

Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/XXXX

## **Study to Explore Early Development**

Interviewer	Study ID#			
	Date of Completion			
	Time of C	ompletion		
Bloo	Blood Draw Information Form			
1. Please tell me all vaccinations, m and over the counter, <you hav<br="">[Interviewer: Check box for MOST F</you>	e> taken in the last m	onth.		
If no medications, vitamins, or supplements given in last month, check here:				
Type of substance	Last 7 days	Last month		
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
List any cold, flu, fever, or other i     Check box for MOST RECENT  If no illness in last 2 weeks, chec	time frame when illne		[Interviewer:	
		Last 2 weeks		
Illness				
1)				
2)				
3)				

Public reporting burden of this collection of information is estimated to average 10 minutes, 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0010).

4)		
3. Have you or anyone else smoked cigarettes, ciga	ars,	□ No
or pipes anywhere inside your home in the past wee	ek?	$\square$ Yes, person giving blood smoked
		Yes, someone else in home smoked