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MY YOUNG 4 YEAR OLD BOY

This questionnaire asks about your child now he is 4 years old. We are interested to know about his health and behaviour and how he gets on with other children. Your answers will help us to understand the developing child and to identify problems that children and their parents have.

This questionnaire is like the other questionnaires you have received. To answer simply tick the box which best describes your child or your child's situation. Please answer all questions that you can. If you cannot answer any question or if they do not apply to you please put a line through them. There are no right or wrong answers. Please just describe what happens in your situation. You may make additional comments at the end. All answers are confidential.

THANK YOU FOR YOUR HELP

14/09/95

SECTION A: ACCIDENTS AND INJURIES

However careful a parent is, most children have accidents at some time or other. Please list on the next pages the times your child has had an accident, whether or not he was injured as a result.

A1. a) Has he been burnt or scalded since he was 3 years old?

Yes

1

No

2

→ If **no**, go to A2a on page 4

If **yes**, b) how many times?

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For each burn or scald please describe below what happened:

	1st accident	2nd accident	3rd accident
c) Place accident happened (e.g. kitchen, garden,nursery)			
d) What was he burnt with? (e.g. tea, iron, electric fire)			
e) Date of accident (month, year)			
f) Injuries caused (if no injury write none)			
g) Who was with him?			
h) What did the person with him do? Nothing			
Treated him themselves			
Took to doctor			
Took to hospital			
Other (please describe)			
i) What treatment did the person with him give?			
j) What other treatment did he have?			

k) Please describe how each accident happened:

Burn 1

Burn 2

Burn 3

A2. a) Has he had a bad fall since he was 3 years old?

Yes

1

No

2

→ If no, go to A3a on page 5

If yes, b) how many times?

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For each fall please describe below what happened:

	1st fall	2nd fall	3rd fall
c) Place accident happened (e.g. kitchen, garden,nursery)			
d) What did he fall from (e.g. table, wall, climbing frame)?			
e) Date of fall (month, year)			
f) Injuries caused (if no injury write none)			
g) Who was with him?			
h) What did the person with him do? Nothing			
Treated him themselves			
Took to doctor			
Took to hospital			
Other (please describe)			
.....			
i) What treatment did the person with him give?			
j) What other treatment did he have?			

k) Please describe how each accident happened:

Fall 1

Fall 2

Fall 3

A3. a) Has he swallowed anything he shouldn't have (such as pills, buttons, disinfectant) since he was 3 years old?

Yes No → If **no**, go to A4a on page 6

If **yes**, b) how many times?

For each time please describe below what happened:

	1st accident	2nd accident	3rd accident
c) Place accident happened (e.g. your home, nursery, at friend's)
d) What did he swallow?
e) Date of accident (month, year)
f) Who was with him?
g) What did the person with him do?			
Nothing	<input type="text"/>	<input type="text"/>	<input type="text"/>
Treated him themselves			
Took to doctor			
Took to hospital			
Other (please describe)	<input type="text"/>	<input type="text"/>	<input type="text"/>

h) What treatment did the person with him give?
i) What other treatment did he have?
j) Please describe how each accident happened:			

Accident 1

Accident 2

Accident 3

A4. a) Has he had any other accidents or injuries since he was 3 years old?

Yes

1

No

2

→ If no, go to A5 on page 7

If yes, b) how many other accidents?

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For each accident or injury please describe below what happened.

	1st accident	2nd accident	3rd accident
c) Place accident happened (e.g. kitchen, garden, street, nursery)
d) What happened?
e) Date of accident (month, year)
f) Injuries caused (if no injury write none)
g) Who was with him?
h) What did the person with him do?			
Nothing			
Treated him themselves			
Took to doctor			
Took to hospital			
Other (please describe)			

i) What treatment did the person with him give?
j) What other treatment did he have?

k) Please describe how each accident happened:

Accident 1

Accident 2

Accident 3

A5. Has he had any of the following happen **since he was born?**

	Yes, aged 0 - 2	Yes, since age 3	No, not at all
a) Broken arm/hand	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
b) Broken leg/foot	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
c) Broken/cracked skull	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
d) Other broken bone (please describe).....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
e) Unconscious because of a head injury	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
f) Cut(s) requiring stitches	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
g) Burn or scald having a skin graft	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
h) A road traffic accident	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
i) An accident in a playground	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
j) An accident at school, nursery, creche	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
k) Stung by wasp or bee	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
l) Bitten by animal or human please describe.....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
m) Badly sunburnt	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
n) Nearly drowned	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>
o) Front tooth (teeth) knocked out	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>

	Yes, aged 0 - 2	Yes, since age 3	No, not at all
p) Front tooth/teeth chipped or injured	<div>1</div>	<div>2</div>	<div>3</div>
q) Other tooth/teeth knocked out or chipped	<div>1</div>	<div>2</div>	<div>3</div>

SECTION B: PROBLEMS AND TREATMENT

B1. Children often have accidents or illnesses that need treatment. Please indicate which of the following have been given to your child since he was 3 years old.

	Never	Yes for one episode only	Yes for 2 or more episodes	If <u>yes</u> , please give full names of substances if you can
a) cough medicine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) antibiotics/penicillin	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) throat medicine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) vitamins	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) paracetamol/calpol	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) ointment for skin	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
g) eye ointment	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
h) diarrhoea mixture or pills	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
i) dimotapp/decongestant	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
j) ear drops	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
k) eye drops	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
l) iron	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
m) laxative	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
n) homeopathic medicine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
o) herbal medicine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
p) other (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

.....

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- B2. a) Are there any pills, ointments or medicines that he has taken every day or nearly every day for the last 3 months? (Include vitamins, skin cream, laxatives as well as antibiotics, homeopathic and herbal remedies etc)

Yes 1 No 2 → If **no**, go to B3a below

If **yes**,

- b) please describe:

.....

.....

- B3. During the child's early years of life various possible problems are often identified - yet when investigated further they are often found not to be problems at all. In this section we are asking about any possible problems that might have arisen.

- a) Since your study child was 3 years old has he been investigated because it was thought he might have something wrong with his hips, his legs or his feet?

Yes 1 No 2 → If **no**, go to B4a on page 11

If **yes**,

- b) were any problems found?

Yes 1 No 2 Don't know 9

→ If **no**, go to B4a on page 11

If **yes**, i) please describe:

- ii) how old was he?

3 years old 1 4 years old 2 5 years old 3

- iii) what treatment did he have?

.....

B4. a) Since he was 3 years old has anyone thought there might be a problem with his hearing?

Yes 1 No 2 → If **no**, go to B5a below

b) Has your child been seen at the Hearing Assessment Centre since he was 3?

Yes 1 No 2 → If **no**, go to B5a below

If **yes**,

c) At what age?

3 years old 1 4 years old 2 5 years old 3

d) What was decided?

.....

B5. a) Has anyone thought there might be a problem with his eyesight?

Yes 1 No 2 → If **no**, go to B6a on page 12

b) What was thought to be wrong with his eyes?

squint (eyes not looking in same direction) 1
something else (please describe) 2
don't know 3

c) Has your child been referred to an eye specialist since he was 3?

Yes 1 No 2 → If **no**, go to B6a on page 12

If **yes**,

d) at what age?

3 years old 4 years old 5 years old

e) What was decided?
.....

f) What treatment was given?
.....

B6. a) Has anyone thought that there might be a problem with his talking?

Yes No → If **no**, go to B7a on page 13

If **yes**, who? (tick all that apply):

b) you or your partner
c) health visitor
d) G.P.
e) grandparents
f) other (please describe)

.....

g) Has he ever been seen by a speech therapist?

Yes No → If **no**, go to B7a on page 13

If **yes**,

i) how old was he? years

ii) what was decided?.....
.....

h) Are there still any worries about his talking?

Yes 1 No 2

If yes, please describe

.....

B7. a) Has anyone **ever** thought there might be a problem with his growth?

Yes 1 No 2 → **If no**, go to B8a on page 14

If yes, who? (tick all that apply):

b) you or your partner

1

c) health visitor

1

d) G.P.

1

e) grandparents

1

f) other (please describe)

1

.....

g) Has he **ever** been seen by a specialist about his growth?

Yes 1 No 2 → **If no**, go to j) below

If yes,

h) how old was he? years (If less than 12 months put 0)

i) what was decided?.....

.....

j) Are there still worries about his growth?

Yes 1 No 2

If yes, please describe.....

.....

- B8. a) Has anyone **ever** thought there might be a problem with clumsiness or his movement or coordination?

Yes 1 No 2 → If **no**, go to B9a below

If **yes**, who? (tick all that apply):

- b) you or your partner 1
c) health visitor 1
d) G.P. 1
e) grandparents 1
f) other (please describe) 1

.....

- g) Has he ever been seen by a specialist about this?

Yes 1 No 2 → If **no**, go to j) below

If **yes**,

- h) how old was he? years (If less than 12 months put 0)

- i) what was decided?.....

.....

- j) Are there still worries about this?

Yes 1 No 2

If **yes**, please describe.....

.....

- B9. a) Has anyone **ever** thought there might be a problem with other aspects of his development?

Yes 1 No 2 → If **no**, go to B10a on page 15

If **yes**, who? (tick all that apply):

- b) you or your partner ☐
c) health visitor ☐
d) G.P. ☐
e) grandparents ☐
f) other (please describe) ☐

.....

g) Has he ever been seen by a specialist about this?

Yes ☐ No ☐ → If **no**, go to j) below

If **yes**,

h) how old was he? years (If less than 12 months put 0)

i) what was decided?.....
.....

j) Are there still worries about this?

Yes ☐ No ☐

If **yes**, please describe.....
.....

B10. a) Have there been any other problems for which your child saw (or is going to see) a specialist since he was 3 years old?

Yes ☐ No ☐ → If **no**, go to B11a on page 17

If yes,

b) For how many different problems?

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Please list, for each problem, what has happened:

	Problem No.1	Problem No.2	Problem No.3
c) What was thought to be the problem?	.....	.....	.....
d) Have you seen the specialist?	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>	Yes <input type="text"/> No <input type="text"/>
e) What age was he the first time he was seen for this problem ? (put 0 if less than 12 months)	<input type="text"/> years	<input type="text"/> years	<input type="text"/> years
f) What was decided?	..... .....	..... .....	..... .....
g) What treatment was given?	..... .....	..... .....	..... .....

If more than 3 problems, continue below or on a separate sheet.

B11. a) Has he visited the dentist in the last 2 years?

yes for treatment

yes, for inspection only

no, not at all

☐☐

→go to B11b below

If **yes**, for treatment, what has he had (tick all that apply)

i) a filling? ☐ Yes

☐

ii) a tooth taken out? ☐ Yes→ If **yes**,

☐

a) How many teeth? ☐

☐

b) Did he have a general anaesthetic for this?

Yes

☐

No

☐

iii) other treatment? ☐ Yes

☐

Please describe

B11. b) Does he use a toothbrush?

yes, adult size brush

☐

yes, child size brush

☐

no, not at all

☐

If **no**, go to B11e on page 18

c) How often does he brush his teeth?

more than

☐

once

☐

every day

less than

☐

once a day

not

☐

at all

once each day

d) Who brushes his teeth?

always brushes himself

☐

usually brushes himself

☐

always brushed by adult

☐

usually brushed by adult

☐

sometimes child,
sometimes adult

☐

other (please describe)

☐

.....

B11. e) Does he ever have toothpaste?

Yes 1 No 2 → If no, go to B11f below

If yes,

i) how much toothpaste does he have on his brush nowadays?

brush full 1 half brush 2 less than half a brush 3 none 4

ii) how many times a day does this happen? times

iii) does he usually swallow it or spit it out?

swallows it 1 spits it out 2 varies 3

iv) what type of toothpaste is usually used:
(please give exact name and brand)

.....

f) Has he ever had a dental X-ray?

Yes 1 No 2

g) Have any of his first (milk) teeth fallen out?

Yes 1 No 2 → If no, go to B12 below

If yes, how many? teeth

B12. Are there any foods or drinks that your child is allergic to?

yes definitely 1 yes possibly 2 no, not at all 3 don't know 9

↓
If no, or don't know
go to B13a on page 20

←

If yes, a) please describe which foods or drinks

b) was the reaction caused by eating or touching the food or drink?

eating/drinking touching both

c) what happens when he does have the reaction? (tick all that apply)

i) bright red rash →If yes, over what part of body?

.....

ii) hives (white raised bumps on skin) →If yes, over what part of body?

.....

iii) wheezing or whistling in the chest

iv) vomiting

v) diarrhoea

vi) difficulty breathing

vii) stop breathing

viii) headache

ix) swelling →If yes, describe where

.....

x) other reaction
(please describe)

.....

d) How long after eating or drinking or touching does this usually happen?

less than 1 hr 1-2 hrs 3-5 hrs 6 hrs or more

don't know

B12. e) How old was he when this first happened?

years old (put 0 if he was under 12 months)

f) How many times has a reaction happened? times

g) How old was he the last time a reaction happened?

years old

h) What have you done about these reactions? (tick all that apply)

i) Avoided the foods that caused them ☐

ii) Took to GP to investigate ☐

iii) Investigated in hospital ☐

iv) Other (please describe) ☐

j) What advice have you been given? (if none, write NONE)

.....

k) What treatment has your child been given for the problem? (if none, write NONE)

.....

B13. a) Apart from food and drink are there any other things to which he is allergic?

Yes ☐

No ☐

→ If **no**, go to Section C on page 22

If yes, b) What is he allergic to? (tick all that apply)

- | | | |
|------|----------------------------------|--|
| i) | pollen | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| ii) | cat | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| iii) | dog | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| iv) | bee sting | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| v) | house dust | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| vi) | other (please tick and describe) | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |

.....

c) How does he react to these? (tick all that apply)

- | | | |
|------|----------------------------------|--|
| i) | wheezing | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| ii) | breathlessness | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| iii) | sneezing | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| iv) | rash | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |
| v) | other (please tick and describe) | <div style="border: 1px solid red; padding: 2px; display: inline-block;">1</div> |

.....

Space for any comments about allergies.

SECTION C: YOUR CHILD'S ENVIRONMENT

C1. Which animals in either your home or elsewhere does he touch at least once a week?

	Yes in our home	Yes elsewhere	No, not at all
a) cat (s)	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) dog (s)	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) other furry animal*(s)	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) birds	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) other creatures*	<input type="text"/>	<input type="text"/>	<input type="text"/>

(*please tick and describe.....)

C2. All children get dirty. How often in a normal day:

a) is his face washed?

not at all 1 1-2 times 2 3-4 times 3 5 or more times 4

b) are his hands washed or wiped?

not at all 1 1-2 times 2 3-4 times 3 5 or more times 4

c) are his hands cleaned before a meal?

always 1 usually 2 sometimes 3 occasionally 4 never 5

C3. How often does he normally:

a) have a bath or shower:

more than 1 once every 2 more than 3 once a week 4 hardly ever 5
once a day day week

b) have his ear holes cleaned:

more than 1 once every 2 more than 3 once a week 4 hardly ever 5
once a day day week

C4. How often during a day is he in a room or enclosed place where people are smoking:

	(i) weekdays	(ii) weekends
all the time	<input type="text"/> 1	<input type="text"/> 1
more than 5 hours	<input type="text"/> 2	<input type="text"/> 2
3-5 hours	<input type="text"/> 3	<input type="text"/> 3
1-2 hours	<input type="text"/> 4	<input type="text"/> 4
less than 1 hour	<input type="text"/> 5	<input type="text"/> 5
not at all	<input type="text"/> 6	<input type="text"/> 6

C5. How often in a normal week does your child:

	Never	Occasional accident but less than once a week	About once a week	More than once a week	Every day
a) wet himself during the day	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
b) wet the bed at night	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
c) dirty his pants during the day	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
d) dirty himself at night	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5

C6. In a normal week for how long is he left at home alone or just with other young children (aged less than 12)?*

i) during the day:

not at all	<input type="text" value="1"/>	only for a few minutes	<input type="text" value="2"/>
for less than an hour	<input type="text" value="3"/>	for more than an hour	<input type="text" value="4"/>

ii) at night:

not at all	<input type="text" value="1"/>	only for a few minutes	<input type="text" value="2"/>
for less than an hour	<input type="text" value="3"/>	for more than an hour	<input type="text" value="4"/>

(* by this we mean with no adults or older children at home at all)

C7. How much time on average does he spend each day:

	(i) on a weekday					(ii) on a weekend day			
	Not at all	less than 1 hour	1-2 hours	3 or more hours		Not at all	less than 1 hour	1-2 hours	3 or more hours
a) in a car, bus or other transport	<input type="text" value="1"/>	<input type="text" value="2"/>	<div></div>			<input type="text" value="1"/>	<input type="text" value="2"/>	<div></div>	
b) out of doors in summer	<input type="text" value="1"/>	<input type="text" value="2"/>				<input type="text" value="1"/>	<input type="text" value="2"/>		
c) out of doors in winter	<input type="text" value="1"/>	<input type="text" value="2"/>				<input type="text" value="1"/>	<input type="text" value="2"/>		
d) watching T.V	<input type="text" value="1"/>	<input type="text" value="2"/>				<input type="text" value="1"/>	<input type="text" value="2"/>		
e) with other children	<input type="text" value="1"/>	<input type="text" value="2"/>				<input type="text" value="1"/>	<input type="text" value="2"/>		
f) drawing, making, constructing things	<input type="text" value="1"/>	<input type="text" value="2"/>				<input type="text" value="1"/>	<input type="text" value="2"/>		
g) playing by himself	<input type="text" value="1"/>	<input type="text" value="2"/>				<input type="text" value="1"/>	<input type="text" value="2"/>		
h) looking at books	<input type="text" value="1"/>	<input type="text" value="2"/>				<input type="text" value="1"/>	<input type="text" value="2"/>		

SECTION D: CHILD CARE AND ACTIVITIES

D1. During the time since he was 3 years old, have you and your partner been employed?
Please answer for each age:

Child's age	(i) Mother			(ii) Partner			
	Full time	Part time	Not employed	Full time	Part time	Not employed	No employed partner
a) 3 years to 3½	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 3½ to 4th birthday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 4th birthday to now	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D2. Apart from yourself, who has regularly looked after your child when you were not with him?
(Please answer for each person or place, including kindergarden, nursery, playgroup, childminder, neighbour or school) regularly involved?

a) **Childcare on weekdays**

Please list below all regular arrangements for your child during weekdays since he was 3 (if none write NONE).

Age of child when started		Person and/or place (eg. childminder-her home; kindergarten etc..)	Number of hours per week	Age of child when stopped (put 777 if still happening)	
years	months			years	months
i)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iii)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
iv)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
v)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

b) **Weekend childcare**

Please list below all regular childcare arrangements during the weekend since he was 3 (if none write NONE).

Age of child when started		Person and/or place (eg. grandmother-my home)	Number of hours per week		Age of child when stopped (put 777 if still happening)	
years	months		Saturday	Sunday	years	months
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

c) **Childcare during holidays of normal carers**

Please list the arrangements made for each time this happened. (If none write NONE)

Age of child when started		Substitute person and/or place	Number of weeks this happened
years	months		
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

D3. Does your child nowadays attend (tick all that apply)

a)	infant school full-time	<input type="checkbox"/>	
b)	infant school part-time	<input type="checkbox"/>	
c)	kindergarten	<input type="checkbox"/>	
d)	nursery/creche	<input type="checkbox"/>	
e)	other (please tick and describe)	<input type="checkbox"/>
f)	none of the above	<input type="checkbox"/>	

If no organised school, kindergarten or creche go to Section E on page 32

D4. Who takes him to and from school, kindergarten or nursery/creche nowadays (tick all that apply).

		(i) Going		(ii) Coming back	
		every day	some days	every day	some days
a)	I take him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	My partner takes him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c)	A grandparent or adult relative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d)	An older child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e)	Childminder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f)	Other person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g)	Goes on his own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D5. How does he get there?

		(i) Going		(ii) Coming back	
		every day	some days	every day	some days
a)	He walks	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
b)	He goes in a pram/pushchair	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
c)	By public transport	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
d)	School bus/coach	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
e)	By car	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
f)	Rides bicycle	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
g)	Other (please tick and describe)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>

D7. We would like to know what happens after school or kindergarten etc.

a) Does he usually go straight home?

No

1

 Yes

2

 → If yes, go to D7c on page 29

b) If no, where does he go?

		Every day	Some days	Never
i)	to a relative's home	<div>1</div>	<div>2</div>	<div>3</div>
ii)	to a friend's home	<div>1</div>	<div>2</div>	<div>3</div>
iii)	to a childminder	<div>1</div>	<div>2</div>	<div>3</div>
iv)	other (please tick and describe)	<div>1</div>	<div>2</div>	<div>3</div>

D7. c) If he goes straight home are you always there too?

yes, always yes, usually yes, sometimes
no, hardly ever

D8. When he first arrives home does he have:

	Yes	No
a) a meal	<input type="text" value="1"/>	<input type="text" value="2"/>
b) a snack	<input type="text" value="1"/>	<input type="text" value="2"/>
c) a drink	<input type="text" value="1"/>	<input type="text" value="2"/>

D9. How does he feel about school/kindergarten/nursery/creche?

	Always	Usually	Sometimes	Not at all
a) He looks forward to going	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) He enjoys it	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) He is stimulated by it	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) He is frightened by it	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) He talks about new friends	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f) He seems bored by school	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
g) He likes his teacher (s)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D10. When he finishes and returns home:

Does he:	Always	Usually	Sometimes	Never
a) Talk about the events of the day	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) Ask about what has happened in your day	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

D10.

Does he: **Always** **Usually** **Sometimes** **Never**

c)	Read, draw or play quietly by himself	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d)	Watch TV	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e)	Play with other children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f)	Fall asleep	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

D11. How many children in his class did he know before attending this school/kindergarten?

None	<div>1</div>	1	<div>2</div>	2-3	<div>3</div>	more than 3	<div>4</div>
		child		children		children	

D12. Had he visited the school/kindergarten before his first day?

Yes	<div>1</div>	No	<div>2</div>
-----	--------------	----	--------------

D13. a) Does he bring home things that he has done during the day (e.g. painting)?

Yes	<div>1</div>	No	<div>2</div>	→ If <u>no</u> , go to D14 on page 31
-----	--------------	----	--------------	--

b) If yes, how often are they put so that everyone can see them?

Always	<div>1</div>	Usually	<div>2</div>	Sometimes	<div>3</div>	Never	<div>4</div>
--------	--------------	---------	--------------	-----------	--------------	-------	--------------

D14. When he gets home from school/kindergarten/nursery/creche how does he behave?

		Always	Usually	Sometimes	Never
a)	excited	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b)	talkative	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c)	withdrawn	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d)	calm	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e)	very active	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f)	sleepy	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
g)	angry	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
h)	hungry	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
i)	tearful	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
j)	anxious	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
k)	affectionate	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
l)	tired	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
m)	other (please tick and describe)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

.....

SECTION E: EATING

- E1. a) Some children just have snacks all day while others wait for meals. How would you describe your child?

snacks all day, no real meals	1
snacks all day, but also has meals	2
doesn't snack much, just has meals	3
other (please describe).....	4

.....

- b) How many real meals a day does your child have now ?

--	--

- E2. a) Which meal do you consider is his main meal of the day?

	Breakfast	Mid morning	Midday	Mid afternoon	Early evening	Late evening	Doesn't have a main meal	
i) on weekdays	1	2	3	4	5	6	7	→ If <u>no main meal</u> go to E3 on page 33
ii) on Saturdays	1	2	3	4	5	6	7	
iii) on Sundays	1	2	3	4	5	6	7	

- b) On a typical week how often does he eat his main meal in these places?

	Never	1-2 days a week	3-5 days a week	6-7 days a week
i) at home	1	2		
ii) at school	1	2		
iii) at nursery/ kindergarten	1	2		
iv) at the childminder's	1	2		
v) other (please tick and describe)	1	2		

.....

E3. In the past year have you had difficulties getting him to eat what you wanted him to?

Yes, great difficulty

Yes, some difficulty

Yes, occasional difficulty

No, no difficulty

1
2
3
4

--

→ If yes, please describe the problems:

.....

.....

E4. In the past year has he at any time:

		Yes, worried me greatly	Yes, worried me a bit	Yes, but did not worry me	No did not happen
a)	deliberately not eaten sufficient amount of food	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b)	refused to eat the food you think he should eat	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c)	been choosy with food	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d)	over-eaten	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e)	been difficult to get into an eating routine	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

E5. We are interested in your child's diet. We would like to know how often nowadays he eats the following foods. Please answer every question even if he never eats the food (in this case tick "Never or rarely").

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
a)	Sausages, Burgers	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	Meat Pies/Pasties (pork pie, steak/meat pie etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Vegetarian Pies/ Pasties (cheese and onion pastie, vegetable samosa, onion bhaji, vegetable grills etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Ham, bacon, pate and cold meats (eg salami, luncheon meat, garlic sausage etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Meat roast, chops, stews and curries etc. (eg. beef, lamb, pork, mince)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	Liver, kidney, heart	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	Chicken/Turkey in crispy coating (eg. chicken nuggets, turkey burgers, chicken fingers etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	Poultry: roast, grilled, fried, boiled, stewed (chicken, turkey etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

E5.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
i)	Shellfish (prawns, crab, cockles, mussels etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
j)	White fish in breadcrumbs or batter (eg fish fingers/shapes, chip shop fish, breaded cod etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
k)	White fish without coating (eg. grilled fish, cod in parsley sauce etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
l)	Tuna	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
m)	Other fish (pilchards, sardines, mackerel, herring, kippers, trout, salmon etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
n)	Eggs, quiche, omelettes, flan etc.	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
o)	Cheese	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
p)	Pizza	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
q)	Oven chips	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
r)	Fried chips, potato waffles or croquettes, Alphabites etc, fried plantain	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
s)	Roast potatoes (cooked in fat or oil)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
t)	Boiled, mashed, jacket potatoes, yam	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

E5.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
u)	Rice (boiled, or fried, <u>not</u> rice pudding)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
v)	Canned pasta (spaghetti rings, ravioli, macaroni cheese etc.) Pot Noodles, Super Noodles etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
w)	Boiled pasta (eg. spaghetti, fusilli, lasagna) bulgar wheat and cous-cous.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

E6.a) Does he eat the fat on meat?

yes, all of it	<div>1</div>	no	<div>3</div>
yes, some of it	<div>2</div>	never eats meat	<div>4</div>

b) How often does he have fried food?

	Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
(eg. fried fish, eggs, bacon, chops etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

E7. How many times nowadays does he eat:

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
a)	Baked beans	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	Peas, broad beans	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Sweetcorn	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Cabbage, brussel sprouts, spinach, broccoli and other dark green leafy vegetables	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Other green vegetables (cauliflower, runner beans, leeks, okra, courgettes etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	Carrots, sweet potato	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	Other root vegetables (turnip, swede, parsnip etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	Tomatoes (cooked or raw)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
i)	Salad (lettuce, cucumber, peppers, other raw vegetables etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	Pulses and pulse dishes(dahl, lentil soup, falafel, dried peas, beans, chick peas)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

E7.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
k)	Soya 'Meat', TVP, Quorn, Soya-type Vegeburgers, Bean Curd (Tofu, Miso etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	Peanuts, peanut butter	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	Other nuts,(eg. cashew), nut roast	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	Fresh citrus fruit (eg. oranges, grapefruit, satsumas, tangerines etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
o)	Other fresh fruit (eg. apple, banana, pear, bunch of grapes, peach etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	Canned fruit	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	Yoghurt, Fromage Frais,	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
r)	Milk puddings (eg. rice pudding, semolina), mousse, Angel Delight etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
s)	Ice cream, choc ice chocolate ice cream bar etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
t)	Ice lollies	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
u)	Pudding (eg fruit pie, crumble, cheesecake, gateaux)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
E7.						
v)	Custard, cream, Elmlea, Tip-Top, evaporated milk etc. on puddings	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
w)	Cakes or buns (fruit cake, sponge, teacake, doughnut, flapjack, scone, custard tart, cream cake etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
x)	Crispbreads (Ryvita, crackerbread etc.)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

E8. a) Does he eat breakfast cereals at all?

Yes 1 No 2 → If **no**, go to E10 on page 40

If **yes**, What type of breakfast cereal does he eat nowadays?

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
b)	Oat cereals (e.g. porridge, Ready Brek, Muesli, chocolate Ready Brek)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
c)	Wholegrain or bran cereals (eg. All Bran, Bran Flakes, Weetabix, Wheatflakes, Fruit & Fibre, Shreddies, Shredded Wheat, sugar puffs)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
d)	Other cereals (e.g. Cornflakes, Rice Krispies, Frosties, Special K, Coco pops)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

E9. When he has breakfast cereals

- a) How often are they sugar/honey coated or chocolate flavoured (eg. Frosties, Coco Pops etc.)

Always

Sometimes

Never

→ If **never** go to E9c below

- b) How many **teaspoonfuls** of sugar does he have on **this type** of cereal (ie. sugar coated etc.)

None

½ teaspoon

One teaspoon

2 teaspoons

More than 2 teaspoons

- c) How many **teaspoonfuls** of sugar does he have on **other types** of cereal (ie. plain cereal)?

None

½ teaspoon

One teaspoon

2 teaspoons

More than 2 teaspoons

- d) How many times per week does he have milk on cereal? times

E10. How often nowadays does he eat:

**Never
or
rarely**

**Once in
2 weeks**

**1-3
times
a week**

**4-7
times
a week**

**More
than
once a day**

- a) Crisps, corn snacks
(eg. Wotsits, Quavers,
tortilla chips, etc.)

- b) Full-coated chocolate
biscuits eg. Club, Kit
Kat, Penguin, Breakaway
etc.

- c) Other biscuits eg.
rich tea, shortcake,
digestive and chocolate
digestive, Hob Nobs

E10.

	Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
--	-----------------------	--------------------	------------------------	------------------------	----------------------------

d) Chocolate (eg. chocolate bars/buttons, milk, plain or white) Smarties, Mars bars, Milky Way, Creme Eggs, Rolos etc.

<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
--------------------------------	--------------------------------	--------------------------------	--------------------------------	--------------------------------

e) Sweets (individual, packets or bars) Cola bottles, penny mix-ups, chews, jelly sweets, flumps, liquorice, sherbert dips, polos, fruit pastilles, refreshers etc.

<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
--------------------------------	--------------------------------	--------------------------------	--------------------------------	--------------------------------

E11. On days when he has sweets, how many individual sweets does he eat in that day?
Count a chew or jelly sweet as one sweet.

1-2 sweets	3-5 sweets	6-10 sweets	11 - 20 sweets	more than 20 sweets	never has sweets
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="7"/>

E12. On days when he has chocolate or chocolate bars (e.g. Mars bars, bag of buttons):

a) What size bar/packet does he have?

Usually eats Funsized

Usually eats Adult size

Never has chocolate

→ Go to

E13 on

page 42

b) How many bars or packets of **this** size does he usually eat in **that** day?

½ or less

1 in a day

2 in a day

3 or more in a day

E13. How many times a week nowadays does he drink?

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than once a day
a)	Fruit juice from a tin (including tomato juice)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	Pure fruit juice from a carton or freshly squeezed	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Squash, fruit drinks or Ribena	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Cola drinks e.g. Coca Cola, Pepsi etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Other fizzy drinks e.g. lemonade	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	Water on its own	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	Milk on its own	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	Flavoured milk drinks (eg. Horlicks, Ovaltine, milkshakes) or yoghurt drinks	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

E14. When he has soft drinks (e.g. lemonade, cola, squash), how often are they low calorie, diet or reduced sugar drinks?

usually	<div>1</div>	not at all	<div>3</div>
sometimes	<div>2</div>	doesn't drink soft drinks	<div>7</div>

E15. When he has cola drinks, how often are they decaffeinated?

usually	<input type="text" value="1"/>	not at all	<input type="text" value="3"/>
sometimes	<input type="text" value="2"/>	doesn't have cola	<input type="text" value="7"/>

E16. What types of bread does he eat?

	Usually	Sometimes	Never
a) white bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) soft grain white bread (Mighty White)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) brown/granary bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) wholemeal bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) chappatis, pitta bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) naan bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

E17. How many slices of bread, rolls or chappatis does he eat on a usual day?

less than 1	<input type="text" value="1"/>	1-2	<input type="text" value="2"/>	3-4	<input type="text" value="3"/>	5 or more	<input type="text" value="4"/>
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E18. How many slices of bread (or rolls) spread with butter or margarine does he eat each day? (include bought sandwiches) slices

E19. What sort of fat does he have:

		(i) on bread or vegetables		(ii) for frying	
		Yes	No	Yes	No
a)	Butter, Ghee, Dripping, Lard, solid cooking fat	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
b)	Polyunsaturated margarine eg. Flora, sunflower margarine, Vitalite	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
c)	Hard or soft margarine eg. Blue Band, Stork, supermarket own brand	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
d)	Low fat spread eg. Delight, St Ivel Gold, Flora Xtra Light	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
e)	Sunflower oil, corn oil, soya oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
f)	Olive oil, hazelnut oil, rapeseed oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
g)	Other vegetable oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
h)	Other (please describe)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>

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E20. What type(s) of milk does he have?

	Yes usually	Yes sometimes	No not at all
a) Full fat (silver or gold top)	<div>1</div>	<div>2</div>	<div>3</div>
b) Semi Skimmed (red stripe)	<div>1</div>	<div>2</div>	<div>3</div>
c) Skimmed (blue stripe)	<div>1</div>	<div>2</div>	<div>3</div>
d) Dried milk (eg. Marvel)	<div>1</div>	<div>2</div>	<div>3</div>
e) Goat/sheep milk	<div>1</div>	<div>2</div>	<div>3</div>
f) Soya milk	<div>1</div>	<div>2</div>	<div>3</div>
g) Breast milk	<div>1</div>	<div>2</div>	<div>3</div>
h) Other (please describe)	<div>1</div>	<div>2</div>	<div>3</div>

.....

E21. Is this milk usually

Pasteurised	Longlife (UHT)	Sterilised	Other (please describe)	Don't know
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>9</div>

E22.

a) Does he drink tea?

Yes

1

 No

2

 → If **no**, go to E23 on page 46

If yes,

b) How many cups of tea does he drink in a day?
(do not include herbal teas) cups a day

c) How many spoons of sugar in each cup? spoons

d) How many of the cups of tea that he drinks are decaffeinated cups a day

e) Which description best fits the amount of milk in the tea he drinks?

no milk	a little milk	about $\frac{1}{4}$ milk	about $\frac{1}{2}$ milk	about $\frac{3}{4}$ milk	almost all milk
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>

E23.

a) Does he drink coffee?

Yes No → If no, go to E24a below

If yes,

b) How many cups of coffee (real, instant or decaffeinated) does he drink? cups a day

c) How many spoons of sugar in each cup? spoons

d) How many of the cups of coffee he drinks are decaffeinated cups a day

e) How many of the cups of coffee he drinks are made using real coffee (ie. not instant)? cups a day

f) How many of these are decaffeinated? cups a day

g) Which description best fits the amount of milk in the coffee he drinks?

no milk	a little milk	about $\frac{1}{4}$ milk	about $\frac{1}{2}$ milk	about $\frac{3}{4}$ milk	all milk
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>

E24. a) Does he drink herbal teas at all?

yes, often yes, occasionally no, not at all → If no, go to E25 on page 47

If yes,

b) how many cups/mugs of herbal tea has he drunk in the past week? cups a day

c) Please list the types of herbal teas he has drunk in the past 3 months:

.....

.....

.....

E25. Apart from herbal teas, are there any other health foods (whether or not bought from a health food shop) that he often eats or drinks?

Yes No → If **no**, go to E26a below

If **yes**, please describe below:

.....

.....

.....

E26. a) What would you say best describes your child's alcohol drinking:

he has a glass of his own containing a normal adult portion

he has a glass of his own, but less than an adult portion

he just has a taste of other people's drink

he has rarely had any alcohol

he has never had any alcohol

→ Go to E27 on page 48

E26. b) How often does he have any of the following:

		More than once a week	Once a week	Less than once a week	Not at all
i)	wine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
ii)	beer, lager	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
iii)	spirits (gin, vodka, brandy)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
iv)	other alcohol (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

.....

E27. Is your child at present a vegetarian?

Yes No

E28. Is your child at present a vegan (i.e. does not eat meat, poultry, fish, eggs, butter, milk or cheese)?

Yes No

E29. Is your child at present on any kind of special diet?

Yes No → If **no**, go to E30 on page 49

If **yes**, please describe below.

.....

.....

E30. Does your child have definite likes and dislikes as far as food is concerned?

no, will eat almost anything

yes, quite choosy

yes, very choosy

☐

E31. a) How often does he suck a dummy or his thumb or finger?

	(i) dummy	(ii) thumb of right hand	(iii) thumb of left hand	(iv) finger(s)
most of the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
no, never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) Apart from his finger, thumb or a dummy does he have a special object that he uses for comfort?

Yes ☐ 1 No ☐ 2 → If no, go to E32 below

c) If yes, what is this?

blanket ☐ 1 cuddly toy ☐ 2 other (please describe) ☐ 3

E32. Does he eat coal, soil, dirt or other non-food substances?

yes, every day	<input type="checkbox"/> 1	→ If <u>yes</u> , please describe what he eats:
yes, at least once a week	<input type="checkbox"/> 2	
yes, less than once a week	<input type="checkbox"/> 3	
no, not at all	<input type="checkbox"/> 4	.....

SECTION F: HIS GROWTH, HIS SHOES, HIS LOOKS

Please list the dates on which your child was weighed since he was 3 years old and how much he weighed each time. Also add height and head circumferences, if they were measured. If you don't know, please write DK and go to F5, below.

	<u>Date</u>	<u>Weight</u>	<u>Height</u>	<u>Head circumference</u>
F1.	...../...../199....	.....	.....	.....
F2.	...../...../199....	.....	.....	.....
F3.	...../...../199....	.....	.....	.....
F4.	...../...../199....	.....	.....	.....

F5. What size shoes does he take?

F6. How often does he wear the following footwear:

		(a) Out of doors			(b) Indoors		
		Usually	Sometimes	Never	Usually	Sometimes	Never
i)	sandals	<div>1</div>	<div>2</div>	<div>3</div>	<div>1</div>	<div>2</div>	<div>3</div>
ii)	trainers/ plimpsols	<div>1</div>	<div>2</div>	<div>3</div>	<div>1</div>	<div>2</div>	<div>3</div>
iii)	slippers	<div>1</div>	<div>2</div>	<div>3</div>	<div>1</div>	<div>2</div>	<div>3</div>
iv)	shoes	<div>1</div>	<div>2</div>	<div>3</div>	<div>1</div>	<div>2</div>	<div>3</div>
v)	other (please tick and describe)	<div>1</div>	<div>2</div>	<div>3</div>	<div>1</div>	<div>2</div>	<div>3</div>

.....

F7. What colour are his eyes?

blue

brown

grey

greenish

other

(please describe)

.....

F8. What colour is his hair?

black

dark brown

mid-brown

light brown

golden

almost white

red

other (please describe)

.....

G1. This questionnaire was completed by: (tick all that apply)

a) mother

☐

b) father

☐

c) other (please describe)

☐

.....

G2. Please give the date on which you completed this questionnaire:

day

month

year

199

G3. Please give the date of birth of your child:

day

month

year

199

THANK YOU VERY MUCH FOR YOUR HELP

Space for any additional comments you would like to make

Please remember we cannot reply personally to your comments unless they are signed.

When completed, please return the questionnaire to:

**Professor Jean Golding
Children of the Nineties - ALSPAC
Institute of Child Health
24 Tyndall Avenue
Bristol
BS8 1BR Tel: Bristol 9285007**

For Office use only

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