

## 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, <child first name> has 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 < child first name> has 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) _____	<input type="checkbox"/>	<input type="checkbox"/>

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

or pipes anywhere inside your child's home  
in the past week?

Yes, person giving blood smoked

Yes, someone else in home smoked