
**Appendix C. CHEERS Longitudinal Study of Young
Children's Exposure to Selected Pesticides**

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Longitudinal Study of Young Children's Exposures in their Homes to Selected Pesticides, Phthalates, Brominated Flame Retardants, and Perfluorinated Chemicals – A Children's Environmental Exposure Research Study (CHEERS)

Food Diary

(Final Draft - 11/24/2003)

INTRODUCTION:

The purpose of this data form is to collect the duplicate diet sample information during the 24-hour post-application data collection period. The form will be completed by the adult care giver of the child. The completed form will be collected by a project staff at the end of the 24-hour data collection period.

There are two versions of the Food Diary: The Regular Form is for participants who will not collect leftover food; the Subgroup Form is for a subset of participants who will collect leftover food. The food diary will be included in the Activity Time Line booklet.

Instructions for Completing the Food Diary – Subgroup Form

PLEASE COMPLETE THE FOOD DIARY FOR YOUR CHILD. WHEN COMPLETED, THE FOOD DIARY WILL CONTAIN A LISTING OF THE FOODS EATEN BY YOUR CHILD AT EACH MEAL DURING THE MONITORING PERIOD.

- (1) We want you to list all the different foods for every meal that your child eats during the 24-hours that you are collecting the food sample for us. This includes all foods eaten at home and away from home. Away from home would include any relatives' house, friend's house, day care center, or restaurant.
- (2) Every time your child eats, write down the name of the meal (breakfast, lunch, dinner, snack) in the first column (Col 1). By breakfast, we mean the meal your child eats in the early morning. By lunch, we mean the meal your child eats in the middle of the day. By dinner, we mean the meal your child eats in the evening. Any time your child eats between meals, please list as a snack.
- (3) In the next column (Col 2) after the meal heading, write down the brand or generic name of the foods your child eats and/or drinks. In the third column (Col 3), write down the number of portions of every food you listed that your child eats and/or drinks. If you are breastfeeding, please include this information.

For example, it is lunchtime and your child ate a cheeseburger and a cookie, and drank a glass of milk. In Col 1 you would write lunch. In Col 2 you would write cheeseburger, cookie, milk. In Col 3, under how many, you would write the amount of food: 1 cheeseburger, 2 cookies, 1 glass of milk. See the food diary as an example. You would repeat this process for all foods eaten at all meals.
- (4) For foods like stews or soups, write down the food on one line, and the major kinds of foods in the mixture on the lines below the name of the food. For example, write "stew" on the first line; then write the type of meat in the stew ("beef", "pork", "chicken", etc.) on the line below.
- (5) Please check (✓) the box in column 4 if the listed food item was not collected as part of the diet (Col 4).
- (6) You should put a check mark (✓) in column 5 if the leftover foods were touched by your child and not eaten (Col 5).
- (7) You should put a check mark (✓) in column 6 if the leftover foods were not touched by your child and not eaten (Col 6).
- (8) Col 7 asks you to list the surfaces that the foods may have touched. For example, if your child dropped the food on the high chair tray and then ate it, you would write high chair tray in Col 7.
- (9) Col 8 asks you to write down the location in the room where this meal or snack was eaten.
- (10) Col 9 asks you to write down the room where this meal or snack was eaten.

Some examples are provided in the Food Diary. Our research staff will also discuss this with you and answer your questions. Please call our toll-free number **(1-877-810-9530, ext. 503)** if you have questions about completing the food diary or about any other study activities. Thanks very much for your participation in this study.

Instructions for Completing the Food Diary – Regular Form

PLEASE COMPLETE THE FOOD DIARY FOR YOUR CHILD. WHEN COMPLETED, THE FOOD DIARY WILL CONTAIN A LISTING OF THE FOODS EATEN BY YOUR CHILD AT EACH MEAL DURING THE MONITORING PERIOD.

- (1) We want you to list all the different foods for every meal that your child eats during the 24-hours that you are collecting the food sample for us. This includes all foods eaten at home and away from home. Away from home would include any relatives' house, friend's house, day care center, or restaurant.
- (2) Every time your child eats, write down the name of the meal (breakfast, lunch, dinner, snack) in the first column (Col 1). By breakfast, we mean the meal your child eats in the early morning. By lunch, we mean the meal your child eats in the middle of the day. By dinner, we mean the meal your child eats in the evening. Any time your child eats between meals, please list as a snack.
- (3) In the next column (Col 2) after the meal heading, write down the brand or generic name of the foods your child eats and/or drinks. In the third column (Col 3), write down the number of portions of every food you listed that your child eats and/or drinks. If you are breastfeeding, please include this information.

For example, it is lunchtime and your child ate a cheeseburger and a cookie, and drank a glass of milk. In Col 1 you would write lunch. In Col 2 you would write cheeseburger, cookie, milk. In Col 3, under how many, you would write the amount of food: 1 cheeseburger, 2 cookies, 1 glass of milk. See the food diary as an example. You would repeat this process for all foods eaten at all meals.
- (4) For foods like stews or soups, write down the food on one line, and the major kinds of foods in the mixture on the lines below the name of the food. For example, write "stew" on the first line; then write the type of meat in the stew ("beef", "pork", "chicken", etc.) on the line below.
- (5) Please check (✓) the box in column 4 if the listed food item was not collected as part of the diet (Col 4).
- (6) Col 5 asks you to list the surfaces that the foods may have touched. For example, if your child dropped the food on the high chair tray and then ate it, you would write high chair tray in Col 5.
- (7) Col 6 asks you to write down the location in the room where this meal or snack was eaten.
- (8) Col 7 asks you to write down the room where this meal or snack was eaten.

Some examples are provided in the Food Diary. Our research staff will also discuss this with you and answer your questions. Please call our toll-free number (**1-877-810-9530, ext. 503**) if you have questions about completing the food diary or about any other study activities. Thanks very much for your participation in this study.

FOOD DIARY (Regular Form)							
START DATE and TIME: Technician: END DATE and TIME: Participant ID No.:							
Col 1	Col 2	Col 3	Col 4	Col 5	Col 6	Col 7	FOR INTERVIEWER USE ONLY
MEAL	PLEASE LIST ALL FOODS AND BEVERAGES THAT YOUR CHILD EATS AND DRINKS	How Many?	Check if NOT part of collected sample	Surfaces food touched	Location in Room	Room	Portion Size
Lunch	EXAMPLE: CHEESEBURGER	1		High chair tray	Sitting in high chair	Kitchen	
Lunch	EXAMPLE: COOKIE	2	✓	High chair tray	Sitting in high chair	Kitchen	
Lunch	EXAMPLE: MILK	1 glass					

FOOD DIARY (Subgroup Form)									
START DATE and TIME: Technician: END DATE and TIME: Participant ID No.:									
Col 1	Col 2	Col 3	Col 4	Col 5	Col 6	Col 7	Col 8	Col 9	FOR INTERVIEWER USE ONLY
MEAL	PLEASE LIST ALL FOODS AND BEVERAGES THAT YOUR CHILD EATS AND DRINKS	How Many?	Check if NOT part of collected sample	Leftover foods touched by hands	Leftover foods untouched	Surfaces food touched	Location in Room	Room	Portion Size
Lunch	EXAMPLE: CHEESEBURGER	1		✓		High chair tray	Sitting in high chair	Kitchen	
Lunch	EXAMPLE: COOKIE	2			✓	High chair tray	Sitting in high chair	Kitchen	
Lunch	EXAMPLE: MILK	1 glass							
CONTINUE ON BACK IF YOU HAVE MORE FOODS TO LIST.									

Food Sample Collection Log
 (For Staff Use Only)

Duplicate Diet Collection Log		
Technician:		
Date:	Participant ID No.:	Data Collection Event No.:
Check Duplicate Diet Sample Type		Remarks
<input type="checkbox"/> Solid Foods		
<input type="checkbox"/> Liquid Foods		
<input type="checkbox"/> Combined Diet, if child <9 months of age		
<input type="checkbox"/> Breast Milk		

Food Sample Collection Log
 (For Staff Use Only)

Leftover Foods Collection Log		
Technician:		
Date:	Participant ID No.:	Data Collection Event No.:
A. Food Type (Check One)		Description of collected food item (common name of food):
<input type="checkbox"/> Leftover Handled <input type="checkbox"/> Leftover Untouched		
B. Time the food was given to the child (Check One):		Remarks
<input type="checkbox"/> Breakfast <input type="checkbox"/> Morning Snack <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack		
C. Surface contacted by food (Check One):		Remarks
<input type="checkbox"/> Plate/bowl only <input type="checkbox"/> Hand only <input type="checkbox"/> Surface(s) only <input type="checkbox"/> Hand and Surface(s)		
D. Surface type (Check All That Apply):		Remarks
<input type="checkbox"/> High Chair <input type="checkbox"/> Table <input type="checkbox"/> Floor <input type="checkbox"/> Chair/Couch <input type="checkbox"/> Other(s); Specify SPECIFY OTHER: _____		

Technician: _____
Date: _____
Participant ID No.: _____
Data Collection Event#: _____

Keyed: <input type="checkbox"/>

Longitudinal Study of Young Children’s Exposures in their Homes to Selected Pesticides, Phthalates, Brominated Flame Retardants, and Perfluorinated Chemicals – A Children’s Environmental Exposure Research Study (CHEERS)

Monitoring Period Questionnaire
(Final Draft - 11/24/2003)

INTRODUCTION:

The purpose of this questionnaire is to collect data to assess the household activities during the 48-hour monitoring period (including the application day and post-application sampling period). Questions regarding indirect ingestion assessment are also included in this questionnaire. This household information collected at the same time as the environmental samples will provide useful data for the interpretation of the sampling results. This interview should take about 30 minutes to complete. The questionnaire will be programmed into a CAPI instrument. The questionnaire will be administered on the second day of the post-application sampling by the research staff using a laptop computer. A hard copy form will also be used as a contingency plan in case of computer malfunction.

A. PRE-INTERVIEW PREPARATION AND UPDATES:

<p>A1. INTERVIEWER: ENTER THE DATES AND TIMES OF THE 48-HOUR MONITORING PERIOD.</p>	<p>START DATE/TIME: _____ END DATE/TIME: _____</p>
<p>A2. INTERVIEWER: MEASURE THE HEIGHT AND WEIGHT OF CHILD.</p>	<p>CHILD'S HEIGHT: _____ (INCHES) WEIGHT: _____ (LBS/OZ)</p>
<p>A3. CAPI: CALCULATE CHILD'S AGE (SAMPLING DATE – CHILD'S DOB)/30</p>	<p>CHILD'S AGE _____ MONTHS</p>
<p>A4. INTERVIEWER: RECORD (WITH VERIFICATION FROM CAREGIVER, AS REQUIRED) CHILD'S MOVEMENTS ARE PRIMARILY...</p>	<p><input type="checkbox"/> NOT MOBILE (NOT CRAWLING YET) (1) <input type="checkbox"/> CRAWLING (2) <input type="checkbox"/> WALKING (3)</p>
<p>A5. INTERVIEWER: IS THIS THE SAME HOUSE (SAME ADDRESS)?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0)</p>
<p>A6. INTERVIEWER: RECORD THE DATE/TIME OF PESTICIDES APPLICATION. REVIEW MONTHLY PESTICIDE USE LOG.</p>	<p>DATE OF APPLICATION: _____ TIME OF APPLICATION: _____ PESTICIDE APPLIED: _____ IF DON'T KNOW PRODUCT NAME, RECORD AS "98"; ADD CAPI REMARKS AS NEEDED. EPA REGISTRATION NUMBER: _____ USE THE FOLLOWING CODES FOR SPECIAL SITUATIONS WHEN THE EPA REGISTRATION NUMBER IS NOT AVAILABLE: NUMBER NOT READABLE = 99991 NO LABEL ON PRODUCT = 99992 PRODUCT NOT IN ORIGINAL CONTAINER = 99993 DON'T KNOW NUMBER = 99998</p>

First, I would like to get some updated information from you.

A7. Since our last visit, have any of the following renovations or repairs been performed in your home?	CAPI: DISPLAY THE LIST. INTERVIEWER: RECORD YES/NO FOR EACH ITEM. IF YES, ASK WHEN IT WAS DONE.
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Activities List	Ye s	No	When
1) Interior painting or wood staining	<input type="checkbox"/>	<input type="checkbox"/>	
2) Exterior painting or wood staining	<input type="checkbox"/>	<input type="checkbox"/>	
3) New flooring, paneling, counter tops, or cupboards installed	<input type="checkbox"/>	<input type="checkbox"/>	
4) Wallpaper removed or applied	<input type="checkbox"/>	<input type="checkbox"/>	
5) Interior grouting applied	<input type="checkbox"/>	<input type="checkbox"/>	
6) New carpet laid	<input type="checkbox"/>	<input type="checkbox"/>	
7) Hardwood floors refinished	<input type="checkbox"/>	<input type="checkbox"/>	
8) Treatments to carpet and fabric, such as Scotchgard™ stain repellent	<input type="checkbox"/>	<input type="checkbox"/>	

A8. Have there been any other changes to your home, household members or activities since our last visit? (PROMPT: For examples, pets, jobs, child care)	<table style="width: 100%; border: none;"> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> YES</td> <td style="text-align: right; padding: 2px 0;">(1)</td> </tr> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> NO</td> <td style="text-align: right; padding: 2px 0;">(0)</td> </tr> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> DON'T KNOW</td> <td style="text-align: right; padding: 2px 0;">(-8)</td> </tr> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> REFUSED TO ANSWER</td> <td style="text-align: right; padding: 2px 0;">(-7)</td> </tr> </table>	<input type="checkbox"/> YES	(1)	<input type="checkbox"/> NO	(0)	<input type="checkbox"/> DON'T KNOW	(-8)	<input type="checkbox"/> REFUSED TO ANSWER	(-7)
<input type="checkbox"/> YES	(1)								
<input type="checkbox"/> NO	(0)								
<input type="checkbox"/> DON'T KNOW	(-8)								
<input type="checkbox"/> REFUSED TO ANSWER	(-7)								

IF YES, ASK A8A; ALL ELSE SKIP TO SECTION B.

A8A. What sort of changes?	RECORD CHANGES: _____
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B. MONITORING PERIOD INFORMATION

Now, I would like to ask you some questions about the daily activities of you and (*CHILD'S NAME*) during the past 48-hour, that is from (*DATE/TIME*) to (*DATE/TIME*).

<p>B1. During the last 48-hours, were any doors or windows opened to allow for natural air ventilation? (NOTE: This includes the application day and the post-application sampling period)</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B2. During the last 48-hours, were any fans or heating/air conditioning units used?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B3. During the last 48-hours, did anyone dust, sweep, wet mop, vacuum, or steam-clean your home (any rooms)?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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IF YES, ASK B3A; ALL ELSE SKIP TO B4.

B3A. Please tell me which rooms were cleaned and how it was cleaned.

CAPI DISPLAY ALL ROOMS IN THE HOUSE

**IF THIS IS A DIFFERENT HOUSE, I.E., SUBJECT MOVED, WE NEED TO UPDATE THE PARTICIPANT AND HOUSING CHARACTERISTICS QUESTIONNAIRE FIRST (DONE ON DAY 1 SAMPLING).
 USE A PAPER COPY BACKUP AS NEEDED.**

ROOMS	DUST	SWEEP	WET MOP	VACUUM	STEAM-CLEAN
#1	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
#2	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
#3	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
#4	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO

<p>B4. Have you used the following toiletries or medical products on (<i>CHILD'S NAME</i>) during the last 48 hours?</p>	<p>CAPI DISPLAY THE LIST. INTERVIEWER: READ THE LIST AND RECORD YES/NO FOR EACH ITEM.</p>
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- 1) Sunscreen
- 2) Baby oil
- 3) Petroleum jelly (Vaseline), including diaper ointment
- 4) Hand cream or hand lotion
- 5) Other cream, lotion, or moisturizer
- 6) Lipstick, chap stick, or lip balm
- 7) Powder (used on face, feet, or body)
- 8) Bath oil, bath gel, or bubble bath
- 9) Had intravenous treatment for a medical problem (IV inserted)
- 10) Used medicinal cream, lotion, or balm (e.g. anti-itch cream, foot treatment, Neosporin, tiger balm)

<p>B5. Does (<i>PARTICIPATING CHILD'S NAME</i>) frequently play in the yard that would involve contact with soil?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B6. Have the following chemical products been used in your home during the last 48 hours (whether by you or others)?</p>	<p>CAPI DISPLAY THE LIST. INTERVIEWER: READ THE LIST AND RECORD YES/NO FOR EACH ITEM.</p>
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- 1) Furniture refinishing chemicals
- 2) Strong-smelling glue
- 3) Spray adhesive
- 4) Paint for furniture, fabric, ceramics, or other hobby item
- 5) Solvents such as paint thinner, turpentine, or degreasers

<p>B7. Were any of the following cleaning products used in your home during the last 48 hours (whether by you or others)?</p>	<p>CAPI DISPLAY THE LIST. INTERVIEWER: READ THE LIST AND RECORD YES/NO FOR EACH ITEM.</p>
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- 1) Laundry detergent that had a fragrance
- 2) Fabric softener or dryer sheet that had a fragrance
- 3) Fabric starch
- 4) Cleaner for spot cleaning clothes, carpet, or upholstered furniture
- 5) Carpet cleaner used in special carpet cleaning equipment
- 6) Furniture polish or wax, such as Pledge or Tongoil
- 7) Shoe cleaner or shoe polish
- 8) Car interior cleaner, such as Armorall

<p>B8. Have you used the following toiletries and cosmetics during the last 48 hours?</p>	<p>CAPI DISPLAY THE LIST. INTERVIEWER: READ THE LIST AND RECORD YES/NO FOR EACH ITEM.</p>
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- 1) Anti-aging or overnight cream
- 2) Cleansing cream product (not astringents or alcohols)
- 3) Facial masks or deep cleanser
- 4) Sunscreen
- 5) Baby oil
- 6) Petroleum jelly (Vaseline), including diaper ointment
- 7) Hand cream or hand lotion
- 8) Other cream, lotion, or moisturizer, including shaving cream and skin bleaching or tanning products
- 9) Lipstick, chap stick, or lip balm
- 10) Foundation makeup
- 11) Eye shadow, liner, or mascara
- 12) Powder (used on face, feet, or body)
- 13) Cologne or perfume
- 14) Bath oil, bath gel, or bubble bath
- 15) Hair conditioner
- 16) Hair nutrient product (“hair food”)
- 17) Hair spray
- 18) Hair styling gel, Mousse, Pomade, or hair grease

<p>B9. ONLY ASK THE CHILD’S MOTHER Are you (still) breastfeeding (<i>CHILD’S NAME</i>)?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON’T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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IF YES, ASK B9A-B9I; ALL ELSE SKIP TO B10.

<p>B9A. Did you visit a beauty salon during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9B. Was your hair permed, straightened, or relaxed during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9C. Did you apply hair perm, straightener, or relaxer to your own hair or someone else's hair during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9D. Was your hair colored or highlighted during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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IF YES, ASK B9D1; ALL ELSE SKIP TO B9E.

<p>B9D1. Please tell me what type of coloring was used. Was it...? INTERVIEWER: READ LIST</p>	<p><input type="checkbox"/> Permanent, (1) <input type="checkbox"/> Semi-permanent, or (2) <input type="checkbox"/> Washable. (3) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9E. Did you apply a hair-coloring product to your own hair or someone else's hair during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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IF YES, ASK B9E1; ALL ELSE SKIP TO B9F.

<p>B9E1. Please tell me what type of coloring was used. Was it...? INTERVIEWER: READ LIST</p>	<p><input type="checkbox"/> Permanent, (1) <input type="checkbox"/> Semi-permanent, or (2) <input type="checkbox"/> Washable. (3) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9F. Was nail polish removed or applied to your finger or toenails during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9G. Did you apply or remove nail polish from your own or someone else's nails during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9H. Did you have someone apply, fill, or remove artificial nails for you during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B9I. Did you apply, fill, or remove artificial nails for someone during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B10. The next few questions are about your pets. If you have a dog or a cat, did (CHILD'S NAME) play with, and have contact with it during the last 48 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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IF YES, ASK B10A; ALL ELSE SKIP TO SECTION C.

*NOTE: IF THE CHILD PLAYED WITH A PET, WE NEED TO COLLECT A WIPE SAMPLE FROM THE PET.

<p>B10A. We would like to see if there are any pesticides on your pet's fur by wiping a dry cloth across your pet. May we collect the sample?</p> <p>NOTE: SAMPLE THE PET THAT THE CHILD PLAYED WITH.</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>B10B. What is your pet's name?</p> <p>NOTE: THE PET THAT THE CHILD PLAYED WITH.</p>	<p>RECORD PET'S NAME: _____</p>
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<p>B10C. INTERVIEWER: RECORD WHETHER PET IS A CAT OR A DOG.</p>	<p><input type="checkbox"/> CAT (1) <input type="checkbox"/> DOG (2)</p>
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C. PESTICIDES USE INFORMATION

The next question is about the activities on the day of your most recent pesticides application. That is on (*DATE*).

C1. On the day of the pesticide application, did you use a central forced air system for air conditioning or heating?	<input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)
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D. INDIRECT INGESTION ASSESSMENT

Now I am going to ask you some more questions about (*CHILD'S NAME*)'s daily activities. The first few questions are about the toy that we gave you during our last visit.

D1. INTERVIEWER: VERIFY WITH THE PARTICIPANT ABOUT THE ITEM PROVIDED TO THE CHILD.	SELECT ONE: <input type="checkbox"/> PACIFIER (1) <input type="checkbox"/> TEETHING RING (2) <input type="checkbox"/> TOY (3)
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D2. Did your child use the item during the last 24 hours?	<input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)
--	--

IF YES, ASK D2A; ELSE SKIP TO D3.

D2A. Approximately how many hours during the last 24-hour period?	RECORD TIME: _____ HOURS <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)
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D2B. How long has it been since your child sucked on the (ITEM IN D1)?	RECORD TIME: _____ MINUTES <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)
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The next questions ask about how often (*CHILD'S NAME*) puts his/her fingers or other toys and objects into his/her mouth.

<p>D3. Is (<i>CHILD'S NAME</i>) currently teething?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>D4. Does (<i>CHILD'S NAME</i>) use a pacifier?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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IF YES, ASK D4A; ELSE SKIP TO D5.

<p>D4A. How often does (<i>CHILD'S NAME</i>) use a pacifier?</p>	<p><input type="checkbox"/> LESS THAN 1 HOUR PER DAY (1) <input type="checkbox"/> 1-2 HOURS PER DAY (2) <input type="checkbox"/> 3-6 HOURS PER DAY (3) <input type="checkbox"/> MORE THAN 6 HOURS PER DAY (4) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
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<p>D5. How often does (<i>CHILD'S NAME</i>) put his/her hands into his/her mouth when indoors?</p>	<p><input type="checkbox"/> ALL THE TIME (1) <input type="checkbox"/> FREQUENTLY (2) <input type="checkbox"/> OCCASIONALLY (3) <input type="checkbox"/> RARELY (4) <input type="checkbox"/> NEVER (5)</p>
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IF NEVER, SKIP TO D6; ALL ELSE, ASK D5A.

<p>D5A. How much of his/her hand does he/she generally put into his/her mouth when indoors?</p>	<p>CHECK ONE: <input type="checkbox"/> 1 FINGER (1) <input type="checkbox"/> 2 FINGERS (2) <input type="checkbox"/> 3 FINGERS (3) <input type="checkbox"/> 4 FINGERS (4) <input type="checkbox"/> THUMB (5) <input type="checkbox"/> WHOLE HAND (6)</p>
---	---

<p>D6. How often does (<i>CHILD'S NAME</i>) put his/her hands into his/her mouth when outdoors?</p>	<p><input type="checkbox"/> ALL THE TIME (1) <input type="checkbox"/> FREQUENTLY (2) <input type="checkbox"/> OCCASIONALLY (3) <input type="checkbox"/> RARELY (4) <input type="checkbox"/> NEVER (5)</p>
---	---

IF NEVER, SKIP TO D7; ALL ELSE, ASK D6A.

<p>D6A. How much of his/her hand does he/she generally put into his/her mouth when outdoors?</p>	<p>CHECK ONE <input type="checkbox"/> 1 FINGER (1) <input type="checkbox"/> 2 FINGERS (2) <input type="checkbox"/> 3 FINGERS (3) <input type="checkbox"/> 4 FINGERS (4) <input type="checkbox"/> THUMB (5) <input type="checkbox"/> WHOLE HAND (6)</p>
---	--

<p>D7. How often does (<i>CHILD'S NAME</i>) put objects into his/her mouth when indoors?</p>	<p><input type="checkbox"/> ALL THE TIME (1) <input type="checkbox"/> FREQUENTLY (2) <input type="checkbox"/> OCCASIONALLY (3) <input type="checkbox"/> RARELY (4) <input type="checkbox"/> NEVER (5)</p>
--	---

<p>D8. How often does (<i>CHILD'S NAME</i>) put objects into his/her mouth when outdoors?</p>	<p><input type="checkbox"/> ALL THE TIME (1) <input type="checkbox"/> FREQUENTLY (2) <input type="checkbox"/> OCCASIONALLY (3) <input type="checkbox"/> RARELY (4) <input type="checkbox"/> NEVER (5)</p>
---	---

<p>D9. Please tell me the 3 most favorite toys, objects, or surfaces that (<i>CHILD'S NAME</i>) likes to put his/her mouth on it while indoors.</p>	<p>RECORD: 1. _____ 2. _____ 3. _____</p> <p>*NOTE: THIS INFORMATION IS IMPORTANT FOR IDENTIFYING THE TARGET FOR WIPE SAMPLING.</p>
--	---

<p>D10. Does (<i>CHILD'S NAME</i>) watch TV?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
---	---

IF YES, ASK D10A; ELSE SKIP TO D11.

<p>D10A. Where does your child normally spend time when watching TV?</p> <p style="text-align: center;">READ LIST</p>	<p><input type="checkbox"/> On the floor (1) <input type="checkbox"/> On the furniture (2) <input type="checkbox"/> On the lap of another person (3) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p>
--	---

<p>D11. Where does your child normally spend time when playing with favorite toys?</p> <p style="text-align: center;">READ LIST</p>	<p><input type="checkbox"/> On the floor (1) <input type="checkbox"/> On the furniture (2) <input type="checkbox"/> On the lap of another person (3) <input type="checkbox"/> Outdoors; (SPECIFY SURFACE) (4) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p> <p>SPECIFY OUTDOORS SURFACE: _____</p>
--	--

<p>D12. Where does your child normally spend time when being read to?</p>	<p><input type="checkbox"/> On the floor (1) <input type="checkbox"/> On the furniture (2) <input type="checkbox"/> On the lap of another person (3) <input type="checkbox"/> Outdoors; (SPECIFY SURFACE) (4) <input type="checkbox"/> NOT APPLICABLE (TOO YOUNG) (5) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p> <p>SPECIFY OUTDOORS SURFACE: _____</p>
--	---

<p>D13. If your child likes to be on the floor, how would you describe his/her typical contact with the floor?</p> <p>INTERVIEWER: READ THE LIST CHECK ALL THAT APPLY</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Laying on back</td> <td style="text-align: right;">(1)</td> </tr> <tr> <td><input type="checkbox"/> Laying on stomach</td> <td style="text-align: right;">(2)</td> </tr> <tr> <td><input type="checkbox"/> Laying on side</td> <td style="text-align: right;">(3)</td> </tr> <tr> <td><input type="checkbox"/> Sits</td> <td style="text-align: right;">(4)</td> </tr> <tr> <td><input type="checkbox"/> Kneels</td> <td style="text-align: right;">(5)</td> </tr> <tr> <td><input type="checkbox"/> Other; SPECIFY</td> <td style="text-align: right;">(6)</td> </tr> <tr> <td><input type="checkbox"/> DON'T KNOW</td> <td style="text-align: right;">(-8)</td> </tr> <tr> <td><input type="checkbox"/> REFUSED TO ANSWER</td> <td style="text-align: right;">(-7)</td> </tr> </table> <p>SPECIFY OTHER: _____</p>	<input type="checkbox"/> Laying on back	(1)	<input type="checkbox"/> Laying on stomach	(2)	<input type="checkbox"/> Laying on side	(3)	<input type="checkbox"/> Sits	(4)	<input type="checkbox"/> Kneels	(5)	<input type="checkbox"/> Other; SPECIFY	(6)	<input type="checkbox"/> DON'T KNOW	(-8)	<input type="checkbox"/> REFUSED TO ANSWER	(-7)
<input type="checkbox"/> Laying on back	(1)																
<input type="checkbox"/> Laying on stomach	(2)																
<input type="checkbox"/> Laying on side	(3)																
<input type="checkbox"/> Sits	(4)																
<input type="checkbox"/> Kneels	(5)																
<input type="checkbox"/> Other; SPECIFY	(6)																
<input type="checkbox"/> DON'T KNOW	(-8)																
<input type="checkbox"/> REFUSED TO ANSWER	(-7)																

<p>D14. If your child likes to be on the furniture, how would you describe his/her typical contact with the furniture?</p> <p>INTERVIEWER: READ THE LIST CHECK ALL THAT APPLY</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Laying on back</td> <td style="text-align: right;">(1)</td> </tr> <tr> <td><input type="checkbox"/> Laying on stomach</td> <td style="text-align: right;">(2)</td> </tr> <tr> <td><input type="checkbox"/> Laying on side</td> <td style="text-align: right;">(3)</td> </tr> <tr> <td><input type="checkbox"/> Sits</td> <td style="text-align: right;">(4)</td> </tr> <tr> <td><input type="checkbox"/> Kneels</td> <td style="text-align: right;">(5)</td> </tr> <tr> <td><input type="checkbox"/> Other; SPECIFY</td> <td style="text-align: right;">(6)</td> </tr> <tr> <td><input type="checkbox"/> DON'T KNOW</td> <td style="text-align: right;">(-8)</td> </tr> <tr> <td><input type="checkbox"/> REFUSED TO ANSWER</td> <td style="text-align: right;">(-7)</td> </tr> </table> <p>SPECIFY OTHER: _____</p>	<input type="checkbox"/> Laying on back	(1)	<input type="checkbox"/> Laying on stomach	(2)	<input type="checkbox"/> Laying on side	(3)	<input type="checkbox"/> Sits	(4)	<input type="checkbox"/> Kneels	(5)	<input type="checkbox"/> Other; SPECIFY	(6)	<input type="checkbox"/> DON'T KNOW	(-8)	<input type="checkbox"/> REFUSED TO ANSWER	(-7)
<input type="checkbox"/> Laying on back	(1)																
<input type="checkbox"/> Laying on stomach	(2)																
<input type="checkbox"/> Laying on side	(3)																
<input type="checkbox"/> Sits	(4)																
<input type="checkbox"/> Kneels	(5)																
<input type="checkbox"/> Other; SPECIFY	(6)																
<input type="checkbox"/> DON'T KNOW	(-8)																
<input type="checkbox"/> REFUSED TO ANSWER	(-7)																

<p>D15. Except when (<i>CHILD'S NAME</i>) is sleeping, typically when he/she is laying on his/her back, stomach, or side, would you describe (<i>CHILD'S NAME</i>) as...</p> <p>INTERVIEWER: READ THE LIST</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Active most of the time – moving a lot</td> <td style="text-align: right;">(1)</td> </tr> <tr> <td><input type="checkbox"/> Quiet most of the time – not moving a lot</td> <td style="text-align: right;">(2)</td> </tr> <tr> <td><input type="checkbox"/> DON'T KNOW</td> <td style="text-align: right;">(-8)</td> </tr> <tr> <td><input type="checkbox"/> REFUSED TO ANSWER</td> <td style="text-align: right;">(-7)</td> </tr> </table>	<input type="checkbox"/> Active most of the time – moving a lot	(1)	<input type="checkbox"/> Quiet most of the time – not moving a lot	(2)	<input type="checkbox"/> DON'T KNOW	(-8)	<input type="checkbox"/> REFUSED TO ANSWER	(-7)
<input type="checkbox"/> Active most of the time – moving a lot	(1)								
<input type="checkbox"/> Quiet most of the time – not moving a lot	(2)								
<input type="checkbox"/> DON'T KNOW	(-8)								
<input type="checkbox"/> REFUSED TO ANSWER	(-7)								

E. DUPLICATE DIET INFORMATION

The next few questions are about the food samples that you collected during the past 24-hour for (*CHILD'S NAME*). Let's take a look at the samples. I also need to collect the Food Diary from you.

INTERVIEWER: COLLECT FOOD SAMPLES AND FOOD DIARY. EXAMINE THE FOOD SAMPLES AND DIARY FOR ANY MISSING SAMPLE OR INFORMATION.

<p>E1. Is this duplicate diet representative of what (<i>CHILD'S NAME</i>) normally eats in a 24-hour period? Did you collect the same amount of food that (<i>CHILD'S NAME</i>) ate and drank during the past 24 hours?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0) <input type="checkbox"/> DON'T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)</p> <p>REMARKS: _____</p>
---	---

IF YES (NO PROBLEM), GO TO EATING HABITS; IF NO, ASK E1A.

<p>E1A. Was breakfast different?</p>	<p><input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0)</p>
--------------------------------------	--

IF YES, ASK E1A1; IF NO, ASK NEXT, MEAL.

<p>E1A1. Why was breakfast not usual? Did (<i>CHILD'S NAME</i>) eat more than the sample collected, did he/she eat less, or did he/she simply eat different food?</p>	<p><input type="checkbox"/> ATE MORE (1) <input type="checkbox"/> ATE LESS (2) <input type="checkbox"/> ATE DIFFERENT FOODS (3)</p>
---	---

<p>E1A2. Why did this happen? CHECK ALL THAT APPLY</p>	<p><input type="checkbox"/> AWAY FROM HOME (1) <input type="checkbox"/> CHANGE TO DAY CARE SCHEDULE (2) <input type="checkbox"/> ENTERTAINMENT OR SOCIAL OCCASION (3) <input type="checkbox"/> HAD PROBLEM COLLECTING BREASTMILK (4) <input type="checkbox"/> ILLNESS OR MEDICAL CONDITION (5) <input type="checkbox"/> NOT ENOUGH FOOD FOR THE SAMPLE (6) <input type="checkbox"/> TOO BUSY TO PREPARE FOOD (7) <input type="checkbox"/> OTHER, SPECIFY (8)</p> <p>SPECIFY OTHER: _____</p>
--	---

NEXT MEAL

E1B. Was lunch different?	<input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0)
---------------------------	---

IF YES, ASK E1B1; IF NO, ASK NEXT, MEAL.

E1B1. Why was lunch not usual? Did (<i>CHILD'S NAME</i>) eat more than the sample collected, did he/she eat less, or did he/she simply eat different food?	<input type="checkbox"/> ATE MORE (1) <input type="checkbox"/> ATE LESS (2) <input type="checkbox"/> ATE DIFFERENT FOODS (3)
---	--

E1B2. Why did this happen? CHECK ALL THAT APPLY	<input type="checkbox"/> AWAY FROM HOME (1) <input type="checkbox"/> CHANGE TO DAY CARE SCHEDULE (2) <input type="checkbox"/> ENTERTAINMENT OR SOCIAL OCCASION (3) <input type="checkbox"/> HAD PROBLEM COLLECTING BREASTMILK (4) <input type="checkbox"/> ILLNESS OR MEDICAL CONDITION (5) <input type="checkbox"/> NOT ENOUGH FOOD FOR THE SAMPLE (6) <input type="checkbox"/> TOO BUSY TO PREPARE FOOD (7) <input type="checkbox"/> OTHER, SPECIFY (8) SPECIFY OTHER: _____
--	--

NEXT MEAL

E1C. Was dinner different?	<input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0)
----------------------------	---

IF YES, ASK E1C1; IF NO, ASK NEXT, MEAL.

E1C1. Why was dinner not usual? Did (<i>CHILD'S NAME</i>) eat more than the sample collected, did he/she eat less, or did he/she simply eat different food?	<input type="checkbox"/> ATE MORE (1) <input type="checkbox"/> ATE LESS (2) <input type="checkbox"/> ATE DIFFERENT FOODS (3)
--	--

E1C2. Why did this happen? CHECK ALL THAT APPLY	<input type="checkbox"/> AWAY FROM HOME (1) <input type="checkbox"/> CHANGE TO DAY CARE SCHEDULE (2) <input type="checkbox"/> ENTERTAINMENT OR SOCIAL OCCASION (3) <input type="checkbox"/> HAD PROBLEM COLLECTING BREASTMILK (4) <input type="checkbox"/> ILLNESS OR MEDICAL CONDITION (5) <input type="checkbox"/> NOT ENOUGH FOOD FOR THE SAMPLE (6) <input type="checkbox"/> TOO BUSY TO PREPARE FOOD (7) <input type="checkbox"/> OTHER, SPECIFY (8)
SPECIFY OTHER: _____	

NEXT MEAL

E1D. Were snacks different?	<input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0)
-----------------------------	---

IF YES, ASK E1D1; IF NO, GO TO EATING HABITS.

E1D1. Why were snacks not usual? Did (<i>CHILD'S NAME</i>) eat more than the sample collected, did he/she eat less, or did he/she simply eat different food?	<input type="checkbox"/> ATE MORE (1) <input type="checkbox"/> ATE LESS (2) <input type="checkbox"/> ATE DIFFERENT FOODS (3)
---	--

E1D2. Why did this happen? CHECK ALL THAT APPLY	<input type="checkbox"/> AWAY FROM HOME (1) <input type="checkbox"/> CHANGE TO DAY CARE SCHEDULE (2) <input type="checkbox"/> ENTERTAINMENT OR SOCIAL OCCASION (3) <input type="checkbox"/> HAD PROBLEM COLLECTING BREASTMILK (4) <input type="checkbox"/> ILLNESS OR MEDICAL CONDITION (5) <input type="checkbox"/> NOT ENOUGH FOOD FOR THE SAMPLE (6) <input type="checkbox"/> TOO BUSY TO PREPARE FOOD (7) <input type="checkbox"/> OTHER, SPECIFY (8) SPECIFY OTHER: _____
--	--

F. **EATING HABITS**

<p>F1. In the next question, I will read a list of activities related to eating habits. Please tell me whether (<i>CHILD'S NAME</i>) did it during the last 24-hours . . .</p>	<p>CAPI: DISPLAY THE LIST INTERVIEWER: READ THE ACTIVITY AND RECORD FREQUENCY. PROMPT THE PARTICIPANT AS NEEDED.</p> <p><input type="checkbox"/> ALL THE TIME (1) <input type="checkbox"/> FREQUENTLY (2) <input type="checkbox"/> OCCASIONALLY (3) <input type="checkbox"/> RARELY (4) <input type="checkbox"/> NEVER (5)</p>
--	---

Activities List

- 1) Puts food on other surfaces
- 2) Uses fingers to eat meals
- 3) Washes hands before meals
- 4) Washes hands after meals
- 5) Uses napkin during meals
- 6) Licks fingers while eating meals
- 7) Uses fingers to eat snacks
- 8) Washes hands before snacks
- 9) Washes hands after snacks
- 10) Uses napkin during snacks
- 11) Licks fingers while eating snacks
- 12) Eats while walking around
- 13) Wipes fingers on clothes
- 14) Wipes fingers on furniture
- 15) Drops food on clothes
- 16) Drops food on floor
- 17) Eats food dropped on floor
- 18) Has sticky fingers
- 19) Plays with food

<p>F2. For (<i>CHILD'S NAME</i>)'s age, do you think his/her eating habits are...? INTERVIEWER: READ THE RESPONSES</p>	<p><input type="checkbox"/> Very neat (1) <input type="checkbox"/> Neat (2) <input type="checkbox"/> Typical for his/her age and gender (3) <input type="checkbox"/> Messy (4) <input type="checkbox"/> Very Messy (5)</p>
--	--

INTERVIEWER: SHOW PROMPT CARDS.

F3. INTERVIEWER: WAS THE CHILD PROVIDED A STANDARD FOOD OBJECT?	<input type="checkbox"/> YES (1) <input type="checkbox"/> NO (0)
--	---

IF YES, ASK F3A; IF NO, GO TO SECTION G, CHILD’S HEALTH INFORMATION.

F3A. The following questions are about the cheese cube we provided to (<i>CHILD’S NAME</i>). I will read a list of eating activities. Please tell me whether (<i>CHILD’S NAME</i>) did it all the time, frequently, occasionally, rarely, or never when he/she was eating the cheese cube.	CAPI: DISPLAY THE LIST INTERVIEWER: READ THE ACTIVITY AND RECORD FREQUENCY. PROMPT THE PARTICIPANT AS NEEDED. <input type="checkbox"/> ALL THE TIME (1) <input type="checkbox"/> FREQUENTLY (2) <input type="checkbox"/> OCCASIONALLY (3) <input type="checkbox"/> RARELY (4) <input type="checkbox"/> NEVER (5)
--	--

Activities List

- 1) Wiped fingers on clothes
- 2) Wiped fingers on furniture
- 3) Dropped food on clothes
- 4) Dropped food on floor
- 5) Ate food from floor
- 6) Had sticky fingers
- 7) Played with food
- 8) Licked fingers

F3B. For (<i>CHILD’S NAME</i>)’s age, do you think the way he/she ate the cheese cube was ...? INTERVIEWER: READ THE RESPONSES	<input type="checkbox"/> Very neat (1) <input type="checkbox"/> Neat (2) <input type="checkbox"/> Typical for his/her age and gender (3) <input type="checkbox"/> Messy (4) <input type="checkbox"/> Very Messy (5)
---	---

G. CHILD’S HEALTH INFORMATION

The next few questions ask about your child’s visits to a health care provider in the past 3 months. We are interested in your child’s visits for health events such as illnesses. This does not include routine well child visits or visits for vaccinations only.

G1. In the past three months, how many times has (<i>CHILD’S NAME</i>) visited a health care provider such as a doctor or nurse practitioner for health events?	RECORD # OF VISITS: _____ OR <input type="checkbox"/> DON’T KNOW (-8) <input type="checkbox"/> REFUSED TO ANSWER (-7)
---	--

IF 0 VISIT or REF/DK (-8 or -7), GO TO CONCLUDING STATEMENT; ALL ELSE GO TO G1A.

G1A. What was the reason or reasons that (<i>CHILD’S NAME</i>) went to the health care provider for the (<i>first</i>) visit?	CAPI: REPEAT QUESTION EACH TIME FOR TOTAL NUMBER OF VISITS – SUBSTITUTE “SECOND VISIT”, “THIRD VISIT”, ETC. INTERVIEWER: CHECK ALL THAT APPLY.
---	---

Visit # (WRITE IN #'S FROM LIST BELOW)	Visit Reasons (WRITE IN SPECIFIC ILLNESS BELOW)
#1	

ILLNESS LIST:

- 1) COLD
- 2) CONVULSIONS (SAME AS SEIZURES)
- 3) COUGH
- 4) DIARRHEA
- 5) EAR INFECTION
- 6) FEVER
- 7) PNEUMONIA
- 8) POISONING (ANY)
- 9) SKIN RASH (ANY)
- 10) SORE THROAT
- 11) VOMITING
- 12) OTHER ILLNESS [SPECIFY]
- 8) DON’T KNOW
- 7) REFUSED TO ANSWER

SPECIFY OTHER ILLNESS: _____

Closing Statement:

Thank you. That concludes our interview. You have been very helpful.

INTERVIEWER: CONDUCT OBSERVATION OF HOUSEHOLD CONDITIONS, COMPLETE SECTION H.

H. OBSERVATION OF HOUSEHOLD CONDITIONS BY THE PROJECT STAFF

INTERVIEW INFORMATION

H1. CONDITIONS	YES	NO	REMARKS
A. SMELL IN THE HOUSE (I.E., STALE CIGARETTE SMOKE, ROTTING FOOD)	<input type="checkbox"/>	<input type="checkbox"/>	
B. FLOOR COVERING IN OTHER ROOMS SOILED, COVERED IN BITS, CRUMBS, ETC.	<input type="checkbox"/>	<input type="checkbox"/>	
C. KITCHEN FLOOR SOILED, COVERED IN BITS, CRUMBS, ETC.	<input type="checkbox"/>	<input type="checkbox"/>	
D. KITCHEN SINK, DRAINING BOARD, WORK SURFACES OR CUPBOARD DOOR HAVE NOT BEEN WASHED FOR A CONSIDERABLE PERIOD OF TIME	<input type="checkbox"/>	<input type="checkbox"/>	
E. OTHER SURFACES IN THE HOUSE HAVE NOT BEEN DUSTED FOR A CONSIDERABLE PERIOD OF TIME	<input type="checkbox"/>	<input type="checkbox"/>	
F. FURNISHINGS OR FURNITURE SOILED	<input type="checkbox"/>	<input type="checkbox"/>	
G. CAREGIVER'S OR CHILDREN'S CLOTHING CLEARLY UNWASHED, OR HAIR MATTED AND UNBRUSHED	<input type="checkbox"/>	<input type="checkbox"/>	

STAFF ID #	DATA COLLECTION EVENT#:	DATE	TIME STARTED	TIME ENDED	RESULTS (IF INCOMPLETE, SPECIFY REASON)
					1) COMPLETE 2) INCOMPLETE
					1) COMPLETE 2) INCOMPLETE
					1) COMPLETE 2) INCOMPLETE
					1) COMPLETE 2) INCOMPLETE
					1) COMPLETE 2) INCOMPLETE
					1) COMPLETE 2) INCOMPLETE

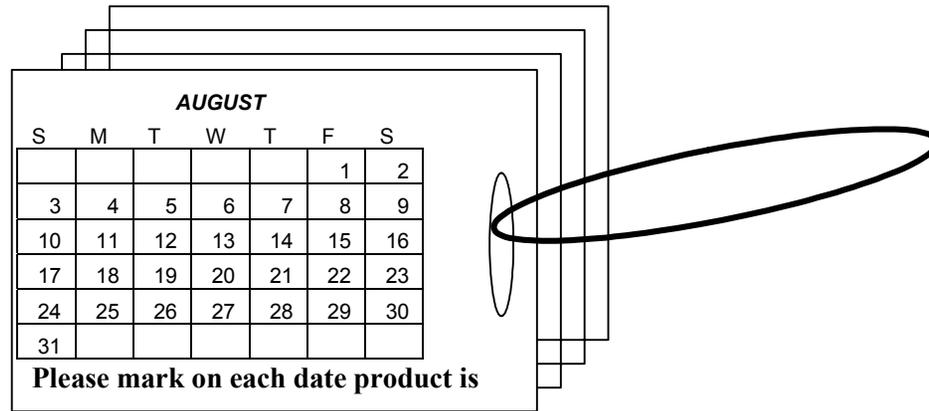
Monthly Cleaning Products Purchase, Inventory, and Use Log
(Final Draft - 11/24/2003)

INTRODUCTION:

The purpose of this data form is to collect information on the purchase and use of cleaning products during each month. This information is only required for cleaning products with an EPA registration number. The form will be completed by the adult care giver of the child. The completed form will be collected by a project staff during each data collection event.

We will develop small calendar tags (Monthly Use Tags) for the participant to record the product use. We can make the Monthly Use Tags and attached it (up to 6 tags) to the cleaning product with a rubber band (See Figure 1). To make it water proof, the Monthly Use Tags can be laminated. A *Sharpie* will be attached to the tags so it will be handy for checking the Monthly Use Tag. The information will be recorded by the research staff when they visit the participant.

Figure 1 - Monthly Use Tags



Monthly Cleaning Products Use Log
(To be completed by staff)

1.	Participant ID	
2.	Product Code	
3.	Product Name	
4.	EPA Registration Number	
5.	Use Dates	
6.	Remarks (locations and Applicators)	

	D Who Used Cleaner	E Method(s) of Application	F Targeted Use
	01=Self	01=Sprayer, Hand Trigger 02=Sprayer, Hand Pump 03=Aerosol Spray 04=Liquid 05=Lotion/Paste/Gel 06=Foam 07=Granular/Tablets/Powder/Pellets 08=Spot-on 09=Shampoo	10=Cloth Wipes 11=Paper Towels 12=Mop 13=Brush 14=Sponge 15=Other (Specify) -8=Don't Know -7=Refused to Answer
			01=Household Germs 02=Mold, Mildew 03=Surface Sanitizer/Disinfectant 04=Carpet Sanitizer 05=Air Freshener/Deodorizer 06=Fabric Freshener/Deodorizer -8=Don't Know -7=Refused to Answer

Note to field technician: List cleaning products purchased this month and products currently in the home.

(This inventory only applies to cleaning products with an EPA registration number.)

A	B	C	D	E	F
Study Code	Name of Product	EPA Registration No.	Who Used Cleaner	Method(s) of Application	Targeted Use
445	ABC Toilet Cleaner	1234-01	1	5	3

VERSION 4 - 11/24/2003

Participant ID:

Date:

Technician:

Longitudinal Study of Young Children's Exposures in their Homes to Selected Pesticides, Phthalates, Brominated Flame Retardants, and Perfluorinated Chemicals – A Children's Environmental Exposure Research Study (CHEERS)

Monthly Pesticide Purchase, Inventory, and Use Log
(Final Draft - 11/24/2003)

INTRODUCTION:

The purpose of this data form is to collect information on pesticide purchase and use during each month. The form will be completed by the adult care giver of the child. The completed form will be collected by a project staff during each data collection event. This data form will be designed in a booklet format and in a calendar format.

MONTHLY PESTICIDE/CLEANERS PURCHASE LOG

1.	Participant ID	
2.	Purchase Date	
3.	Product Code	
4.	Product Name	
5.	EPA Registration Number	

MONTHLY PESTICIDE USE LOG		
1.	Participant ID	
2.	Application Date	
3.	Product Code	
4.	Product Name	
5.	Pesticide Applied By (Check One) SPECIFY FAMILY MEMBER OR OTHER:	<input type="checkbox"/> Self <input type="checkbox"/> Family Member, (SPECIFY) <input type="checkbox"/> Professional Pest Control Applicator <input type="checkbox"/> Lawn Care Specialist/Contractor <input type="checkbox"/> Building maintenance staff <input type="checkbox"/> Other, (SPECIFY)
6.	Method of Application (Check All That Apply) SPECIFY OTHER:	<input type="checkbox"/> Sprayer, Aerosol <input type="checkbox"/> Sprayer, Hand Pump <input type="checkbox"/> Sprayer, Hand Trigger <input type="checkbox"/> Sprayer, Hose-end <input type="checkbox"/> Sprayer, Spritz <input type="checkbox"/> Bait Station/Trap <input type="checkbox"/> Candles/Coil <input type="checkbox"/> Fly Strip <input type="checkbox"/> Foam/Gel <input type="checkbox"/> Fogger <input type="checkbox"/> Granules/Dust/Powder/Pellets <input type="checkbox"/> Liquid <input type="checkbox"/> Lotion <input type="checkbox"/> Pet Collar/Spot-on <input type="checkbox"/> Shampoo <input type="checkbox"/> Other, (SPECIFY)

MONTHLY PESTICIDE USE LOG		
7.	Pests Targeted (Check All That Apply)	<input type="checkbox"/> Ants <input type="checkbox"/> Cockroaches <input type="checkbox"/> Crickets <input type="checkbox"/> Fleas/Ticks <input type="checkbox"/> Flies <input type="checkbox"/> Lice <input type="checkbox"/> Mice/Rats <input type="checkbox"/> Mold/Mildew <input type="checkbox"/> Mosquitoes <input type="checkbox"/> Termites <input type="checkbox"/> Wasps/Bees <input type="checkbox"/> Water bugs <input type="checkbox"/> Weeds/grass
8.	Locations Applied SPECIFY OTHER INDOOR AREA: SPECIFY OTHER OUTDOOR AREA:	Indoor Locations: <input type="checkbox"/> Attic <input type="checkbox"/> Basement <input type="checkbox"/> Bathroom - Child's <input type="checkbox"/> Bathroom - Other <input type="checkbox"/> Bedroom - Child's <input type="checkbox"/> Bedroom - Other <input type="checkbox"/> Child's Play Room <input type="checkbox"/> Dining Room <input type="checkbox"/> Family Room <input type="checkbox"/> Game Room <input type="checkbox"/> hallway <input type="checkbox"/> Indoor Enclosed Porch/Sunroom <input type="checkbox"/> Kitchen <input type="checkbox"/> Laundry/Utility Room <input type="checkbox"/> Living Room <input type="checkbox"/> Office/Study/Den <input type="checkbox"/> Other indoor area (SPECIFY) Outdoor Locations: <input type="checkbox"/> Aquatic Garden/Pond <input type="checkbox"/> Deck/Patio/Porch <input type="checkbox"/> Garage - Attached <input type="checkbox"/> Garage - Detached <input type="checkbox"/> Garden <input type="checkbox"/> Greenhouse <input type="checkbox"/> Lawn <input type="checkbox"/> Ornamental Flowers <input type="checkbox"/> Shed <input type="checkbox"/> Shrubs/Bushes <input type="checkbox"/> Structure/Foundation <input type="checkbox"/> Trees - Fruit/Nut <input type="checkbox"/> Trees - Ornamentals/Other Types

MONTHLY PESTICIDE USE LOG		
		<input type="checkbox"/> Other outdoor area (SPECIFY) On Pets and People: <input type="checkbox"/> Participating Child <input type="checkbox"/> Other Children under 18 years old <input type="checkbox"/> Self <input type="checkbox"/> Other Adult <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other Pet
9.	How long before child entered treated room after application?	Time: _____ <input type="checkbox"/> Hours or <input type="checkbox"/> Minutes

ACTIVITY TIME LINE [MORNING 12 - 4 AM]

Activity Number: 1 2 3 4

PID: Data Collection Event:

Date: --



Sleeping



Eating



Quiet Play



Active Play

VERSION 7 - 11/24/2003

midnight 12:30 am 1 am 1:30 am 2 am 2:30 am 3 am 3:30 am 4 am

Activity Number(s):	<input type="text"/>								
Location: Inside Home 	<input type="checkbox"/>								
Outside Near Home 	<input type="checkbox"/>								
Away from Home 	<input type="checkbox"/>								
Room: Fill in the name of each room.	<input type="text"/>								
	<input type="text"/>								
	<input type="text"/>								
	<input type="text"/>								
	<input type="text"/>								
Parts of Body Covered:									
Torso 	<input type="checkbox"/>								
Arms 	<input type="checkbox"/>								
Legs 	<input type="checkbox"/>								
Feet 	<input type="checkbox"/>								
Bottom 	<input type="checkbox"/>								
Washing:									
Bath/Shower 	<input type="checkbox"/>								
Hands 	<input type="checkbox"/>								