

STUDY ID: \_\_\_\_\_  
 DATE: \_\_\_ / \_\_\_ / \_\_\_ (dd/mm/yy)  
 INTERVIEWER: \_\_\_

**SCREENING QUESTIONNAIRE**

*“These questions are about [your child]. They will cover initial questions to determine if he/she is eligible to participate in the study. Please answer each question as carefully as possible. ALL INFORMATION THAT YOU GIVE WILL BE KEPT STRICTLY CONFIDENTIAL.”*

*(Note to interviewer: do not record “uncertain” as an answer unless the subject absolutely cannot answer. “Uncertain” should not be offered as a choice of answer. If the subject insists on responding uncertain/unsure, write a note of this response next to*

*the question, or fill with “999...” all numeric fields.)*

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0593). Do not return the completed form to this address.

**GENERAL SCREENING:**

1)	How many weeks along were you when [your child] was born?	___ ___ weeks
	1A) <i>If unsure: Was it less than 34 weeks? Less than 7 ½ months?</i>	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
<b>ASTHMA SCREENING:</b>		
2)	Has [your child] ever been diagnosed with any of the following: cystic fibrosis, chronic lung disease, chronic bronchitis, or recurrent pneumonias?	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
3)	Has [your child] ever been diagnosed with any other diseases?	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
	3A) <i>If yes: which?</i>	_____ _____ _____
4)	Has [your child] had a cough, runny nose, or other cold or flu symptoms in the last 2 weeks?	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
5)	Has [your child] been diagnosed with pneumonia or bronchiolitis in the last 2 months?	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
7)	Has [your child] had an attack or recurrent attacks of wheezing?	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
	7A) <i>If yes: how many in the last year?</i>	<input type="checkbox"/> 0 - Less than 3 <input type="checkbox"/> 1 - Three or more
8)	Does [your child] have wheezing in the chest when he/she is <b>not</b> sick with a cold or the flu?	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes