

ALL IN

Allergy and Infection Study

24 month interview

General Instructions:

1. Questions to be read to respondents in **bold**
2. Instructions to interviewers marked: **Interviewer**
3. Instructions meant to be read to respondents are in *italics*
4. For multiple choice questions: CROSS boxes
5. For single response questions: enter value in drop down box

Hello my name is from the Born in Bradford project. Thank you for agreeing for us to visit you again.

This questionnaire asks about you and your child. We are interested to know about your child's health and environment, how your child is feeding and who looks after your child. The questions are similar to those we asked at the 12 month visit. We would like to know how these things have changed over the last year.

We would be grateful if you would help us by answering as many of these questions as possible but if there are any questions you do not want to answer that is fine. There are no right or wrong answers.

All the answers you give are confidential. Your name and address will not appear anywhere on the questionnaire.

We apologise if any questions cause offence – we are asking everyone the same questions but we realize some religions do not permit certain things.

I will ask most of the questions but there are some sections of the questionnaire that I will ask you to complete yourself. I will be here to help you if you have any queries.

Thank you for agreeing to answer these questions.

FRONT SHEET

BiB study ID:

Date completed:

Interviewer name/code:

Child's date of birth:

Mother's date of birth:

Questionnaire completed: at home

at clinic

other *please specify* -----

Completed by: child's mother

child's father

other *please specify* -----

				Not able to take	Already taken at BiB 1000 24 mth visit
Mother's weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	kgs	<input type="checkbox"/>	<input type="checkbox"/>
Child's weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	gms	<input type="checkbox"/>	<input type="checkbox"/>
Child's height	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	cms	<input type="checkbox"/>	<input type="checkbox"/>
Child's abdominal circumference	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	cms	<input type="checkbox"/>	<input type="checkbox"/>

SECTION A

GENERAL HEALTH

This first section asks about you and your child's general health

A1. I would now like to ask you about your health. How would you describe your own health generally. Would you say it is

Excellent

Very Good

Good

Fair

Poor

A2. I would now like to ask you about your child's health. How would you describe his/her general health?

Excellent

Very Good

Good

Fair

Poor

SECTION B: CHILDHOOD ILLNESSES

We would like to know about any health problems (child's name) has been taken to the GP surgery for. How many separate health problems, if any, has (child's name) had, not counting any accidents or injuries?

B1. Has (child's name) seen a doctor or nurse since their first birthday because he/she had a problem you were worried about? (Cross ONE box only)

Yes No Don't know Refused

Interviewer: If NO, go to Q4

B2. How many times? (Cross ONE box only)

Once Twice 3-4 5 - 10
11 or more Don't know Refused

B3. What was the reason for the visit? (Cross ALL that apply)

	Yes and saw a doctor	Yes but did not see a doctor
Tummy upset/wind/colic	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Crying	<input type="checkbox"/>	<input type="checkbox"/>
High temperature	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/fits	<input type="checkbox"/>	<input type="checkbox"/>
Snuffles/cold	<input type="checkbox"/>	<input type="checkbox"/>
Chest infection	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>
Not gaining enough weight	<input type="checkbox"/>	<input type="checkbox"/>
Gaining too much weight	<input type="checkbox"/>	<input type="checkbox"/>
Other Please describe	<input type="checkbox"/>	<input type="checkbox"/>

.....
B4. Has (child's name) been given any medical diagnosis since their first birthday?

Yes No

Please list a. _____
b. _____
c. _____
d. _____

B5. Has (child's name) been admitted to hospital since their first birthday? (Cross ONE box only)
(Child must have been in hospital at least 24 hours)

Yes No Don't know Refused

Interviewer: If YES how many times?

B6. Has (child's name) been to a hospital outpatient clinic since their first birthday? (Cross ONE box only)

Yes No Don't know Refused

Interviewer: If YES how many times?

B7. Since their first birthday, has (child's name) been hurt, injured or had an accident and needed medical attention from a doctor or hospital? (Cross ONE box only)

Yes None Don't know Refused

If YES, how many times?

SECTION C: FEEDING YOUR CHILD

This next section asks questions about how you have been feeding your child.

C1. Is (child's name) currently being breastfed?

Yes No Don't know

If yes go to C3

C2. How old was (child's name) when he/she completely stopped being breastfed?

Interviewer: Include expressed breast milk (Cross ONE box only)

Still having breast milk

Days

Weeks

Months

Don't know

C3. Have you ever been told by a doctor that (child's name) has a food allergy?

Yes No

If yes, please specify which food(s):

.....

.....

.....

SECTION D: WHO YOU LIVE WITH

Can I just check, has your marital status changed since we last saw you?

D1. Are you: (Cross ONE box only)

- Married
- Re-married
- Single (never married)
- Separated (but still legally married)
- Divorced
- Widowed

D2. Are you: (Cross ONE box only)

- Living with child's father
- Living with another partner
- Not living with a partner but in a relationship (e.g. partner living abroad or in another property)
- Not living with a partner and not in a relationship

I would also like to ask you about the people who usually live here, even if they are away at present. A household involves living at the same address and sharing cooking facilities and sharing a living room, dining room or kitchen. Please remember that all answers you give me will be completely confidential.

D3. Since your child's first birthday, have there been any changes in the number of people who live regularly as members of the household you live in?

- Yes
No Go to Section E

D4. Including yourself, how many people live regularly as members of the household you live in?

Number of people

I would now like to ask you a few details about each person you live with. We can start with whoever you like.

What is the first name of that person?

And what is their relationship to you?

Interviewer: Please show Prompt Card 1. - If gender not obvious ask

Is this person male or female?

Do you know their date of birth?

Interviewer: Enter month and year only. If not known ask:

Do you know their age at their last birthday?

Now moving on to the next person in your house...

What is the first name of that person?

ALL IN 24 month questionnaire Version2_20May10

	Name	Sex M/F	Date of birth	Age
Your husband/partner			____/____	
Your boy children			____/____	
Your girl children			____/____	
Your mother			____/____	
Your father			____/____	
Your husband/partner mother			____/____	
Your husband/partners father			____/____	
Your brother			____/____	
Your sister			____/____	
Your husband/partners brother			____/____	
Your husband/partners sister			____/____	
Your grandmother			____/____	
Your grandfather			____/____	
Your husband/partners grandmother			____/____	
Your husband/partners grandfather			____/____	
Other adult male relatives of yours (adult here means 16 or over)			____/____	
Other adult female relatives of yours			____/____	
Adult male non-relatives			____/____	
Adult female non- relatives			____/____	
Other boy children			____/____	
Other girl children			____/____	

Repeat as necessary

We are also interested to know if you and/or your husband/partner are working nowadays.

SECTION E: EMPLOYMENT STATUS

E1. Since your child's first birthday, have there been any changes in the paid work that you or your husband/partner do?

- Yes
No Go to Section F

E2. First can you tell me which of the things on this card best describes what you are currently doing? (Cross ONE box only)

Interviewer: If respondent is on annual leave/sick leave from their employer, code as working

- In a job and currently working for an employer
- On maternity leave from an employer
- Self employed
- Full time student
- Looking after the home and family
- Doing something else

Other

Interviewer: Write in 'doing something else' answer (description of activity).

E3. Can I just check, have you returned to work since (child's name) was born, or are you still on leave?

- Yes, has returned to work
- No, still on leave

Interviewer: If answers

a. 'in a job and currently working for an employer'

OR

'on maternity leave from an employer'

-ask questions in **Employment Status** section for mother **Question E4**

b. If mother does not work and living with a husband/partner

-go to **Employment Status** section and ask from **QE8**

EMPLOYMENT STATUS - Contd.

Now we have some questions about any paid work you or your husband/partner may have undertaken since your baby was born.

About yourself

Employed or self-employed

E4. Do you work as an employee or are you self employed? (Cross ONE box only)

- Employee
- Self employed with employees
- Self employed/freelance without employees (go to **E7**)
- Student/in training (go to **E8**)

Number of employees

E5. For employees: 'How many people work for your employer at the place where you work?'

For self employed: 'How many people do you employ?'

Interviewer: Go to **E7** when you have completed this question.)

- 1-24 25 or more

Supervisory status

E6. Do you supervise any other employees? (A supervisor or foreman is responsible for overseeing the work of other employees on a day-to-day basis).

(Cross ONE box only)

- Yes No

Occupation

E7. What best describes the sort of work you did/do?

(Cross ONE box only)

- Modern professional occupations
- Clerical and intermediate occupations
- Senior managers or administrators
- Technical and craft occupations
- Semi routine manual and service occupations
- Routine manual and service occupations
- Middle or junior managers
- Traditional professional occupations

Interviewer: If mother has a partner/husband living with her, please ask the following:

EMPLOYMENT STATUS - Contd.

About your partner/husband

E8. Is/was your partner/husband employed? (Cross ONE box only)

Yes No Never been in employment

If never in employment go to Section F

Employed or self-employed

E9. Does/did he work as an employee or is/was he self-employed? (Cross ONE box only)

Employee

Self employed with employees

Self employed/freelance without employees (go to QE12)

Student/in training (go to Section F)

Number of employees

E10. For employees: 'How many people work/ed for your partner/husband's employer at the place where he works/worked?'

For self employed: 'How many people do/did your partner/husband employ?'

Interviewer: Go to **E12** when you have completed this question.)

1-24 25 or more

Supervisory status

E11. Does/did he supervise any other employees? (A supervisor or foreman is responsible for overseeing the work of other employees on a day-to-day basis).

(Cross ONE box only)

Yes No

E12. What best describes the sort of work he did/does?(Cross ONE box only)

- Modern professional occupations
- Clerical and intermediate occupations
- Senior managers or administrators
- Technical and craft occupations
- Semi routine manual and service occupations
- Routine manual and service occupations
- Middle or junior managers
- Traditional professional occupations

SECTION F: CHILD CARE

F1. Have you ever made any *regular* arrangement for your child to be looked after, either while you are at work or for any other reasons?

By regular we mean an arrangement that normally runs for at least five hours a week and has lasted for at least one month.

Yes No

If no go to Section H

F2. If YES, have your regular childcare arrangements changed in any way since your child's first birthday?

Yes No

If no go to Section H

F3. If YES, who currently looks after (child's name)? This question is about *current* arrangements.

Interviewer: Please complete *all current arrangements* on the one grid below.

	How many hours per week on average?	In your home?		Does the carer feed your child?		How many other children are usually present when your child is being looked after?	How old was your child when this childcare arrangement started? Enter age in months
		Yes	No	Yes	No		
Husband/Wife/Partner	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Child's non-resident father/mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your partner's mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your partner's father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Child's non-resident father's/mother's mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Child's non-resident father's/mother's father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other relative	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Friends/Neighbours	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

ALL IN 24 month questionnaire Version2_20May10

Live-in nanny/au pair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other nanny/au pair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Registered childminder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unregistered childminder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workplace/college nursery/crèche	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Local authority day nursery/crèche	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Private day nursery/crèche	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Other specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interviewer: Write in other carer

F4. a) If your child attends a nursery could you please tell us the name and address of the nursery?

Name of nursery:

Address:

Postcode:

Age started at this nursery (months):

Interviewer: If the child *currently* attends more than one nursery please give the details of the other nurseries below and specify the age at which the child started at each.

F4. b) If your child attends a nursery could you please tell us the name and address of the nursery?

Name of nursery:

Address:

Postcode:

Age started at this nursery (months):

F4. c) If your child attends a nursery could you please tell us the name and address of the nursery?

Name of nursery:

Address:

Postcode:

Age started at this nursery (months):

SECTION G: PREVIOUS CHILDCARE ARRANGEMENTS

We are also interested in any other childcare arrangements you may have had since your child's first birthday.

Interviewer: If the child has only attended the current childcare arrangements described above since their first birthday do not continue. ONLY add any other regular arrangements attended before the current arrangements but since their first birthday.

G1. Starting with the first childcare arrangement after your child's first birthday, who looked after (child's name)?

Interviewer: Please complete *all previous arrangements since the child's first birthday* on the one grid below. Some arrangements may have been concurrent or overlapping.

	How many hours per week on average?	In your home?		Does the carer feed your child?		How many other children are usually present when your child is being looked after?	How old was your child when this childcare arrangement started? <small>Enter age in months</small>	How old was your child when this childcare arrangement stopped? <small>Enter age in months</small>
		Yes	No	Yes	No			
Husband/Wife/Partner	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Child's non-resident father/mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your partner's mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Your partner's father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Child's non-resident father's/mother's mother	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Child's non-resident father's/mother's father	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other relative	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Friends/Neighbours	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Live-in nanny/au pair	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other nanny/au pair	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Registered childminder	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Unregistered childminder	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

ALL IN 24 month questionnaire Version2_20May10

Workplace/college nursery/crèche	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Local authority day nursery/crèche	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Private day nursery/crèche	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other specify	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Interviewer: Write in other carer

G2. a) If your child attended nursery since their first birthday please tell us the name and address of the nursery?

Name of nursery: -.....

Address:.....

Postcode:

From age months to age months.

Interviewer: If child attended more than one nursery since their first birthday, please complete details below and specify ages when baby attended each.

G2. b) If your child attended any other nursery since their first birthday please tell us the name and address of the nursery?

Name of nursery: -.....

Address:.....

Postcode:

From age months to age months.

G2. c) If your child attended any other nursery since their first birthday please tell us the name and address of the nursery?

Name of nursery: -.....

Address:.....

Postcode:

From age months to age months.

SECTION H: MOTHER AND BABY ACTIVITIES

H1. From 12 months of age until now, how often did you and your child attend activities with other babies or young children, other than child care, e.g. playgroups, mother and baby groups? (Cross ONE box only)

- Rarely
- At least once a month
- Usually once a week
- More than once a week

SECTION I: YOUR CHILD'S ENVIRONMENT

The following questions are about **your child's** home. We asked you some of these questions at the 12 month visit but would like to ask them again in case there have been any changes.

Interviewer: assuming respondent is mother of child and lives in same home

11. a) Are there any pets living in your home? We would like to know about pets who spend any time inside your home but please do not include pets who always live outside.

- Yes
- No

b) If yes, which of the following pets do you have? (CROSS as many boxes as apply)

- Dog
- Cat
- Other furry pets
- Bird
- Others

12. a) From 12 months of age until now, did your child usually share a *bedroom* with other people (adults or children)?

- Yes
- No

b) If yes, who?

- Parent(s) only
- Parent(s) and sibling(s)
- Sibling(s) only
- Other please specify _____

13. a) From 12 months of age until now, did your child usually share a *bed* with other people (adults or children)?

- Yes
- No

b) If yes, who?

- Parent(s) only
- Parent(s) and sibling(s)
- Sibling(s) only
- Other please specify _____

14. Which fuel do you use for cooking?
(CROSS as many boxes as apply)

- Electricity
- Gas
- Coal or wood
- Other

15. Which fuel do you use for heating?

(CROSS as many boxes as apply)

- Gas
- Oil
- Electricity
- Coal or coke
- Wood
- Other

16. a) Does your home have central heating?

- Yes
- No

b) If no, type of heating _____

17. Does your home have a wood or coal fire with a chimney?

- Yes
- No

18. Does your home have a gas fire?

- Yes
- No

19. Does your home have damp spots on the walls or ceiling?

- Yes
- No

110. Does your home have visible moulds or fungus on the walls or ceiling?

- Yes
- No

111. What kind of floor covering is there in the following rooms in your home?

	Kitchen	Sitting Room	Other living area	Play room	Your child's bedroom
Fitted carpets					
Loose carpets					
Hard flooring (e.g. wooden floorboards, laminate, lino, tiles)					

I12. What kind of windows are there in your child's bedroom?

(CROSS as many boxes as apply)

- Single glazing
- Sealed unit/double glazing
- No windows

I13. What kind of pillow(s) does your child use? (CROSS as many boxes as apply)

- Foam
- Synthetic fibre
- Feather
- Does not use a pillow
- Don't know
- Other

I14. What kind of bedding does your child use? (CROSS as many boxes as apply)

- Synthetic quilt
- Feather quilt
- Blankets
- Other materials
- Don't know

I15. a) Have you made any changes in your home* because your child had asthma, eczema or allergic problems?

* **Interviewer:** i.e. relating to the factors in Section I.

- Yes
- No

b) If yes, give details

SECTION J:

J1. Has your child ever had an itchy rash which was coming and going for at least six months?

- Yes
 No

If No, please skip to question J3

J2. Has this itchy rash at any time affected any of the following places:

the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck, ears or eyes?

- Yes Don't know/can't remember
 No

J3. Has your child ever had eczema?

- Yes Don't know/can't remember
 No

J4. Has your child ever had a problem with sneezing or a runny or blocked nose, when he/she DID NOT have a cold or the 'flu?

- Yes
 No

If No, please skip to question J7

J5. Has this nose problem been accompanied by itchy-watery eyes?

- Yes Don't know/can't remember
 No

J6. In which of the past 12 months did this nose problem occur? (Please tick any which apply)

- | | | | | | |
|----------|--------------------------|--------|--------------------------|-----------|--------------------------|
| January | <input type="checkbox"/> | May | <input type="checkbox"/> | September | <input type="checkbox"/> |
| February | <input type="checkbox"/> | June | <input type="checkbox"/> | October | <input type="checkbox"/> |
| March | <input type="checkbox"/> | July | <input type="checkbox"/> | November | <input type="checkbox"/> |
| April | <input type="checkbox"/> | August | <input type="checkbox"/> | December | <input type="checkbox"/> |

- Don't know/can't remember

J7. Has your child ever had hay fever?

- Yes Don't know/can't remember
 No

SECTION K: TRAVEL ABROAD

K1. Has your child travelled outside the UK since their first birthday? (Cross ONE box only)

- No
- Within Europe only
- Outside Europe

K2. If they have travelled *outside Europe* since their first birthday please give the details of each visit below:

Visit	Age at visit (months)	Country	Length of visit (weeks)
1			
2			
3			
4			
5			

Add more rows as necessary

K3. Did your child travel *outside Europe* before their first birthday?

- Yes
- No

K4. If yes, did they receive any medical treatment such as blood transfusions or injections while abroad?

- Yes
- No

K5. If yes, please give details below:

	Age (months)	Country	Type of medical treatment received
1			
2			
3			
4			
5			

SECTION L: LIFESTYLE

SMOKING

L1. Have you ever regularly smoked cigarettes; that is at least one cigarette a day?
(CROSS one box only)

Yes for more than 1 year Yes less than 1 year No

If NO, go to question L4

L2. Do you smoke cigarettes nowadays? (CROSS one box only)

Yes No

L2a. If no, when did you stop smoking?

Age Years old Don't remember

L3. If yes, how many cigarettes do/did you smoke since giving birth to (child's name)? (CROSS one box only)

None	1-5 a day	6-10 a day	11-20 a day	Over 20 a day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

L4. Are you exposed to other peoples' smoke at work or at home and if YES, for how many hours per day approx

Yes No Less than one hour per day/occasionally

If yes – Hours

L5. Is (child's name) exposed to other peoples' smoke and if YES, how many hours per day approx?

Yes Less than one hour per day/occasionally No

If yes – Hours

SECTION M: IMMUNISATIONS AND INFECTIONS

M1. Which immunisations has your child had since their first birthday?

Interviewer: please check red book (personal child health record). If not available, please complete the table if the parents can remember (and indicate that red book was not checked in the last column)

Usual age at immunisation	Diseases protected against	Vaccine	Tick box if given	Date given (dd/mm/yy)	Don't know if given	Checked in red book? Circle as appropriate
Around 12 months	Haemophilus influenzae type b (Hib) and meningitis C	Hib/MenC	<input type="checkbox"/>		<input type="checkbox"/>	Yes/No
Around 13 months	Measles, mumps and rubella (German measles)	MMR (1 st dose) and PCV	<input type="checkbox"/>		<input type="checkbox"/>	Yes/No
	Pneumococcal infection		<input type="checkbox"/>		<input type="checkbox"/>	Yes/No
	Measles, mumps and rubella (German measles)	MMR (2 nd dose)	<input type="checkbox"/>		<input type="checkbox"/>	Yes/No

Please add any other immunisations below (including any travel immunisations)

Vaccine	Date given (dd/mm/yy)	Checked in red book? (Y/N)

Add more rows as necessary

M2.a) Has your child had chickenpox? (CROSS one box only)

Yes No Don't know

b) If yes, at what age (months)?

Enter age in months or weeks

Months old Weeks

c) Was the chickenpox diagnosed by a doctor?

Yes No

SECTION N: SELF COMPLETION

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a CROSS how often you felt or thought a certain way.

N1. In the last month, how often have you been upset because of something that happened unexpectedly?

Never

Almost never

Sometimes

Fairly often

Very often

N2. In the last month, how often have you felt that you were unable to control the important things in your life?

Never

Almost never

Sometimes

Fairly often

Very often

N3. In the last month, how often have you felt nervous and "stressed"?

Never

Almost never

Sometimes

Fairly often

Very often

N4. In the last month, how often have you felt confident about your ability to handle your personal problems?

Never

Almost never

Sometimes

Fairly often

Very often

N5. In the last month, how often have you felt that things were going your way?

Never

Almost never

Sometimes

Fairly often

Very often

N6. In the last month, how often have you found that you could not cope with all the things that you had to do?

Never

Almost never

Sometimes

Fairly often

Very often

N7. In the last month, how often have you been able to control irritations in your life?

Never

Almost never

Sometimes

Fairly often

Very often

N8. In the last month, how often have you felt that you were on top of things?

Never

Almost never

Sometimes

Fairly often

Very often

N9. In the last month, how often have you been angered because of things that were outside of your control?

Never

Almost never

Sometimes

Fairly often

Very often

N10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Never

Almost never

Sometimes

Fairly often

Very often

Thank you for completing this questionnaire.

