

Study to Explore Early Development Survey of Gastrointestinal Function

The following questions will ask about your child's dietary habits and stool patterns. Please check your responses.

1. Do you feel like your child's diet is...

- Good
- Limited
- Poor
- Don't know

2. Does your child currently have any diet restrictions?

- Yes
- No (*go to question 6*)
- Don't know (*go to question 6*)

3. If yes, what are the diet restrictions? Please list all.

4. Is your child's diet... *Check all that apply*

- Self restricted
- Parent restricted
- Medically prescribed
- Don't know

5. Why does your child have diet restrictions? Please describe symptoms that are affected by food, such as stool consistency, stool frequency, rash, or behavior.

6. Has your child ever had difficulty swallowing on a regular basis (for 2-3 weeks)?

- Yes
- No (*go to question 11*)
- Don't know (*go to question 11*)

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7. At what age did your child have this problem? Please record the age of your child for each instance he/she had this problem.

1st instance: _____ months or _____ years

2nd instance: _____ months or _____ years

3rd instance: _____ months or _____ years

8. What consistencies of food did your child have difficulty swallowing?

	Yes	No	Don't know
a. Liquid.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Solid.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Nectar.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Has your child ever had a swallow study?

- Yes
- No (go to question 11)
- Don't know (go to question 11)

10. Was the result of the study normal or abnormal for...

	Normal	Abnormal	Don't know
a. Thin liquids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Solids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Nectar consistency....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Has your child ever rejected certain textures of foods for more than 2 to 3 weeks?

- Yes
- No (go to question 14)
- Don't know (go to question 14)

12. At what age did your child reject textures? Please record the age of your child for each instance he/she rejected textures.

1st instance: _____ months or _____ years

2nd instance: _____ months or _____ years

3rd instance: _____ months or _____ years

13. What textures of food did your child reject?

	Yes	No	Don't know
a. Hard to chew (tough meat or raw carrot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Crunchy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Mushy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sticky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Mixed texture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(mixture of at least two of the above textures)

- g. Other
Specify: _____

14. Do you feel that your child currently has gastrointestinal (bowel) problems on a regular basis (more than twice a month)?

- Yes
- No (go to question 18)
- Don't know (go to question 18)

15. Does your child have any of the following gastrointestinal problems?

- | | Yes | No | Don't know |
|---|--------------------------|--------------------------|--------------------------|
| a. Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Loose stools | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Loose stools alternating with constipation ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Abdominal pain with meals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Abdominal pain relieved by defecation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Pain on stooling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Gaseousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify _____ | | | |

If yes for any condition in question 15, please complete questions 16 and 17.
If no or don't know for all the above conditions, go to question 18.

16. How old was your child when the problem started? Please refer back to the conditions listed in question 15 and write the name of the condition under "Condition".

Condition	Age Problem Started
Example: <u>diarrhea</u>	<u>32</u> months or _____ years
1. _____	_____ months or _____ years
2. _____	_____ months or _____ years
3. _____	_____ months or _____ years
4. _____	_____ months or _____ years
5. _____	_____ months or _____ years

17. How often did your child have each problem? Please refer back to the conditions listed in question 15 and write the name of the condition under "Condition".

Condition	2-4 times per month	1-2 times per week	3-6 times per week	Daily	Don't know
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- | | | | | | |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

18. Do you feel that your child had gastrointestinal symptoms in the past that are not present now?

- Yes
- No (*go to question 21*)
- Don't know (*go to question 21*)

19. At what age did the symptoms go away?

_____ months or _____ years

20. What did you do that made the symptoms go away? Please be specific.

21. In the past 30 days, has your child used stool softeners, laxatives or fiber supplements?

- Yes
- No (*go to question 24*)
- Don't know (*go to question 24*)

22. What was the name of the product(s)?

23. How many times during the month did your child use the product(s)?

- Product 1 _____
- Product 2 _____
- Product 3 _____

24. Does your child vomit more than once a month when not associated with an illness?

- Yes
- No (*go to question 26*)
- Don't know (*go to question 26*)

25. What seems to be causing the vomiting? *Check all that apply.*

- Crying
- Stress

- Certain smells
- Eating too quickly
- Eating too much
- Reflux
- Other: _____
- Don't know

26. Is there ever any blood in your child's stool?

- Yes
- No
- Don't know

27. Has there ever been a time when your child's stools were greasy, mucousy, frothy, or more foul smelling than usual, more than one time per week for a long period of time?

	Yes	No	Don't know
a. Greasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Mucousy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Frothy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. More foul smelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes for any condition in 27, please answer question 28.

If no or don't know for all conditions, please go to question 29.

28. At what age(s)? Please refer to the conditions in question 27 and write the name of the condition under "Condition".

Condition	Age Problem Started
<i>Example: <u>greasy</u></i>	<i><u>32</u> months or _____ years</i>
1. _____	_____ months or _____ years
2. _____	_____ months or _____ years
3. _____	_____ months or _____ years
4. _____	_____ months or _____ years

29. Has your child ever had a severe episode of dehydration requiring medical intervention?

- Yes
- No (*go to question 32*)
- Don't know (*go to question 32*)

30. How many times has your child had these dehydration episodes?

_____ times

31. What type of medical intervention did your child receive during these episodes?

Episode 1 _____

Episode 2 _____

We are interested in getting some more information about your child's current stool patterns.

32. How many stools does your child have per day? Would you say it is...

- 0 – 1 stools
- 2 – 3 stools
- more than 3 stools
- Don't know

33. How many stools does your child have per week? Would you say it is...

- less than 3 stools
- 3 – 7 stools
- more than 7 stools
- Don't know

34. Does your child currently wear diapers?

- Yes (*go to question 35 and refer to LIST A*)
- No (*go to question 35 and refer to LIST B*)
- Don't know

35. What is the typical consistency of your child's stools? Would you say it is...

LIST A (use this list if your child wears diapers)

- Separate hard lumps, like nuts or rabbit pellets
- Sausage-shaped but lumpy
- Like a sausage or snake but with cracks on its surface, form may be changed slightly by sitting on stool
- Like a sausage or snake, smooth and soft, may be deformed by sitting on stool
- Soft blobs with clear cut edges, never a sausage
- Runny, no form
- Watery, no solid pieces, soaks into diaper
- Don't know

LIST B (use this list if your child does not wear diapers)

- Separate hard lumps, like nuts
- Sausage-shaped but lumpy
- Like a sausage or snake but with cracks on its surface
- Like a sausage or snake, smooth and soft
- Soft blobs with clear-cut edges
- Fluffy pieces with ragged edges, a mushy stool
- Watery, no solid pieces
- Don't know

36. Are your child's stools like separate hard lumps, fluffy pieces with ragged edges (mushy stool), or watery with no solid pieces two or more times per week?

- Yes

- No
- Don't know

37. Does your child alternate between loose stools and hard stools?

- Yes
- No
- Don't know