OMB Number: 0925-0593
Expiration Date: July 31, 2013

STUDY ID: __ __ __ __ __

DATE: __ __ / __ __ / __ __ *(dd/mm/yy)*

INTERVIEWER: __ __

Demographic and Health Questionnaire

"These questions are about [your child]. They will only be used for scientific purposes. 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, make a note of this response next to the questions, or fill with "999…" all numeric fields.)*

DEMOGRAPHICS:		
1.	What is your relationship to [the child]?	1 - Biological mother 2 - Biological father 3 - Stepmother 4 - Stepfather 5 - Grandparent 6 - Sibling 7 - Legal guardian 8 - Other
1A	***If "other":*** *Please specify?*	______________________
2.	What is [your child]'s date of birth?	__ __ / __ __ / __ __ __ __
3.	[Child]'s gender:	1 - male 2 - female
4.	Was [the child] born in the U.S.?	1 - yes 0 - no
5.	What is [your child]'s ethnicity?	1 - Hispanic 2 - not Hispanic -1 – Refused -2 – Don't know
6.	Race of [the child]:	1 - White 2 - Black or African American 3 – American Indian or Alaska Native 4 – Asian, or Native Hawaiian or other Pacific Islander 5 – Some other race -1 – Refused

Public reporting burden for this collection of information is estimated to average 10 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.

		-2 – Don’t know
7.	Highest level of education completed by parent or legal guardian in the household:	1 – Less than a HS diploma or GED 2 - HS diploma (or GED) 3 - some college but no degree 4 – associate degree 5 – bachelor’s degree 6 – post graduate degree -1 – Refused -2 – Don’t know
<u>PREGNANCY AND PERINATAL PERIOD</u>:		
8.	Was [the child] born prematurely? (less than 37 weeks)	1 - Yes☐☐ 0 - No
9.	How many weeks pregnant were you when the child was born?	__ __ weeks
10.	Was [the child] in the intensive care unit (NICU)? ***<u>If no</u>: Skip to question #11***	1 - Yes☐☐ 0 - No
	*10A. **<u>In the NICU</u>**, did [the child] need a ventilator or a tube in his/her lungs to help him/her breathe?*	1 - Yes☐☐ 0 - No
	10B. Did [the child] need oxygen at home after leaving the NICU?	1 - Yes☐☐ 0 - No
	10C. Did [the child] need a monitor at home after leaving the NICU?	1 - Yes☐☐ 0 - No
<u>ASTHMA QUESTIONS</u>:		
11.	Has [the child]'s mom and/or dad ever been diagnosed with asthma by a doctor?	1 - Yes☐☐ 0 - No
12.	Has [the child] ever been diagnosed with eczema by a doctor?	1 - Yes☐☐ 0 - No
13.	Has [the child] ever been diagnosed with allergic rhinitis or hay fever by a doctor?	1 - Yes☐☐ 0 - No
14.	Does [the child] have wheezing in the chest apart from when he/she is sick with a cold or the flu?	1 - Yes☐☐ 0 - No
15.	Has [the child] ever been tested by a doctor and found to have food allergies?	1 - Yes☐☐ 0 - No
16.	Does [your child] have a wheeze or cough after exercise?	1 - Yes☐☐ 0 - No
17.	Does [your child] have wheeze, chest tightness, or cough after exposure to airborne allergens or pollutants?	1 - Yes☐☐ 0 - No
18.	Do [your child]’s “go to the chest” or take more than 10 days to resolve?	1 - Yes☐☐ 0 - No
19.	Are symptoms improved by anti-asthma treatment?	1 - Yes☐☐ 0 - No
<u>OTHER PERSONAL/MEDICAL HISTORY</u>:		
20.	Has [the child] ever been diagnosed with any of the following?	
	20A) Bronchiolitis / RSV	1 - Yes☐☐0 - No
	20B) Pneumonia	1 - Yes☐☐0 - No
	20C) Recurrent pneumonia	1 - Yes☐☐0 – No
	20D) Eczema	1 - Yes☐☐0 – No
	20E) Allergic rhinitis / hay fever	1 - Yes☐☐0 - No
	20F) Cystic fibrosis	1 - Yes☐☐0 - No

	20G) Chronic lung disease	1 - Yes□□0 – No
FAMILY / SOCIAL HISTORY:		
21.	Has [the child]'s mother ever been diagnosed with:	
	25A) Asthma	1 - Yes□□0 – No
	25B) Allergic rhinitis or hay fever	1 - Yes□□0 – No
	25C) Eczema	1 - Yes□□0 – No
	25D) Emphysema or COPD	1 - Yes□□0 – No
22.	Has [the child]'s father ever been diagnosed with:	
	26A) Asthma	1 - Yes□□0 – No
	26B) Allergic rhinitis or hay fever	1 - Yes□□0 – No
	26C) Eczema	1 - Yes□□0 – No
	26D) Emphysema or COPD	1 - Yes□□0 – No
23.	Have any of [the child]'s siblings ever been diagnosed with:	1 - Yes□□0 – No
	23A) Asthma	1 - Yes□□0 – No
	23B) Allergic rhinitis or hay fever	1 - Yes□□0 – No
	23C) Eczema	1 - Yes□□0 – No