

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