Study Specific Number

The First 1,000 Days of Life … And Beyond

APPROVED: Inova IRB
Date Approved: January 10, 2019
IRB File # 15-1804

30 Months Survey

1. My child can identify one color.
- ❑ Yes
- ❑ No

2. My child can name about six body parts.
- ❑ Yes
- ❑ No

3. My child can put on clothing.
- ❑ Yes
- ❑ No

4. I started toilet training.
- ❑ Yes
- ❑ No

5. My child can Jump up.
- ❑ Yes
- ❑ No

6. Is there a smoker in your house or any other place that your child is cared for?
- ❑ Yes
- ❑ No

7. Is there a pet in your house or any other place that your child is cared for?
- ❑ Yes
- ❑ No

8. Are there difficulties with feeding your child?
- ❑ Yes
- ❑ No

8a. If yes, please specify:

a. Picky eater b. Does not eat enough c. Choking d. Reflux e. Other

9. Has your child been admitted to a hospital, in the past 6 months?
- ❑ Yes
- ❑ No

9a. If yes how many times? ☐

9b. Please specify the reason: ☐

10. Is your child currently seeing a physician because of a specific medical concern?

- ❑ Yes
- ❑ No

10a. If yes, which condition your child is consulting a physician for, please check all that apply:

- ❑ Vision problem
- ❑ Hearing problem
- ❑ Overweight
- ❑ Underweight
- ❑ Height concern
- ❑ Asthma
- ❑ Allergy
- ❑ Anemia
- ❑ Developmental concerns
- ❑ Other (Please Specify) ☐

11. Has your child had any surgery or procedure?

- ❑ Yes
- ❑ No

12. Has your child had any blood draw in the last 6 months?

- ❑ Yes
- ❑ No

13. Is your child taking any medication? (Do not include vitamins and minerals)

- ❑ Yes
- ❑ No

13a. If yes:

- ❑ Over the counter
- ❑ Prescription

14. Has your child been to a dentist?

- ❑ Yes
- ❑ No

15. How many cavities has your child had? ☐

16. Has your child received any services listed below in the past 6 months?

- ❑ Speech Therapy
- ❑ Physical Therapy
- ❑ Play Therapy
- ❑ Dietitian or Nutritionist

We would like to know your interest in genetics and genetic testing.

1. How would you describe your understanding of how genetic information can be used in healthcare? Would you say understand?

    - Very well
    - Somewhat well
    - A little
    - Not at all

2. Have you or anyone in your family ever had a genetic test to predict or diagnose a disease or condition?

    - Yes
    - No
    - Unsure

3. Have you or anyone in your family ever had a genetic test to predict how well a medicine may work for you or your risk for having a side effect?

    - Yes
    - No
    - Unsure

4. Do you have a family history of:

	Yes	No
Cancer		
Heart disease		
Obesity		
Diabetes		
High cholesterol		
High blood pressure		
Asthma		
Alzheimer Disease		
Parkinson Disease		
Other Neurologic conditions		

5. How interested would you be in learning more about how genomics can help predict risk of or guide treatment for the following:

	Very Interested	Somewhat Interested	Unsure	A Little Interested	Not Interested at all
Cancer					
Heart disease					
Obesity					
Diabetes					
High cholesterol					
High blood pressure					
Asthma					
Alzheimer Disease					
Parkinson Disease					
Other Neurologic conditions					

6. Do you have a family history of adverse reaction to medicine or side effects to medications?

   - ❑ Yes
   - ❑ No

7. Are you interested in availability of genetic tests that may predict how you may respond to different medications?

☐ Very Interested ☐ Somewhat Interested ☐ Unsure ☐ A Little Interested ☐ Not Interested at all

If we do discover information that might be important to your child's health, we can report those results back to your child's doctor if you want us to. Please provide us the name and phone number of your child's doctor if you grant us permission to contact the doctor with any discoveries important to your child's health.

Doctor's Name: _____

Doctor's Phone number: _____