|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Q** | | | | |  | | | | | **Response options** | | | | **Variable name** | | |
| **1** | | | | | **What is the child’s height and weight now at 7 years old?** | | | | | | | | | | | |
|  | | | | | Height | | | | | \_ \_ \_ cm | | | |  | | |
| Weight | | | | | \_ \_, \_kg | | | |  | | |
| **Only in version A** | | | | | Date of measurement | | | | | Day, month, year | | | |  | | |
| Measured self | | | | |  | | | |  | | |
| Measured by doctor/nurse | | | | |  | | |
| **Q** | |  | | | | | | | | **Response options** | | | | **Variable name** | | |
| **2** | | **Outside of school: Approximately how many times per week is the child physically active/takes part in sports such that he/she becomes short of breath or sweaty?** | | | | | | | | | | | | | | |
|  | | \_ \_ times per week | | | | | | | | Number 0-99 | | | |  | | |
| **3** | | **Outside of school: Approximately how many times per week does the child spend on physical**  **activity/sports (soccer, handball, skiing or gymnastics/dance or similar)?** | | | | | | | | | | | | | | |
|  | | Summer | | | | | | | | 1. Less than 1 hour per week 2. 1-2 hours per week 3. 3-4 hours per week 4. 5-7 hours per week 5. 8-10 hours per week 6. 11 hours or more per week | | | |  | | |
| Winter | | | | | | | |  | | |
| **4** | | **Outside of school on a regular week day: approximately how many hours per day is the child usually**  **outdoors?** | | | | | | | | | | | | | | |
|  | | Summer | | | | | | | | Number 0-99 | | | |  | | |
| Winter | | | | | | | |  | | |
| **Q** | | |  | | | | **Response options** | | | | | **Variable name** | | |
| **5** | | | **Outside of school, on a regular week day: How many hours per day does the child usually spend watching TV, videos, playing electronic video games, DVDs or using a computer?** | | | | | | | | | | | |
|  | | | Summer | | | | 1. Less than 1 hour 2. 1-2 hours per day 3. 3-4 hours per day 4. 5 hours or more per day | | | | |  | | |
| Winter | | | |  | | |
| **Q** | | | | | |  | | | | **Response options** | | | | **Variable name** | | |
| **6** | | | | | | **How many days has the child missed school in the past three months because of illness?** | | | | | | | | | | |
|  | | | | | |  | | | | Number 0-99 | | | |  | | |
| **Only in**  **version A** | | | | | | Number of days of interruption from play and leisure activities | | | | Number 0-99 | | | |  | | |
| **Q** | |  | | | | | | | | **Response options** | | | | **Variable name** | | |
| **7** | | **Has the child been swimming in an indoor swimming pool in the past 12 months?** | | | | | | | | | | | | | | |
|  | |  | | | | | | | | 1. No 2. Sometimes 3-Weekly | | | |  | | |
| If sometimes, number of hours per month | | | | | | | | Number 0-99 | | | |  | | |
| If weekly, number of hours per week | | | | | | | |  | | |
| **8** | | **When the child was 4-6 years old, approximately how often did he/she use an indoor swimming**  **pool?** | | | | | | | | | | | | | | |
|  | |  | | | | | | | | 1-Never/rarely 2-Sometimes 3-Weekly | | | |  | | |
| If sometimes, number of hours per month | | | | | | | | Number 0-99 | | | |  | | |
| If weekly, number of hours per week | | | | | | | |  | | |
| **Q** | |  | | | | | | | | **Response options** | | | | **Variable name** | | |
| **9** | | **How often does the child get to school by?** | | | | | | | | | | | | | | |
|  | | Walking/riding a bike | | | | | | | |  | | | |  | | |
| Car | | | | | | | |  | | |
| Public transportation | | | | | | | |  | | |
| **10** | | **How far is the child’s home from school?** | | | | | | | | | | | | | | |
|  | |  | | | | | | | | 1) Less than 1km 2) 1-2 km  3) 3-4 km  4) More than 4 km | | | |  | | |
| **Q** | | | | | | |  | | | | | **Response options** | | **Variable name** | | |
| **11** | | | | | | | **Does the child’s father live together with you?** | | | | | | | | | |
|  | | | | | | |  | | | | | 1-Yes 2-No | |  | | |
| If not, how much of the time does the child live with you? | | | | | 1. Almost always 2. Half of the time or more 3-Less than half of the time | |  | | |
| **Only in version A** | | | | | | | If not, how much of the time does the child live with you and his/her father, respectively? | | | | | | | | | |
| Mother | | | | | 1. Almost always 2. Half of the time or more 3-Less than half of the time | |  | | |
| Father | | | | |  | | |
| **12** | | | | | | | **What year did you move to your current address?** | | | | | | | | | |
|  | | | | | | |  | | | | | Number 0-9999 | |  | | |
| **13** | | | | | | | **On which floor is the child’s bedroom?** | | | | | | | | | |
|  | | | | | | |  | | | | | Number 0-99 | |  | | |
| **Q** | | |  | | | | | | **Response options** | | | | | **Variable name** | | | |
| **14** | | | **Approximately how many hours does the child usually sleep on a week nights?** | | | | | | | | | | | | | | |
|  | | |  | | | | | | 1. 8 hours or less 2. 9 hours 3. 10 hours 4. 11 hours 5. 12 hours or more | | | | |  | | | |
| **15** | | | **How often does the child snore?** | | | | | | | | | | | | | | |
|  | | |  | | | | | | 1. Never 2. Less than one night a week 3. Approximately one night per week 4. Several night per week 5. Almost every night | | | | |  | | | |
| **Q** | | | |  | | | | | | **Response options** | | | | **Variable name** | | | |
| **16** | | | | **Has there been any damage caused by damp, any visible mould growth or smell of mould in the child’s home during the last year?** | | | | | | | | | | | | | |
|  | | | | No | | | | | |  | | | |  | | | |
| Yes, damage caused by damp during the last year | | | | | |  | | | |
| Yes, visible mould during the last year | | | | | |  | | | |
| Yes, smell of mould during the last year | | | | | |  | | | |
| **Q** | | |  | | | | | | | | **Response options** | | | | **Variable name** | | | |
| **17** | | | **Do you smoke now? If yes, how many cigarettes?** | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | 1. Do not smoke 2. Smoke sometimes 3. Smoke daily | | | |  | | | |
| If smoke sometimes, number of cigarettes per week | | | | | | | | Number 0-99 | | | |  | | | |
| If smoke daily, number of cigarettes daily | | | | | | | | Number 0-99 | | | |  | | | |
| **18** | | | **Does the child’s father smoke? If yes, how many cigarettes?** | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | 1. Do not smoke 2. Smokes sometimes 3. Smokes daily | | | |  | | | |
| If smokes sometimes, number of cigarettes per week | | | | | | | | Number 0-99 | | | |  | | | |
| If smokes daily, number of cigarettes daily | | | | | | | | Number 0-99 | | | |  | | | |
| **Q** | | |  | | | | | | **Response options** | | | | | **Variable name** | | | |
| **19** | | | **Did you use wood-burning heating (stove or open fire) in the child’s home in the time before the child was 3 years old?** | | | | | | | | | | | | | | |
|  | | |  | | | | | | 1- Never 2-Rarely  3- Sometimes 4-Often | | | | |  | | | |
| **20** | | | **During the last year, did you ever use an open fire?** | | | | | | | | | | | | | | |
|  | | |  | | | | | | 1- Never 2-Rarely  3- Sometimes 4-Often | | | | |  | | | |
| **21** | | | **During the last year, has wood-burning heating been used as heating in the child’s home?** | | | | | | | | | | | | | | |
|  | | |  | | | | | | 1. No 2. Yes | | | | |  | | | |
|  | | | 1. If yes, is wood-burning heating the main source of heating in this home? | | | | | | 1. No 2. Yes | | | | |  | | | |
| 2. If yes, are you using a wood burning stove made before 1997? | | | | | | 1. No 2. Yes 3. Don’t know | | | | |  | | | |
| **22** | | | **Approximately how often do you burn candles in the home during the winter months?** | | | | | | | | | | | | | | |
|  | | |  | | | | | | 1. Never/less than 4 times 2. Only in December (4 times or more) 3. 1-3 times a week 4. 4-6 times a week 5. Daily/almost daily 6. Several times a day on most days | | | | |  | | | |
| **Q** | | |  | | | | | | | | **Response options** | | | | **Variable name** | | | |
| **23** | | | **Are there pets in the child’s home?** | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | 1. No 2. Yes | | | |  | | | |
| If yes, which? | | | | | | | | | | | | | | | |
| Dog | | | | | | | |  | | | |  | | | |
| Cat | | | | | | | |  | | | |
| Other furry animals (guinea pig, rabbit or the like) | | | | | | | |  | | | |
| Bird | | | | | | | |  | | | |
| Other | | | | | | | |  | | | |
| **24** | | | **Is the child in contact with farm animals at least once a week?** | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | 1. No 2. Yes | | | |  | | | |
| If yes, which? | | | | | | | | | | | | | | | |
| Horse | | | | | | | |  | | | |  | | | |
| Pig | | | | | | | |  | | | |
| Sheep/goat | | | | | | | |  | | | |
| Cattle | | | | | | | |  | | | |
| Hens/poultry | | | | | | | |  | | | |
| Other | | | | | | | |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Q** |  | | | | **Response options** | | | | | | **Variable name** | | |
| **25** | **Cross off if your child has or had the following illnesses or conditions.** | | | | | | | | | | | | |
|  | 1. Rheumatoid arthritis/chronic joint inflammation | | | |  | | | | | |  | | |
| 2. Cancer | | | |  | | |
| 3. Diabetes | | | |  | | |
| 4. Cerebral palsy | | | |  | | |
| 5. ADHD | | | |  | | |
| 6. Coeliac disease | | | |  | | |
| 7. Fractures | | | |  | | |
| 8. Epilepsy | | | |  | | |
| 9. Mentally disabled | | | |  | | |
| 10. Autistic characteristics/autism | | | |  | | |
| 11. Asperger’s syndrome | | | |  | | |
| 12. Chronic Fatigue Syndrome/ME | | | |  | | |
| 13. Removed tonsils | | | |  | | |
| 14. Middle ear drains | | | |  | | |
| 15. Other conditions, congenital syndrome | | | |  | | |
| 16. Other conditions, congenital syndrome, describe | | | |  | | |
| **Q** |  | | **Response options / Variable name** | | | | | | | | | | |
| **26** | **Does the child have or has he/she ever had, any of the following illnesses or health problems? Give the child’s age at the first sign of the illness. If the child no longer has the illness, state the age when he/she recovered.** | | | | | | | | | | | | |
|  | In version B & C | | Has or has had **1-No**  **2-Yes** | Confirmed by a doctor?  **Yes** | Health problems started at  **Age** | | | Symptoms the last year? **1-No**  **2-Yes** | | Child no longer has the health problems  **Age** | | | |
|  | 1. Trouble sleeping | |  |  |  | | |  | |  | | | |
| 2. Anaemia (low blood percent) | |  |  |  | | |  | |  | | | |
| 3. Delayed motor development | |  |  |  | | |  | |  | | | |
| 4. Delayed or deviating language development | |  |  |  | | |  | |  | | | |
| 5. behavioural problems (difficult and unruly) | |  |  |  | | |  | |  | | | |
| 6. Emotional difficulties (sad and anxious) | |  |  |  | | |  | |  | | | |
| 7. Overweight | |  |  |  | | |  | |  | | | |
| 8. Asthma | |  |  |  | | |  | |  | | | |
| 9. Allergy to pollen/hay fever | |  |  |  | | |  | |  | | | |
| 10. Allergy to cat or dog | |  |  |  | | |  | |  | | | |
| 11. Atopic eczema/dermatitis | |  |  |  | | |  | |  | | | |
| 12. Allergy to milk | |  |  |  | | |  | |  | | | |
| 13. Allergy to egg | |  |  |  | | |  | |  | | | |
| 14. Allergy to peanuts | |  |  |  | | |  | |  | | | |
| 15. Allergy to other nuts | |  |  |  | | |  | |  | | | |
| 16. Allergy to fish | |  |  |  | | |  | |  | | | |
| 17. Allergy to shellfish | |  |  |  | | |  | |  | | | |
| 18. Allergy to fruit | |  |  |  | | |  | |  | | | |
| 19. Allergy to other foods | |  |  |  | | |  | |  | | | |
|  | If yes, which? (In all versions) | | | | | | | | | | | | |
| Wheat | |  | | | | | | |  | | | |
| Soy | |  | | | | | | |  | | | |
| Rye | |  | | | | | | |  | | | |
| Other | |  | | | | | | |  | | | |
| Other, describe | |  | | | | | | |  | | | |
| **Q** |  | | **Response options / Variable name** | | | | | | | | | | |
| **26** | **Does the child have or has he/she ever had, any of the following illnesses or health problems? Give the child’s age at the first sign of the illness. If the child no longer has the illness, state the age when**  **he/she recovered.** | | | | | | | | | | | | |
|  | In version A | | **Yes** | If yes, the first sign of  illness started at **Age** | Child no longer has the illness **Age** | | | Yes, still have the illness | | The illness is diagnosed by a doctor | | | |
|  | 1. Asthma | |  |  |  | | |  | |  | | | |
| 2. Allergy to pollen/hay fever | |  |  |  | | |  | |  | | | |
| 3. Atopic eczema/dermatitis | |  |  |  | | |  | |  | | | |
| 4. Hearing loss | |  |  |  | | |  | |  | | | |
| 5. Impaired vision | |  |  |  | | |  | |  | | | |
| 6. Overweight | |  |  |  | | |  | |  | | | |
| 7. Too little weight gain | |  |  |  | | |  | |  | | | |
| 8. Trouble sleeping | |  |  |  | | |  | |  | | | |
| 9. Rheumatoid/arthritis | |  |  |  | | |  | |  | | | |
| 10. Heart defects | |  |  |  | | |  | |  | | | |
| 11. Crohn disease | |  |  |  | | |  | |  | | | |
| 12. Ulcerative colitis | |  |  |  | | |  | |  | | | |
| 13. Chronic fatigue syndrome | |  |  |  | | |  | |  | | | |
| 14. Celiac Disease | |  |  |  | | |  | |  | | | |
| 15. Diabetes | |  |  |  | | |  | |  | | | |
| 16. Epilepsy | |  |  |  | | |  | |  | | | |
| 17. Cerebral palsy | |  |  |  | | |  | |  | | | |
| 18. Anaemia | |  |  |  | | |  | |  | | | |
| 19. Cancer | |  |  |  | | |  | |  | | | |
| 20. Delayed motor  development | |  |  |  | | |  | |  | | | |
| 21. Delayed or deviate language development | |  |  |  | | |  | |  | | | |
| 22. Hyperactivity/ADHD | |  |  |  | | |  | |  | | | |
| 23. Autistic  characteristics/autism | |  |  |  | | |  | |  | | | |
| 24. Asperger syndrome | |  |  |  | | |  | |  | | | |
| 25. Behavioural problems (difficult and unruly) | |  |  |  | | |  | |  | | | |
| 26. Emotional difficulties (sad and anxious) | |  |  |  | | |  | |  | | | |
| 27. Allergy to milk | |  |  |  | | |  | |  | | | |
| 28. Allergy to egg | |  |  |  | | |  | |  | | | |
| 29. Allergy to fish | |  |  |  | | |  | |  | | | |
| 30. Allergy to other foods | |  |  |  | | |  | |  | | | |
| **Q** | |  | | | | **Response options** | | | | | | **Variable name** | | | |
| **27** | | **During the last year, has the child used medication, spray, inhaler or other medications for treatment of asthma?** | | | | | | | | | | | | | |
|  | |  | | | | 1. No 2. Yes | | | | | |  | | | |
| If yes… | | | | | | | | | | | | | |
| Name of medication used on a regular basis | | | |  | | | | | |  | | | |
| Name of medication used during attacks | | | |  | | | |
| When did your child last use medications for asthma? | | | | 1-Yesterday 2-Last 7 days 3-Last month 4-Last year | | | | | |  | | | |
| **Q** |  | | **Response options / Variable name** | | | | | | | | | | |
| **28** | **Has the child ever had, or does the child have, any of the following symptoms or health problems?** | | | | | | | | | | | | |
|  | In version B & C | | Has or has had   1. **No** 2. **Yes** | | Before 3 years | | | 3 years or older | | Number of times last 12 months  Number 0-99 | | | |
| 1.Tightness/wheezing/w histling in the chest | |  | |  | | |  | |  | | | |
| 2. Night cough without a cold | |  | |  | | |  | |  | | | |
| 3. Tightness/wheezing in  the chest during or after physical exercise | |  | |  | | |  | |  | | | |
| 4. Runny nose without a cold | |  | |  | | |  | |  | | | |
| 5. Itchy/runny eyes  without a cold | |  | |  | | |  | |  | | | |
| 6. Itchy rash that has come and gone for at least 6 months | |  | |  | | |  | |  | | | |
| 7. Hives/urticaria | |  | |  | | |  | |  | | | |
| 8. Stomach pains | |  | |  | | |  | |  | | | |
| 9. Migraine | |  | |  | | |  | |  | | | |
| 10. Other headache | |  | |  | | |  | |  | | | |
| 11. Diarrhoea | |  | |  | | |  | |  | | | |
| 12. Heartburn/acid reflux | |  | |  | | |  | |  | | | |
| 13. Ear infection | |  | |  | | |  | |  | | | |
| 14.Pneumonia/bronchitis | |  | |  | | |  | |  | | | |
| 15. Urinary tract infection | |  | |  | | |  | |  | | | |
| 16. Other | |  | |  | | |  | |  | | | |
| Other, describe | |  | |  | | |  | |  | | | |
| **Q** |  | | **Response options / Variable name** | | | | | | | | | | | |
|  | **Does the child have or has he/she ever had, any of the following illnesses or health problems? Give the child’s age at the first sign of the illness. If the child no longer has the illness, state the age when he/she**  **recovered.** | | | | | | | | | | | | | |
|  | **In version A** | | **Yes** | If yes, the first  sign of illness started at **Age** | | | Child no longer has the illness at  **Age** | | Yes, still have the illness | | | | The illness is diagnosed by a  doctor | |
|  | 1. Wheezing/whistling in the chest | |  |  | | |  | |  | | | |  | |
| 2. Tightness in the chest | |  |  | | |  | |  | | | |  | |
| 3. Nocturnal cough  without a cold | |  |  | | |  | |  | | | |  | |
| 4. Tightness/wheezing in the chest during or after physical exercise | |  |  | | |  | |  | | | |  | |
| 5. Running nose without a cold | |  |  | | |  | |  | | | |  | |
| 6. Itchy/runny eyes without a cold | |  |  | | |  | |  | | | |  | |
| 7. Itchy rash that has  come and gone for at least 6 months | |  |  | | |  | |  | | | |  | |
| 8. Stomach pains | |  |  | | |  | |  | | | |  | |
| 9. Migraine | |  |  | | |  | |  | | | |  | |
| 10. Other headaches | |  |  | | |  | |  | | | |  | |
| 11. Diarrhoea | |  |  | | |  | |  | | | |  | |
| 12. Febrile convulsions | |  |  | | |  | |  | | | |  | |
| 13. Sore throat | |  |  | | |  | |  | | | |  | |
| 14. Ear infection | |  |  | | |  | |  | | | |  | |
| 15. Bronchitis | |  |  | | |  | |  | | | |  | |
| 16. Pneumonia | |  |  | | |  | |  | | | |  | |
| 17. Urinary tract infection | |  |  | | |  | |  | | | |  | |
| 18. Fractures | |  |  | | |  | |  | | | |  | |
| 19. Other injuries | |  |  | | |  | |  | | | |  | |
| 20. Meningitis | |  |  | | |  | |  | | | |  | |
| 21. Other symptoms or illnesses | |  |  | | |  | |  | | | |  | |
| Other, describe | |  | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Q** |  | | **Response options / Variable name** | | | | | |
| **25** | **Does your child take any of the following dietary supplements?** (Enter a cross for each line, for both frequency,  amount and write brand name) | | | | | | | |
|  |  | |  | | *No. of times per week* | *Amount per time* | | |
|  | | 1) 6-7 | 1)1tsp | | |
|  | | 2) 4-5 | 2)1childsp | | |
|  | | 3)1-3 | 3)1dessertsp | | |
|  | | 4) ˂1 |  | | |
| **Liquid supplements** | | 5) 0 |  | | |
|  | 1. Cod liver oil | |  | |  |  | | |
| 2. Omega 3, | |  |  | | |
| Omega 3, brand name: | |  | | | |
| 3. Sanasol/Biovit | |  |  | | |
| 4. Other liquid dietary supplement | |  |  | | |
| Other liquid dietary supplement, brand name: | |  | | | |
|  | **Capsules/tablets** | | | | | | | |
|  | 1. Omega 3 | |  | |  |  | | |
| Omega 3, brand name: | |  | | | |
| 2. Cod liver oil | |  |  | | |
| 3. Multivitamins | |  |  | | |
| Multivitamins, brand name: | |  | | | |
| 4. Fluoride tablets | |  |  | | |
| 5. Other dietary supplements | |  |  | | |
| Other dietary supplements, brand name: | |  | | | |
| **Q** |  | | | **Response options** | | | **Variable name** |
| **30** | **How many slices of bread/crisp bread does your child usually eat per day?** | | | | | | |
|  | White bread | | | Number 0-99 | | |  |
| Medium refined grain bread | | |  |
| Whole grain | | |  |
| Crisp bread | | |  |
| **Q** |  | | | **Response options** | | | **Variable name** |
| **31** | **How often does your child usually eat the following?** | | | | | | |
|  | Carrot | | | 1. Never/seldom 2. 1-3 times per month 3. 1-2 times per week 4. 3-4 times per week 5. 5-6 times per week 6. 1 time or more per day | | |  |
| Cabbage, cauliflower, broccoli | | |  |
| Lettuce | | |  |
| Potatoes | | |  |
| Other vegetables | | |  |
| Oranges, clementine | | |  |
| Apple, pear, grapes | | |  |
| Banana | | |  |
| Other fresh fruit or berries | | |  |
| Ecologically grown fruits/vegetables | | |  |
| Sliced meat, liver pate, bologna or similar | | |  |
| Fish spread, including roe | | |  |
| Cheese (white/brown), cheese spread | | |  |
| Jam | | |  |
| Chocolate and nut spread | | |  |
| Peanut butter | | |  |
| Cornflakes, Honeycorn, Frosties or similar | | |  |
| Muesli/oatmeal | | |  |
| Yogurt (all types) | | |  |
| Egg | | |  |
| Rice, spaghetti, pasta | | |  |
| Fatty fish (salmon, mackerel, herring) | | |  |
| Other fish (cod, Pollock or similar) | | |  |
| Fish balls/fish pudding or similar | | |  |
| Shell fish | | |  |
| Pure meat (chops, steak etc.) | | |  |
| Pizza | | |  |
| Processed meats (beef-patties, sausages, meat balls) | | |  |
| Vegetarian dishes | | |  |
| Pancakes | | |  |
| Sweet buns/waffles/cakes | | |  |
| Ice cream and milk based desserts | | |  |
| Chocolate, sweets/candy | | |  |
| Peanuts | | |  |
| Other nuts | | |  |
| Potato crisps or similar | | |  |
| **Q** |  | | | **Response options** | | | **Variable name** |
| **32** | **How often does your child usually drink the following?** | | | | | | |
|  | Whole fat milk (sweet/sour) | | | 1. Never/seldom 2. 1-3 glasses per month 3. 1-3 glasses per week 4. 4-6 glasses per week 5. 1-3 glasses per day 6. 4 glasses or more per day | | |  |
| Low fat-and skimmed milk | | |  |
| Chocolate milk | | |  |
| Biola/Cultured milk | | |  |
| Orange juice, other juice | | |  |
| Apple nectar/other nectar | | |  |
| Diluting squash with added sugar | | |  |
| Artificially sweetened diluting squash | | |  |
| Sodas with sugar (Coke or similar) | | |  |
| Diet sodas | | |  |
| Water | | |  |
| **Q** | |  | | **Response options** | | | **Variable name** |
| **33** | | **How old was the child when he/she lost his/her first milk tooth?** | | | | | |
|  | |  | | 1. Age: 2. Don’t remember 3. Hasn’t lost one yet | | |  |
|  | | **How old was the child when he/she got his/her first milk tooth?** | | | | | |
| Only in version A | |  | | 1. Age: 2. Don’t remember | | |  |
| **34** | | **How often are the child’s teeth brushed by the child or others?** | | | | | |
|  | |  | | 1- Twice daily or more often 2- Once daily   1. Sometimes 2. Never/seldom | | |  |
| **35** | | **Have any cavities or early stages for cavities been found in the child’s teeth?** | | | | | |
| In B & C | |  | | 1. No 2. Yes | | |  |
|  | | **Has the child got filling in some of his/her teeth?** | | | | | |
| In version A | |  | | 1. No 2. Yes | | |  |
| **36** | | **Does the child get help to brush his/her teeth?** | | | | | |
|  | |  | | 1- Twice daily or more often 2- Once daily   1. Sometimes 2. Never/seldom | | |  |
| **37** | | **Does the child use dental floss (with help)?** | | | | | |
| In B & C | |  | | 1. Once daily 2. Sometimes 3. Never/seldom | | |  |
|  | | **Does the child use fluoride tablets?** | | | | | |
| In version A | |  | | 1. No 2. Yes 3. Sometimes | | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Q** |  | **Response options / Variable name** | | | | |
| **38** | **Do you or have you ever had, any of the following illnesses or health problems?** | | | | | |
|  |  | **Yes** | Confirmed by a doctor?  **Yes** | Symptoms started at **Age** | Symptoms the last year? **1-No**  **2-Yes** | Used medication for this during the last 12 months?  **Yes** |
| 1. Asthma |  |  |  |  |  |
| 2. Pollen allergy/hay fever |  |  |  |  |  |
| 3.  Tightness/wheezing/whi stling in chest |  |  |  |  |  |
| **Q** |  | **Response options / Variable name** | | | | |
| **39** | **Do you have, or have you ever had, a food allergy?** | | | | | |
|  |  | 1. No 2. Yes 3. Don’t know | | | |  |
| **40** | **If yes, do you have, or have you had, an allergy to the following foods?** | | | | | |
|  |  | **Yes** | Confirmed by a doctor?  **Yes** | Symptoms started at **Age** | Symptoms the last year? **1-No**  **2-Yes** | Used medication for this during the last 12 months?  **Yes** |
| 1. Allergy to milk |  |  |  |  |  |
| 2. Allergy to egg |  |  |  |  |  |
| 3. Allergy to peanuts |  |  |  |  |  |
| 4. Allergy to other nuts |  |  |  |  |  |
| 5. Allergy to shellfish |  |  |  |  |  |
| 6. Allergy to fish |  |  |  |  |  |
| 7. Allergy to fruit |  |  |  |  |  |
| 8. Allergy to other foods |  |  |  |  |  |
|  | If yes, which? | | | | | |
| Wheat |  | | | |  |
| Soy |  | | | |  |
| Rye |  | | | |  |
| Other |  | | | |  |
| Other, describe |  | | | |  |