REV – 11B. All together, how many times during the past three months has your child been to the doctor's office for ANY symptoms? ☐☐

REV- 11Bi How many of these times for asthma? (7 – 10) above? ☐☐

REV – 11C. All together, how many times during the past three months has your child been hospitalized for ANY symptoms? ☐☐

REV- 11Ci How many of these times for asthma (7 – 10) above? ☐☐

REV – 11D. All together, how many times during the past three months has your child been hospitalized overnight for ANY symptoms? ☐☐

REV- 11Di How many of these times for asthma (7 – 10) above? ☐☐

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Cumulative History. C

1) Since the birth of your child, has the doctor said that he/she has asthma?

Yes	(Ask 1A)	01
No	(Ask 2)	02
DK		888
NR		999

1A. At which ages has the doctor said your child has asthma?

Birth – 1year

Yes	01
No	02
DK	888
NR	999

1-2 years

Yes	01
No	02
DK	888
NR	999

2-3 years

Yes	01
No	02
DK	888
NR	999

3-4 years

Yes	01
No	02
DK	888
NR	999

4-5

Yes	01
No	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

2 . Has your doctor ever said that your child MIGHT HAVE asthma or asthma symptoms?

Yes	(Ask 2A)	01
No		02
DK		888
NR		999

2A.Which best describes your child's level of symptoms in the last 3 months?

The child has had asthma and needed medication on a regular basis, and also had one or more attacks requiring additional treatment.	01
The child has had asthma and needed medication on a routine basis, but did not have any attacks while on medication.	02
The child has had some asthma, needing medication only for occasional attacks	03
The child has had some asthma, but did not take any medicine for it	04
The child has not been troubled by asthma	05
DK	888
NR	999

3.) Has your child ever had visits to the emergency room because of asthma?

Yes	(if yes ask A)	01
No		02
DK		888
NR		999

3A. At which ages have you taken your child to the emergency room for asthma?

Birth – 1year

Yes	01
No	02
DK	888
NR	999

1-2 years

Yes	01
No	02
DK	888
NR	999

2-3 years

Yes	01
No	02
DK	888
NR	999

3-4 years

Yes	01
No	02
DK	888
NR	999

4-5

Yes	01
No	02
DK	888
NR	999

4.) Has your child ever been hospitalized because of asthma?

Yes	(if yes ask A)	01
No		02
DK		888
NR		999

4A. At which ages has your child been hospitalized because of asthma?

Birth – 1year

Yes	01
No	02
DK	888
NR	999

1-2 years

Yes	01
No	02
DK	888
NR	999

2-3 years

Yes	01
No	02
DK	888
NR	999

3-4 years

Yes	01
No	02
DK	888
NR	999

4-5

Yes	01
No	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Since we last spoke, which was about three months ago, have you been told by a doctor or a nurse that (insert name of child) had any of the following problems:

Medical Problem	A. Has your child had: Yes = 1 No = 2 DK = 888 NR = 999	I. If yes, Was he/she hospitalized for this? Yes = 01 No = 02 DK=888 NR=999	J. Which hospital Was he/she in? (List name and location of hospital) 1=Harlem Hospital 2=CPMC 3=Other (Please Specify _____)	K. What was the date of your child's admission? (List Month/Day/ Year)	L. Could you give us your child's medical record number? (List MRN if it is given)
4. Pneumonia					
5. Bronchiolitus					
6. Bronchitis					
7. Croup					
8. Sinus trouble					
9. Pulmonary 10. Tuberculosis					
61. Other Infections					
REV-11A. Specify					
62. Any other illnesses/ Accidents					
REV-12A. Specify					

63. Does your child ever get attacks of runny or itchy eyes other than from colds?

Yes	01
No	02
DK	888
NR	999

64. Does your child ever get attacks of sneezing or runny nose other than from colds?

Yes	01
No	02
DK	888
NR	999

65. Has your doctor ever said that your child has asthma?

Yes	(Ask A-C)	01
No		02
DK		888
NR		999

15A. Has your doctor ever said that your child MIGHT HAVE asthma or asthma symptoms?

Yes	(Ask A-C)	01
No	(skip to 18)	02
DK		888
NR		999

C. Which best describes your child's level of symptoms in the last 3 months?

The child has had asthma and needed medication on a regular basis, and also had one or more attacks requiring additional treatment.	01
The child has had asthma and needed medication on a routine basis, but did not have any attacks while on medication.	02
The child has had some asthma, needing medication only for occasional attacks	03
The child has had some asthma, but did not take any medicine for it	04
The child has not been troubled by asthma	05
DK	888
NR	999

B. At what age did your child's asthma start? _____ Age in Months

C. Does your child take medicine for his/her asthma at this time?

Yes	(Ask D)	01
No	(SKIP to F)	02
DK		888
NR		999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

D. If yes, What is the name of the medicine used for his/her asthma? What Dose? How often does he/she take the medicine?
How is the medicine given? (As a pill (P), capsule (c), liquid (L), inhaler pump (I), or nebulizer machine (N) ?

Medication Name	Dosage Taken (Amount taken each time)	Frequency (Number of times per day)	Form/Route (pills,caps,liquid,MDI,Neb)
1)			P C L I N
2)			P C L I N
3)			P C L I N
4)			P C L I N

E. In the past 3 months has your child taken any asthma medication on a daily basis (i.e. every day for more than 2 weeks)?

Yes	01
No	02
DK	888
NR	999

F. Has he/she been hospitalized overnight for asthma in the last 3 months?

Yes (Ask G-H)	01
No	02
DK	888
NR	999

G. Specify Hospital _____

H. Date of Admission: Month_____ Day_____ Year_____

66. In the past 3 months has your child required steroid pills, liquid or intravenous medication for an asthma attack?

Yes	01
No	02
DK	888
NR	999

67. In the last 3 months, on how many nights during a typical week (7 nights) was your sleep interrupted because your child has asthma?

_____ nights

18. Over the last 4 weeks, how often did your child wake up at night with shortness of breath, wheezing, cough, or chest tightness?

Every day	01
3 times a week	02
1 time a week	03
0 times a week	04

19. In the past three months, have you or your baby's father, or whomever else takes care of your baby, lost *work time* because of your child's asthma? Include time you were not able to do your daily work even if you are not employed outside of the home.

Yes	01
No	02
DK	888
NR	999

20.Has he/she been hospitalized overnight for the asthmatic or wheezy bronchitis in the last 3 months?

Yes	(Ask A-C)	01
No	(SKIP to C)	02
DK		888
NR		999

A. Specify Hospital _____

B. Date of Admission: Month_____ Day_____ Year_____

C. Does he/she currently take medicine for his/her asthmatic or wheezy bronchitis?

Yes	01
No	02
DK	888
NR	999

21. Have you given your child antibiotics in the last 2 years, (since your child turned 3)?

Yes	(if yes ask A)	01
No		02
DK		888
NR		999

21A. If yes; how many times? (circle one)

0-1= 1
2-3= 2
4-5= 3
6-7= 4
8-9= 5
10-11= 6
12 or more =7
DK= 888
NR= 999

23. If your child has asthma, what triggers his/her wheezing? (circle number)

Codes 1=yes, 2= no

1. Pollen ___
2. cats ___
3. dogs ___
4. other pets ___
5. house dust ___
6. roaches ___
7. mice/rats ___
8. mold ___
9. other_____

24. Has a doctor told you that your child has hay fever or allergies to pollens or pets?

Yes	(if yes ask A)	01
No		02
DK		888
NR		999

24A. What triggers his/her symptoms?

		Codes	**1=yes, 2= no**
1.	Pollen	___	
2.	cats	___	
3.	dogs	___	
4.	other pets	___	
5.	house dust	___	
6.	roaches	___	
7.	mice/rats		___
8.	mold	___	
9.	other_____		

25. Have you given your child? (circle number)	Yes=1	No= 2
25a. *Allergy meds* e.g. Claritin, Zyrtec, Benadryl, loratidine,allegra, cetirizine, dimetapp, chlortrimeton, traiminic, contac,benadryl, atarx, vistaril, periactin, chlorpheniramine, fexofenadine	1	2
25b. *Acetominophen* e.g. Tylenol?	1	2
25c. *Aspirin* e.g. Ecotrin, Bayer, ASA?	1	2
25d. *Ibuprofen* e.g. Advil, Motrin, Indocin	1	2
25e. *Primatene mist* or other over the counter asthma meds	1	2

26. Has your child ever received allergy shots?

Yes	(If yes ask A)	01
No		02
DK		888
NR		999

26A. Is your child currently receiving allergy shots?

Yes	01
No	02
DK	888
NR	999

27. Has a doctor told you that your child is overweight?

Yes	01
No	02
DK	888
NR	999

28. Has your child missed school or daycare because of asthma?

Yes	01
No	02
DK	888
NR	999

29. Has your child missed gym class or playing sports in school because of asthma?

Yes	01
No	02
DK	888
NR	999

30. Does your child have trouble exercising or playing sports due to breathing problems?

Yes	01
No	02
DK	888
NR	999

31. Does your child have trouble exercising or playing sports due to asthma?

Yes	01
No	02
DK	888
NR	999

32. Has your doctor ever said that your child has eczema?

Yes	(Ask A-C)	01
No	(SKIP to 33)	02
DK		888
NR		999

32A. Does he/she currently take medicine on the skin or by mouth for eczema?

Yes	01
No	02
DK	888
NR	999

32B. Does he/she currently use creams on the skin for eczema?

Yes	01
No	02
DK	888
NR	999

32C. Which creams?_____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

33. Some parents have told us they find other remedies helpful for breathing problems such as soups, teas, oils, and salves that they make at home or buy from a store. In the past 3 months have you used any home remedies for your child's breathing problems?

Yes (Ask A)	01
No	02
DK	888
NR	999

33A. If, yes list names of remedies and how they are used (taken by mouth, rubbed, inhaled by patient)?

Name of Remedy	Route of Administration (Oral, topical, inhaled)	Frequency (Number of times per day)
1)		
2)		
3)		
4)		

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

34. Please tell me if your child has been given any of the following medications during the past three months:
(Circle Yes = 1 or No = 0)

		Yes	No	DK	If Yes Dose	If Yes: Frequency
1)	proventil, ventolin, albuterol	1	0	8	_____	_____
2)	salmeterol, serevent	1	0	8	_____	_____
3)	flovent, beclovent, vanceril, aerobid, azmacort	1	0	8	_____	_____
4)	intal, cromolyn, tilade, nedocromil	1	0	8	_____	_____
5)	theophylline, slobid, theodur, uniphyl	1	0	8	_____	_____
6)	prednisone, prelone, pediapred	1	0	8	_____	_____
7)	singulair	1	0	8	_____	_____
8)	budesonide	1	0	8	_____	_____
9)	alupent	1	0	8	_____	_____
10)	maxair	1	0	8	_____	_____
11)	brethene	1	0	8	_____	_____
12)	accolate	1	0	8	_____	_____

35. Since the birth of your child, has he/she received any special services such as Early Intervention, speech therapy, physical therapy, mental health services, or behavioral therapy or other specials services?

Yes	(if yes ask 35 A)	1
No		2
DK		888
NR		999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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35a. If yes was it for:

	yes	no
1) Early Intervention	1	2
2) speech therapy	1	2
3) physical therapy	1	2
4) mental health	1	2
5) behavioral therapy	1	2
6) other special services	1	2
7) other specify:_____	1	2
8) other specify:_____	1	2
9) other specify:_____	1	2

36. Who cared regularly for you child at age 1, 2, 3, 4, 5 ?

A.Age 1

	YES	NO	DK	NR
1) self	01	02	888	999
2) relative/friend/sitter	01	02	888	999
3) daycare	01	02	888	999
4) preschool	01	02	888	999

B. Age 2

	YES	NO	DK	NR
1) self	01	02	888	999
2) relative/friend/sitter	01	02	888	999
3) daycare	01	02	888	999
4) preschool	01	02	888	999

C. Age 3

	YES	NO	DK	NR
1) self	01	02	888	999
2) relative/friend/sitter	01	02	888	999
3) daycare	01	02	888	999
4) preschool	01	02	888	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

D. Age 4

	YES	NO	DK	NR
1) self	01	02	888	999
2) relative/friend/sitter	01	02	888	999
3) daycare	01	02	888	999
4) preschool	01	02	888	999

E. Age 5

	YES	NO	DK	NR
1) self	01	02	888	999
2) relative/friend/sitter	01	02	888	999
3) daycare	01	02	888	999
4) preschool	01	02	888	999

Employment D.

1. Has your employment status changed in the last 2 years?

Yes		01
No	(SKIP next section)	02
DK		888
NR		999

4. What type of work have you been doing?

Sales	01
Restaurant/Fast Food	02
Telemarketing	03
School Employee	04
Health Care	05
Factory	06
Office Work	07
Other (Specify_____)	08

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Smoking E.

1. Have you smoked cigarettes in the last 2 years?

Yes	(Ask 2)	01
No	(SKIP 10)	02
DK		888
NR		999

1A. How many cigarettes have you smoked on average a day?

☐☐

INAP = 777
DK = 888
NR = 999

2**. Since our last visit**, has a household member or regular visitor to your home/apartment smoked cigarettes, pipes, marijuana, or cigars in your home? (PROBE: These people may include family, friends, housekeepers, babysitters or roommates).

Yes	(ASK A-D)	01
No		02
DK		888
NR		999

L. Can you please tell me the number of smokers in your home, and by home, we mean the place where you spend the most time?

☐☐

M. In your home **since our last full interview**, how many months in a row was your child exposed to **(INSERT TOBACCO)** smoke in the air from other people smoking?

[RECORD ANSWER IN TABLE BELOW]

N. In your home since our last full interview - about how many hours a day is your child exposed to smoke from **[INSERT TOBACCO]** ? (PROBE: About how many hours each day is your child exposed to your own or someone else's smoke?)

O. In your home **since our last full interview**, how many **(INSERT TOBACCO)** per day was your child exposed to?

[RECORD ANSWER IN TABLE BELOW]

	B.Months Exp.	**C. Hrs/Day**	**D. Cig/Day**
3) Cigarette			
4) Marijuana			
5) Pipe			
6) Cigar			

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

7**. In the last 2 years or since your child turned 3**, outside of your home/apartment, has your child been exposed to smoke from cigarettes, pipes, marijuana, or cigars?

Yes	(ASK A-D)	01
No		02
DK		888
NR		999

8-11. Outside of your home, in the last 2 years has your child been exposed to smoke from:

A. Where, outside of your home, is your child exposed to **[INSERT TOBACCO].**

[RECORD ANSWER IN TABLE BELOW]

B. Outside of your home/apartment in the last 2 years, how many consecutive months was your child exposed to **(INSERT PRODUCT)** smoke?

[RECORD ANSWER IN TABLE BELOW]

C. Outside of your home/apartment in the last 2 years - about how many hours a day is your child exposed to smoke from **[INSERT PRODUCT]** ?

[RECORD ANSWER IN TABLE BELOW]

D.

	A. Place of Exposure (i.e. Relatives home)	**B. Months Exp.**	**C. Hrs/Day**	**D. Cig/Day**
8) Cigarette				
9) Marijuana				
10) Pipe				
11) Cigar				

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

12. In a typical week, how many nights a week does your child spend at your current address? Would you say:

6 -7 days		01
4 -5 days		02
2 -3 days	(ASK A-B)	03
0 -1 day	(ASK A-B)	04
DK		888
NR		999

12A. What is the address where your baby stays 4-7 nights a week?

Address City State Zip☐☐☐☐☐

_____

12B. In a typical week, how many nights does your baby sleep at this address? ☐

13. Has your child spent a total of one month or more outside of Northern Manhattan and/or the South Bronx, *since he/she has turned 3?*

Yes	(ASK A)	01
No		02
DK		888
NR		999

B. Where, outside of this area, has your child been for a total of one month or more and how much time has he/she spent there?

Place 1 _____ Number of Months _____

Place 2 _____ Number of Months _____

Place 3 _____ Number of Months _____

Place 4 _____ Number of Months _____

Place 5 _____ Number of Months _____

Place 6 _____ Number of Months _____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Residence F

1. Have you moved to a different residence in the last 2 years?

Yes	(ASK 1- 10)	01
No		02
INAP		777
DK		888
NR		999

CHECK TO SEE IF RESPONDENT HAS MOVED
SINCE THE LAST INTERVIEW

If NO, SKIP to Q. 2

A) Please tell me your address including the street, city, state, zip code and country ?
[RECORD ANSWER IN TABLE BELOW]

C) Is this a house or apt?
[RECORD ANSWER IN TABLE BELOW]

C) What are the dates during which you lived at this residence?
[RECORD ANSWER IN TABLE BELOW]

D) Would you consider this area predominantly urban, suburban, or rural ?
[RECORD ANSWER IN TABLE BELOW]

Repeat Questions A - D until all residences since last full interview are listed. Begin with the remarks: "Please tell me. . .)

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Residence	A. Street	B. City	C. State Code (Postal)	D. Zip Code	E. Country USA=1 DR =2 Other = 3 (List other below in Q. 11A)	F. House/ Apt. H = 01 A = 02	G. Dates: From: __ /__ __ __	H. To: __ /__ __ __	I. Area Urban=1 Suburb=2 Rural=3 DK=888 NR=999
1.Current									
2.Previous									
3.Previous									
4.Previous									
5.Previous									
6. Previous									
7. Previous									
8. Previous									
9. Previous									
10. Previous									

*if outside the U.S. do not ask street

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

2. For the purposes of this study, let's refer to the address where your child spends most of his/her time as your home. Which of the following best describes your home/apartment? Is it a.....

single family house, like a town house?	(Ask A)	01
2 or 3 family house?	(Ask A)	02
building for 4-6 families, like a brownstone?	(Ask A)	03
100% residential apartment building?	(Ask A)	04
combined residential and commercial building? Or	(Ask A)	05
a temporary shelter or commune?		06
DK		888
NR		999

A. Do you . . .

own,	01
rent, (pay ½ or more of rent)	02
or live with family or friends?	03
DK	888
NR	999

3. Does your building have a basement?

Yes	01
No	02
INAP	777
DK	888
NR	999

4. Excluding a basement and/or attic, how many floors are in your building? ☐☐floors

DK=888
NR=99

5. Excluding the basement, what floor do you live on? (Note to Interviewer: Number basement as "0" and floors above consecutively).

☐☐ fl

DK	888
NR	999

6. Excluding bathrooms and kitchens, how many rooms are there in your home/apartment?

☐☐rooms

DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

7. Since our last visit, please tell me if you notice any [INSERT PROBLEM] in your home/apartment.

A.Mice	
B. Rats	
C. Roaches	
D. Other Insect Pests (i.e. ants, fleas, waterbugs, silverfish, bedbugs, bees.)	
E. Leaky pipes	
F. Mold	
G. Holes in ceilings/walls	
H paint or paint chips	

Codes

Yes	1
No	2
DK	8
NR	9

[Note to Interviewer: Remember to refer to the place where the child spends most of his/her time for the remaining Residential Questions]

9. How often do you see cockroaches in your home/apartment?

Never	01
Rarely	02
< Weekly	03
Weekly	04
Daily	05
DK	888
NR	999

10. How often do you see mice in your home/apartment?

Never	01
Rarely	02
< Weekly	03
Weekly	04
Daily	05
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

11. How often do you see rats in your home/apartment?

Never	01
Rarely	02
< Weekly	03
Weekly	04
Daily	05
DK	888
NR	999

12 .Have you had an exterminator (i.e. anyone other than your super) spray chemicals or any other material in your home/apartment to get rid of insects or animal pests? (Probe: Did someone/an exterminator from a company come to your home to spray for pests?)

Yes (Ask 31-38)	01
No	02
DK	888
NR	999

13. Have you, your super, or anyone else (not an exterminator) used any pest control measures (pesticides, traps, etc.) to control pests (insects, rodents) in you home/apartment?

Yes (Ask 31-38)	01
No	02
DK	888
NR	999

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

[RECORD ANSWERS IN TABLE BELOW]

A. What kind of traps or pesticides have been used?

B. What pests are they used for?

C. What brand or types of traps or pesticide (i.e. spray or powder) are used?

D. How often have you used these pest control measures?

	C. Type Yes = 1 No = 2 DK = 8 NR = 9	B. Pest(s) Used For Roaches = 1 Mice or Rats = 2 Ants = 3 Roaches/Mice or Rats = 4 Roaches/Ants = 5 Mice or Rats/Ants = 6 All Three = 7	C. Brand(s) or Type(s) Used	D. Frequency/Duration of Use: > 1 Time /Week =1 1 Time /Week =2 1-3 Times / Month = 3 Once a month =4 < Once a month =5
14. Sticky traps				
15. Bait traps (e.g. Combat)				
16. Boric Acid				
17. Gel				
18. Spray by an exterminator				
19. Can Sprays				
20. The Bomb				
21. Other (specify)_____				

22. Can you give me any additional information about your pest control (rodents /roaches), (e.g., brand name, foreign products, description of original methods, etc.) ?

23. Is there any water damage in your home/apartment that has not been fixed? (signs such as scaled off paint, swollen panels, wet spots etc)

Yes	01
No	02
DK	888
NR	999

24. Do you ever add moisture to the air in your home/apartment (Probe: a humidifier or pans of water on the radiator)?

Yes (Ask A)	01
No (SKIP to 37)	02
DK	888
NR	999

24 A. What method do you use?

Cool Mist Humidifier	01
Hot Mist Humidifier	02
Pans of Water on Radiators	03
Boiling Water on Stove	04
DK	888
NR	999

25. Has your home/apartment been renovated or had any repairs done since our last visit?

Yes (Ask 26)	01
No	02
DK	888
NR	999

26. What type of repairs/renovations occurred in your home/apartment? (ASK A-G)

A. Leaky pipes _____
B. Holes/Cracks in the Ceiling/Wall _____
C. Refinishing Floors _____
D. Painting _____
E. Construction (Specify_____) _____
F. Other (Specify_____) _____

G. Please describe the type of repairs/renovations and give the dates that they occurred.

TYPE OF REPAIR/RENOVATION	DATE
_____	_____
_____	_____
_____	_____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

27. Now I'd like to ask some questions about the heating in your home/apartment. What is the main type of heating fuel in your home?

Gas	(Ask 39A)	01
Electric	(Ask 39A)	02
Fuel oil	(Ask 39A)	03
Coal		04
Wood		05
Other (SPECIFY) _____		06
DK		888
NR		999

27a. How is your home heated?

Radiator (steam or hot water)	01
Forced hot air vents	02
Other Please Specify_____	03

28. Is your stove or oven gas?

Yes	(if yes ask A)	01
No		02
INAP		777
DK		888
NR		999

28A. Does it have a continuously burning pilot light?

Yes	01
No	02
INAP	777
DK	888
NR	999

29. Since our last visit, how often did you use the range or oven to heat your home/apartment? Would you say. . .

More than once a week,	01
2 - 4 times per month,	02
Once a month or less,	03
Only in case of power failure, or	04
Never	05
DK	888
NR	999

30. Do you burn candles in your home/apartment?

Yes (ASK A)	01
No	02
DK	888
NR	999

42A. Since our last visit, how many times have you burned candles?

☐☐/month

INAP	777
DK	888
NR	999

31. Do you burn incense or similar products in your home/apartment?

Yes (ASK A)	01
No	02
DK	888
NR	999

31A. Since our last visit, how many times have you burned incense?

☐☐/month

INAP	777
DK	888
NR	999

Activities G

1. In a typical week, since our last visit, how many hours a day does your child spend *outdoors*?
Would you say your child spends…?

0-1 hrs	01
1-2 hrs,	02
3-4 hrs,	03
5-6 hrs,	04
7 or more hrs outdoors	05
DK	88
NR	99

2. In a typical week, since our last visit, how many hours per day does your child spend *inside your home/apartment?*
Would you say your child spends. .

0-1 hrs	01
1-2 hrs,	02
3-4 hrs,	03
5-6 hrs,	04
7 or more hrs outdoors	05
DK	88
NR	99

3. How many hours *per day* does your child exercise or play sports?

0-1hrs	01
1-2 hrs,	02
3-4 hrs,	03
> 4 hours	04
DK	88
NR	99

4. How many hours *per week* does your child exercise or play sports?

0-1 hrs	01
1-2	02
3-4 hrs,	03
5-6 hrs,	04
7 or more hrs	05
DK	88
NR	99

5. How many hours *per day* does your child watch TV?

0-1 hrs	01
1-2	02
3-4 hrs,	03
5-6 hrs,	04
7 or more hrs	05
INAP	06
DK	88
NR	99

6. How many hours *per week* does your child watch TV?

0-1 hrs,	01
1-2,	02
3-4 hrs,	03
5-6 hrs,	04
7 or more hrs	05
INAP	06
DK	88
NR	99

7. How many hours *per day* does your child use a computer at home/apartment?

0-1 hrs,	01
1-2 hrs,	02
3-4 hrs,	03
5-6 hrs,	04
7 or more hrs in your home	05
INAP	06
DK	88
NR	99

8. How many hours *per week* does your child use a computer at home/apartment?

0-1 hrs,	01
1-2 hrs,	02
3-4 hrs,	03
5-6 hrs,	04
7 or more hrs in your home	05
INAP	06
DK	88
NR	99

9. Do you have a pet?

Yes	(ASK A-C)	01
No		02
DK		888
NR		999

A. Do you have a dog?

Yes	(ASK A1)	01
No		02

A1. How many dogs do you have in your home/apartment?

1 2 3 4 5 or more

B. Do you have a cat?

Yes	(ASK B1)	01
No		02

B1. How many cats do you have in your home/apartment?

1 2 3 4 5 or more

C. What other pets do you have? (specify)

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Infant Vitamins H.

2. Do you give your child vitamin or mineral supplements of any kind?

Yes	(Ask 2)	01
No	(Skip to Demoralization Q. 1)	02
DK		888
NR		999

3. Does the child get *multivitamin* drops, tablets or pills?

Yes	(Ask A-D)	01
No		02
DK		888
NR		999

F. Which vitamins/supplements do you give your child?

[RECORD ANSWER IN TABLE BELOW]

G. What kind or brand do you use? [PROBE FOR DETAIL]

[RECORD ANSWER IN TABLE BELOW]

H. On average, how many times per week or month do you give them to the child?

[RECORD ANSWER IN TABLE BELOW]

I. On average, how much liquid (or how many pills) do you give each time?

[RECORD ANSWERS IN TABLE BELOW]

J. For how long have you been giving this to the child?

[RECORD ANSWER IN TABLE BELOW]

F. What is the dosage of the vitamins you give to your child?

[RECORD ANSWER IN TABLE BELOW]
Which vitamins/supplements do you give your child?

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

[RECORD ANSWER IN TABLE BELOW]

A. Vitamins/ Supplements Given	B. Brand or Type	C. Frequency of Use (days per wk, per mo)	D. Number of Pills Given	E. Months or Years Given	F. Dosage

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Now we are going to ask you a few questions about your eating behaviors and house cleaning.

Cleaning I.

1. Where do people in your household usually eat meals? (Circle One)

Kitchen	1
Living room	2
Bedroom	3
Dining room	4
Other (Specify)_____	5

2. Are there any other areas where people in your household eat or snack?

Yes (Ask A)	01
No	02
DK	888
NR	999

A-E. What areas? (Circle all that apply)

	Yes	No
A. Kitchen	1	2
B. Living room	1	2
C Bedroom	1	2
D. Dining room	1	2
E. Other (Specify) _____	1	2

House cleaning questions

3. Which of these methods are ever used to clean the floors of your home/apartment?

	Never	**1-3 times /month**	**1 time per week**	**More than 1/week**
a. Vacuum	1	2	3	4
b. Dust mop or dry mop	1	2	3	4
c. Damp mop (no water spilled on floor)	1	2	3	4
d. Wet mop (involves pouring water on floor)	1	2	3	4
e. Broom	1	2	3	4
f. Other (Specify_____)	1	2	3	4

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

4. Do you own a vacuum cleaner?

Yes	(SKIP to 6)	01
No	(ASK 5)	02
DK		888
NR		999

5. Is there a vacuum in the building that you can use?

Yes	01
No	02
DK	888
NR	999

7. How often are the following conditions found in your home overnight?

	Never	**1-3 times /month**	**1 time per week**	**More than 1/week**	**INAP**
a. Food waste in an uncovered garbage can	1	2	3	4	777
b. Uncovered food in cupboards	1	2	3	4	777
c. Dirty dishes in the sink or on the countertop	1	2	3	4	777
d. Food spills or scraps on countertops, table, or stove	1	2	3	4	777
e. Un-rinsed bottles or cans	1	2	3	4	777
f. Pet food	1	2	3	4	777
g. Cat litter/feces	1	2	3	4	777
h. Dirty diapers	1	2	3	4	777

8. How frequently is your child in the room with you when you are vacuuming, sweeping, or dusting?

Never	01
Seldom	02
Sometimes	03
Usually	04
DK	05
NR	06

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Demoralization J.

Now we are going to ask you some questions about your feelings and your state of mind during the past year.

28. During the past year, how often have you felt you were bothered by all different kinds of ailments in different parts of your body….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

29. During the past year, how often have you been bothered by feelings of sadness or depression – feeling blue….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

30. In general, how satisfied have you been with yourself in the last year….

very satisfied	0
somewhat satisfied	1
somewhat dissatisfied	3
very dissatisfied	4

31. During the past year, how often have you had attacks of sudden fear or panic….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

32. During the past year, how often have you felt confident….

very often	0
fairly often	1
sometimes	2
almost never	3
never?	4

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33. During the past year, how often have you felt lonely….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

34. During the past year, how often have you been bothered by feelings of restlessness….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

35. During the past year, how often have you felt useless….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

36. During the past year, how often have you feared going crazy; losing your mind….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

37. During the past year, how often have you felt anxious….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

38. During the past year, how often have you feared something terrible would happen to you….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

39. During the past year, how often have you felt confused and had trouble thinking….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

40. During the past year, how often have you had trouble concentrating or keeping your mind on what you are doing….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

41. During the past year, how often have you felt that nothing turns out for you the way you want it to – would you say.

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

42. During the past year, how often have you felt completely hopeless about everything….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

43. During the past year, how often have you felt completely helpless….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

44. During the past year, how often have you had times when you couldn't help wondering if anything was worthwhile anymore….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

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45. During the past year, how often have you been bothered by cold sweats….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

46. During the past year, how often have you had trouble with headaches or pains in the head….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

47. During the past year, how often has your appetite been poor….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

48. In general, if you had to compare yourself with the average woman your age , what grade would you give yourself for the past year….

excellent	0
good	1
average	2
below average	3
a lot below average?	4

Do you:

You are the kind of person….	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
49. who feels she has much to be proud of….	0	1	2	3	4
50. who is the worrying type – you know, a worrier….	4	3	2	1	0
51. who feels that she is a failure generally, in life….	4	3	2	1	0

52. When you have gotten angry in the last year, how often have you felt uncomfortable, like getting headaches, stomach pains, cold sweats and things like that….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

53. During the past year, how often have you feared being left all alone or abandoned….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

54. During the past year, how often have you been bothered by nervousness, being fidgety or tense….

very often	4
fairly often	3
sometimes	2
almost never	1
never?	0

Stress Questions K.

5. In the last month, how often have you felt that you were unable to control the important things in your life?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

6. In the last month, how often have you felt confident about your ability to handle personal problems?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

7. In the last month, how often have you felt that things are going your way?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

8. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Never	01
Almost Never	02
Sometimes	03
Fairly Often	04
Very Often	05

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K4. In the last month, how often have you felt any of the following?

	Very often	Fairly often	sometimes	Almost never	never
a. You have been upset because of something that happened unexpectedly.	**4**	**3**	**2**	**1**	**0**
b. You have felt nervous and "stressed".	**4**	**3**	**2**	**1**	**0**
c. You have dealt successfully with irritating life hassles.	**4**	**3**	**2**	**1**	**0**
d. You have felt that you were effectively coping with important changes that were occurring in your life.	**4**	**3**	**2**	**1**	**0**
e. You have found that you could not cope with all the things you had to do.	**4**	**3**	**2**	**1**	**0**
f. You have been able to control irritations in your life.	**4**	**3**	**2**	**1**	**0**
g. You have felt that you were on top of things.	**4**	**3**	**2**	**1**	**0**
h. You have been angered because of things that happened that were outside of your control.	**4**	**3**	**2**	**1**	**0**
i. You have found yourself thinking about things that you have to accomplish.	**4**	**3**	**2**	**1**	**0**
J. You have been able to control the way you spend your time.	**4**	**3**	**2**	**1**	**0**

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PREFACE DIALOGUE NEEDED- GINNY

HOUSING L

Now, I would like to ask you some questions about your housing.

1. How many times have you moved in the last 2 years?

   Record # times _____

2. Have you been homeless at any time in the last 2 years? That is, have you ever slept outside, in a car or in a homeless shelter?

   No 0
   Yes 1

3. How much do YOU pay for rent or mortgage each month?

   $_____ per month

4. Are you currently living in…?

	No	**Yes**
Section 8 housing	0	1
HUD (Housing and Urban Development)	0	1
High Riser (Public Housing)	*0*	*1*
Low Riser (Public Housing)	0	1
A rented apartment or house & no housing assistance	0	1
Your own home & no housing assistance	*0*	*1*
With family or friends & paying someone	*0*	*1*
With family or friends & not paying someone	*0*	*1*
Other	*0*	*1*

Please specify other: _____

_____

_____

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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5. Now I would like to ask you a bit about the quality of the housing you live in now.

Does your housing have…?

	No	Yes
Peeling paint	0	1
A lot of bugs	0	1
Broken windows	0	1
Broken or missing window screens	0	1
Broken or dangerous steps	0	1
Broken or missing locks on the doors	0	1
Graffiti in public spaces	0	1
Stopped up or overflowing toilets	0	1
Other busted plumbing	0	1
Leaking roof	0	1
A lot of rats or mice	0	1
Other serious problems with your housing	0	1

Please specify other: _____

6. How long have you lived in this particular house or apartment?

Record # of years _____

Record # of months _____

7. Including all rooms (bathrooms, bed rooms, kitchen etc but NOT closets) how many rooms are there in the house or apartment where you currently live?

Record # of rooms _____

8. Thinking about your current house or apartment, would you say that:

There is enough space for all people to live comfortably …….0
Living space is tight but I still can have some privacy……1
Conditions are very cramped and there is no private space……2

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Neighborhood Quality M

I am now going to ask you questions about your neighborhood. For example, I will ask you about how safe you feel and what services are located there.

1. How long have you lived in your neighborhood?

Record # of years _____

Record # of months _____

2. Please tell me **how often these things are a problem or are found in your neighborhood** on a scale from 1 to 10 with *1* being *Rarely* and *10* being *Frequently*.

Rarely									**Frequently**	**SCORE**	
1	2	3	4	5	6	7	8	9	10		
										DK=888	
NR=999											
1. Litter or trash on the sidewalks or streets									|_____|		
2. Graffiti on buildings and walls									|_____|		
3. Abandoned cars									|_____|		
4. Vacant, abandoned, or boarded up buildings									|_____|		
5. Drug dealers or users hanging around									|_____|		
6. Drunks hanging around									|_____|		
7. Unemployed adults hanging around									|_____|		
8. Young adults hanging around									|_____|		
9. Gang activity									|_____|		
10. Houses and yards not kept up									|_____|		
11. Racial slurs or attacks									|_____|		
12. Gunshots									|_____|		

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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3. How worried are you about the following things in your neighborhood on a scale of 1 to 10 with *1* being *Not Worried At All* and *10* being *Very Worried*.
(HAND CARD #10)

Not Worried **Very Worried**

1 2 3 4 5 6 7 8 9 10

1. Having property stolen |_____|
2. Walking alone during the day |_____|
3. Letting children go outside during the day |_____|
4. Letting children go outside during the night |_____|
5. Being robbed |_____|
6. Being murdered |_____|
7. Being harassed by persons of another race or ethnic group |_____|

4. I am going to read several statements about your neighborhood. Use the scale on this Card. As I read each one, tell me whether you would say it is mostly false or mostly true, with *1* being *Mostly False* and *10* being *Mostly True*.

Mostly false **Mostly true**

1 2 3 4 5 6 7 8 9 10

*1. My neighborhood is a good place to live. |_____|

2. My neighborhood is a good place to raise children. |_____|

Reverse: 1 only

3. The people moving into the neighborhood in the past year or so are good for the neighborhood. |_____|
4. I would like to move out of this neighborhood |_____|
5. When the weather is nice, the people living on my street visit with one another outside. |_____|
6. The people in my neighborhood visit one another in their homes |_____|
7. The people in my neighborhood loan things to one another. |_____|
8. The people in my neighborhood make sure other's homes are safe when someone is away. |_____|
9. On Halloween, most of the children living here go trick-or-treating in my neighborhood. |_____|
10. People move in and out of my neighborhood a lot. |_____|

11. There are some children in the neighborhood that I do not want my children to play with. |_____|
12. Neighbors should mind their own business about other's children. |_____|
13. The people moving into the neighborhood in the past year or so are bad for the neighborhood. |_____|

D5. Do you ever avoid going outside for safety reasons?

Never.....	.0
Rarely.....	.1
Sometimes …	2
Often.....	3
All the time...	4

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

Discrimination N.

1. I am now going to ask you some questions about discrimination that you may or may not experience in your day to day life. By discrimination, we mean being treated unfairly because of your race, ethnicity, income level, social class, sex, gender, age, sexual orientation, physical appearance, or religion. In your day to day life how often have any of the following things happened to you?

	Almost everyday	**At least once a week**	**A few times a month**	**A few times a year**	**Once a year**	**never**
a. You are treated with less courtesy than other people	**5**	**4**	**3**	**2**	**1**	**0**
b. You are treated with less respect than other people.	**5**	**4**	**3**	**2**	**1**	**0**
c. You receive poorer service than other people at restaurants and stores	**5**	**4**	**3**	**2**	**1**	**0**
d. People act as if they think you are not smart.	**5**	**4**	**3**	**2**	**1**	**0**
e. People act as if they are afraid of you.	**5**	**4**	**3**	**2**	**1**	**0**
f. People act as if they think you are dishonest.	**5**	**4**	**3**	**2**	**1**	**0**
g. People act as if they're better than you are.	**5**	**4**	**3**	**2**	**1**	**0**
h. You are called names or insulted.	**5**	**4**	**3**	**2**	**1**	**0**
i. You are threatened or harassed	**5**	**4**	**3**	**2**	**1**	**0**

2. For unfair reasons, do you think that you have ever not been hired for a job?

No ..... 0 **[SKIP TO 4]**

Yes 1

3. What do you think the main reason was for not hiring you? (please circle one)

Ethnicity…….1

Gender……2

Race……3

Age……..4

Religion……5

Physical Appearance……6

Sexual Orientation……7

Income level/social class….8

Other……9

Please specify other:_____

4. Have you ever been unfairly stopped, searched, questioned, physically threatened or abused by the police?

No 0

Yes 1

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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Religion and Social Support O

1. About how often do you attend religious services?
Record frequency and check time period

_____times ..... per week ☐

..... per month ☐

..... per year ☐

2. About how often do you seek spiritual guidance or advice?

_____times ..... per week ☐

..... per month ☐

..... per year ☐

3. Do you tend to go to religious services more often when things get tough in your life?

No 0

Yes 1

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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Inter-Personal Violence/ Role Strain/Partner P

1. In your life how often do you turn to prayer, meditation or reflection as a source of comfort or strength?

_____times ..... per week ☐

..... per month ☐

..... per year ☐

2. Many of us have been forced into situations where we have felt scared or uncomfortable. I would like to ask you some questions regarding **threats** of physical or emotional violence. **HOW OFTEN HAS YOUR CURRENT (or most recent) PARTNER DONE ANY OF THE FOLLOWING?**

	0	**1**	**2**	**3**
	Never	**Rarely**	**Sometimes**	**Often**
1. Threatened to hurt you in any way?	0	1	2	3
2. Caused a serious injury due to a 3. to a fight you had?	0	1	2	3
4. Used other forms of force during a fight 5. (kicked, pushed, shoved or slapped)	0	1	2	3
9. Insulted you or embarrassed you in front of 6. others (friends/family/colleagues)?	0	1	2	3
7. Sworn or cursed at you?	0	1	2	3
8. Treated you like an inferior?	0	1	2	3
9. Yelled and screamed at you?	0	1	2	3
10. Monitored and accounted for your whereabouts?	0	1	2	3
11. Been jealous or suspicious of your friends?	0	1	2	3
12. Accused you of having an affair 13. with someone else?	0	1	2	3
14. Interfered in your relationship with 15. other family members?	0	1	2	3
16. Kept you from doing things to help yourself?	0	1	2	3

Date __ __/__ __ /__ __ __ __ I.D. Number __ __ __ Subject Initials _____

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Social Support Q

Now, I would like you to think about people you are close to. Think of the people you live with, your family, and your friends.

1. Do you think there is someone who feels very close to you?
   No……1 [If No, SKIP TO G4]
   Yes……...0

2. Who is this person? (specify relationship not name)

   _____

3. Is there someone who you can lean on for support?
   No……0 **[skip to G6]**
   Yes……...1

4. Who is this person? (specify relationship not name)

   _____

5. When you are happy, is there someone you can share it with… Someone who will feel happy simply because you are happy?

   No……0
   Yes……...1

6. I am going to mention several kinds of support most of us need at times. For each, please tell me whether you believe you could get this help if you need it. Do you know…

	No	Yes
1. Someone that would take you to the doctor, if needed? ……. ……	1	0
2. Someone that would loan you $100 if you needed it?…….…	1	0
3. Someone that would help with daily chores if you were sick? …….. ……	1	0
4. Someone that you could talk to about problems in your life? …….	1	0
5. Someone who would watch your children when needed?….…….	1	0

WELL, we've come to the end of the interview. THANK YOU AGAIN for your participation and in helping us with this important study.

Date __ __/__ __/__ __ __ __ I.D. Number __ __ __ Subject Initials _____

Given on Final Version Y/N

ACTIVITY TIME LINE
[MORNING 12 - 4 AM]

PID: ☐☐☐☐☐ Data Collection Event: ☐☐

Date: ☐☐-☐☐-☐☐☐☐

Activity Number:	1	2	3	4
	Sleeping	Eating	Quiet Play	Active Play

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	midnight	12:30 am	1 am	1:30 am	2 am	2:30 am	3 am	3:30 am	4 am
Activity Number(s):	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	
Location: Inside Home	☐	☐	☐	☐	☐	☐	☐	☐	
Outside Near Home	☐	☐	☐	☐	☐	☐	☐	☐	
Away from Home	☐	☐	☐	☐	☐	☐	☐	☐	
Room: Fill in the name of each room.	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
Parts of Body Covered: Torso	☐	☐	☐	☐	☐	☐	☐	☐	
Arms	☐	☐	☐	☐	☐	☐	☐	☐	
Legs	☐	☐	☐	☐	☐	☐	☐	☐	
Feet	☐	☐	☐	☐	☐	☐	☐	☐	
Bottom	☐	☐	☐	☐	☐	☐	☐	☐	
Washing: Bath/Shower	☐	☐	☐	☐	☐	☐	☐	☐	
Hands	☐	☐	☐	☐	☐	☐	☐	☐	