Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

CHILD BIOMETRIC MEASURES

(Ages 3-11)

CHILD BIOMETRIC MEASURES (Ages 3-11)

Interviewer_____ Study ID # |_|_|_|_|-

Date of Completion

_____

Time of Completion_____

Now I'm going to begin with some general questions about your child's health that relate to the biometric measures we will be collecting today.

PART A.
DEMOGRAPHICS

1. How are you related to (CHILD)?
   1. BIOLOGICAL MOTHER.....(SKIP TO 3)
   2. BIOLOGICAL FATHER(SKIP TO 3)
   3. ADOPTIVE/STEP/FOSTER/MOTHER(SKIP TO 3)
   4. ADOPTIVE/STEP/FOSTERFATHER(SKIP TO 3)
   5. PARTNER OF CHILD'S MOTHER OR FATHER
   6. GRANDPARENT
   7. BROTHER/SISTER (BIOLOGICAL/ADOPTIVE/STEP/IN-LAW/FOSTER
   8. AUNT/UNCLE
   9. OTHER RELATIVE
   10. OTHER NONRELATIVE
   11. LEGAL GUARDIAN(SKIP TO 3)
   12. CHILD IS WARD OF STATE OR
   13. COURT.....(SKIP TO 3)
   97. DON'T KNOW
   98. REFUSED

2.Are you (CHILD)'s guardian?

1 YES
2. NO
3. DON'T KNOW
4. REFUSED

WEIGHT

3. How do **you** describe your child's weight? Would you say:

A. Very underweight
B. Slightly underweight
C. About the right weight
D. Slightly overweight
E. Very overweight
DON'T KNOW
REFUSED

TOBACCO SMOKE/EXPOSURE

4. During the past 7 days, on how many days was your child in the same room with someone who was smoking cigarettes?

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0. 0 days
1. 1 or 2 days
2. 3 or 4 days
3. 5 or 6 days
4. 7 days
7. Don't know
9. Refused

RECENT FOOD INTAKE

5What food or foods did child <> eat during his/her last meal or snack? Please list all the food and drinks you had .List:

5a. what time was that food eaten? _____

5b.Is child you currently fasting?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

RECENT ILLNESS

6. Please tell me about any cold, flu or other illness your child has had in the last 2 weeks. For each one, please tell me how recently the illness occurred.

If no illness in last 2 weeks, check here: _____

Illness	Today	Last 2 days	Last 2 weeks
1) _____	☐	☐	☐
2) _____	☐	☐	☐
3) _____	☐	☐	☐
4) _____	☐	☐	☐
5) _____	☐	☐	☐

DON'T KNOW
REFUSED

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The next few questions will help us understand the results of your child's saliva sample.

7. Before this visit, when was the last time your child brushed his/her teeth?
   Time: _____ AM/PM
   DON'T KNOW
   REFUSED

8 The last time your child brushed his/her teeth, did *he/she* see any pink or reddish color when he/she spit into the sink?

Yes

No

DON'T KNOW

REFUSED

9.In the past 24 hours has your child had any injuries to his/her mouth or any dental work that caused bleeding?

Yes

No
DON'T KNOW
REFUSED

10. Does your child have any open sores or cuts in his/her mouth?

Yes

No
DON'T KNOW
REFUSED

11. In the last 24 hours, has {child} lost a tooth?

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Yes
No
DON'T KNOW
REFUSED

PART B.

1. CHILD HEIGHT
   MEASURED CM..... .|_|_|
   RF.....9999
2. CHILD WAIST CIRCUMFERANCE
   MEASURED CM..... .|_|_|
   RF.....9999
3. CHILD WEIGHT
   MEASURED KG..... .|_|_|
   RF.....9999
4.

5. SALIVA SAMPLE COLLECTED YES/NO.....

5a. SALIVA SAMPLE # ID..... -|_|_|_|_|-

5b. SALIVA SAMPLE SHIPPING # ID..... -|_|_|_|_|-

6. CHILD ACCELEROMETRY STUDY PARTICIPANT? YES/NO.....

6a. ACCELEROMETER ID # ID..... -|_|_|_|_|-