ATTACHMENT C.3.2
OMB Number: 0925-0593
Expiration Date: July 31, 2013

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