

Name of participant: Participant ID:

For each of your children, please answer the following questions about them. If more than 5 children, please record the details on a separate piece of paper.

	1 st Child	2 nd Child	3 rd Child	4 th Child	5 th Child
1. What was the mother of this child's age when they became pregnant with this child? (age in years)	_____ (years)	_____ (years)	_____ (years)	_____ (years)	_____ (years)
2. What is this child's date of birth?	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
3. What was this child's birth weight? (in Pounds and ounces OR Kilograms)	_____ (lb,oz) _____ (kgs)	_____ (lb,oz) _____ (kgs)	_____ (lb,oz) _____ (kgs)	_____ (lb,oz) _____ (kgs)	_____ (lb,oz) _____ (kgs)
4. How many weeks pregnant was the mother of this child when she delivered this child?	_____ (weeks)	_____ (weeks)	_____ (weeks)	_____ (weeks)	_____ (weeks)
5. Was this child delivered by Caesarean section?	<input type="radio"/> Yes - Elective <input type="radio"/> Yes - Emergency <input type="radio"/> No	<input type="radio"/> Yes - Selective <input type="radio"/> Yes - Emergency <input type="radio"/> No	<input type="radio"/> Yes - Selective <input type="radio"/> Yes - Emergency <input type="radio"/> No	<input type="radio"/> Yes - Selective <input type="radio"/> Yes - Emergency <input type="radio"/> No	<input type="radio"/> Yes - Selective <input type="radio"/> Yes - Emergency <input type="radio"/> No
6. What city did the mother of this child spend the majority of her pregnancy with this child?	_____	_____	_____	_____	_____
7. Was the mother of this child working indoors during her pregnancy with this child?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
8. Did the mother of this child smoke during her pregnancy with this child?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?
9. Did you (the father of this child) smoke during the pregnancy with this child?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?	<input type="radio"/> No <input type="radio"/> stopped before pregnancy <input type="radio"/> cut down or stopped during pregnancy <input type="radio"/> smoked as usual during pregnancy?
10. Was the mother of this child hospitalised with nausea and vomiting (hyperemesis) during her pregnancy with this child?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know

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11. Did the mother of this child develop a high blood pressure during her pregnancy with this child?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
12. Did the mother of this child have protein in her urine during her pregnancy with this child?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
13. Did the mother of this child have sugar in her urine (glycosuria) during her pregnancy with this child?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
14. Did the mother of this child develop diabetes during her pregnancy with this child?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
15. How was this child breast fed for the first 3 months of life?	<input type="radio"/> Breast only <input type="radio"/> Bottle only <input type="radio"/> Breast and Bottle	<input type="radio"/> Breast only <input type="radio"/> Bottle only <input type="radio"/> Breast and Bottle	<input type="radio"/> Breast only <input type="radio"/> Bottle only <input type="radio"/> Breast and Bottle	<input type="radio"/> Breast only <input type="radio"/> Bottle only <input type="radio"/> Breast and Bottle	<input type="radio"/> Breast only <input type="radio"/> Bottle only <input type="radio"/> Breast and Bottle
16. Has this child ever had eczema or atopic dermatitis?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
17. Has this child ever had hayfever or allergic rhinitis?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
18. Did this child have asthma before the age of ten years?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
19. Did this child have asthma after the age of ten years?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

In the future we would like to contact your children to ask them to take part the TAHS study. We are therefore asking for the contact details of the children not currently living with you:

Child's first name	_____	_____	_____	_____	_____
Child's middle name	_____	_____	_____	_____	_____
Child's surname	_____	_____	_____	_____	_____
Does this child live with you?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Address	_____	_____	_____	_____	_____
Suburb	_____	_____	_____	_____	_____
Phone numbers	_____	_____	_____	_____	_____