

Study to Explore Early Development

Interviewer _____

Study ID# _____

Date of Completion _____

Time of Completion _____

Blood Draw Information Form

1. Please tell me all vaccinations, medications, vitamins, and supplements, both prescription and over the counter, <you have> taken in the last month.

[Interviewer: Check box for MOST RECENT time frame when medication was last taken.]

If no medications, vitamins, or supplements given in last month, check here: _____

| Type of substance _____ | Last 7 days | Last month |
|-------------------------|--------------------------|--------------------------|
| 1) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) _____ | <input type="checkbox"/> | <input type="checkbox"/> |

2. List any cold, flu, fever, or other illness <you have> had in the last 2 weeks. *[Interviewer: Check box for MOST RECENT time frame when illness occurred.]*

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

| Illness _____ | Last 2 days | Last 2 weeks |
|---------------|--------------------------|--------------------------|
| 1) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) _____ | <input type="checkbox"/> | <input type="checkbox"/> |

4) _____

3. Have you or anyone else smoked cigarettes, cigars, No

or pipes anywhere inside your home in the past week? Yes, person giving blood smoked

Yes, someone else in home smoked