MY SON'S HEALTH

This questionnaire should be completed by the chief carer of the study child

15/04/00

This questionnaire is all about your study son’s health.

To answer simply tick the box that is most accurate in your opinion.

If you cannot answer certain questions leave them out and go on to the next one.

All answers are confidential.

THANK YOU FOR YOUR HELP

SECTION A: YOUR CHILD'S HEALTH

The health of your study child is still of great importance to us. We would like to know about any recent illnesses or medical treatments.

A1. How would you assess the health of your child nowadays?

	(i) in the past month	**(ii) in the past year**
very healthy, no problems	1	1
healthy, but a few minor problems	2	2
sometimes quite ill	3	3
almost always unwell	4	4

A2. a) **In the past 12 months** has the doctor been called to your home because your son was unwell?

Yes 1 No 2 → **If <u>no,</u> go to A3 below**

If <u>yes</u>,

b) how many times?

once 1 2 times 2 3-4 times 3 5 or more times 4

A3. Has he had any of the following in the past 12 months?

In the past 12 months:	**Yes and saw a doctor**	**Yes but did not see doctor**	**No did not have**
a) diarrhoea	1	2	3
b) blood in the stools	1	2	3
c) vomiting	1	2	3
d) cough	1	2	3
e) high temperature	1	2	3

		In the past 12 months:	Yes and saw a doctor	Yes but did not see doctor	No did not have
A3.	f)	snuffles/cold	1	2	3
	g)	ear ache	1	2	3
	h)	ear discharge (pus not wax)	1	2	3
	i)	convulsions/fits	1	2	3
	j)	stomach ache(s)	1	2	3
	k)	rash	1	2	3
	l)	wheezing	1	2	3
	m)	breathlessness	1	2	3
	n)	episodes of stopping breathing	1	2	3
	o)	an accident	1	2	3
	p)	urinary infection	1	2	3
	q)	headache(s)	1	2	3
	r)	constipation	1	2	3
	s)	worm infections	1	2	3
	t)	head lice	1	2	3
	u)	scabies	1	2	3
	v)	asthma	1	2	3
	w)	eczema	1	2	3
	x)	hay fever	1	2	3
	y)	other (please tick and describe)	1	2	3

.....

A4. In the past 12 months, has he had any of the following infections?

In the past 12 months:

		Yes	No
a)	measles	1	2
b)	chicken pox	1	2
c)	mumps	1	2
d)	meningitis	1	2
e)	cold sores	1	2
f)	whooping cough	1	2
g)	urinary infection	1	2
h)	eye infection	1	2
i)	ear infection	1	2
j)	chest infection	1	2
k)	tonsillitis or laryngitis	1	2
l)	german measles	1	2
m)	scarlet fever	1	2
n)	influenza (flu)	1	2
o)	a cold	1	2
p)	other infection (please tick & describe)	1	2

.....

A5. a) Has your child been admitted to hospital **in the past 2 years**?

Yes [1] No [2] → **If no, go to A6 below**

If yes,

b) how many times? [ ][ ]

c) please describe for each admission:

	Age of child (years)	**Reason for admission**	**No. of nights child stayed in hospital**
1.	[ ]	.....	[ ][ ]
2.	[ ]	.....	[ ][ ]
3.	[ ]	.....	[ ][ ]

Write 00 if child did not stay overnight

If more than 3 admissions please describe on separate sheet

d) How often did you see him while he was in hospital?

	1st admission	**2nd admission**	**3rd admission**
Not at all	1	1	1
Quite often	2	2	2
Every day	3	3	3
Stayed in the hospital with him	4	4	4

A6. Has he **ever** had any of the following operations?
(Please tick all that apply)

		Yes	
a)	hernia repair	1	→ **If yes**, please give type ……..
b)	tonsils out	1	
c)	adenoids out	1	
d)	appendicectomy (appendix out)	1	

			Yes
A6.	e)	tubes (grommets) put in his ears	1
	f)	squint repair (to put eyes straight)	1
	g)	teeth pulled out	1
	h)	other operations (please describe)	1

.....

A7. How many days has he had to take off school for health reasons?
[If you can't remember, make a guess and write G in column (ii)]

In the past 12 months:	**(i) No. of days off school**	**(ii) Guess?**
a) For one or more infections (including colds, cough, flu)		
(i) please describe ……		
……		
b) For hospital investigation including admission		
(i) please describe ……		
……		
c) For other investigation(s)		
(i) please describe ……		
……		
d) For asthma, eczema or hayfever		
e) For other reasons		
please describe: (i) ……..		
(ii) ……..		
(iii) ……..		

A8. Children often have accidents or illnesses that need treatment. Please indicate which of the following have been given to your child **in the last 12 months**.

In the last 12 months:		**Never**	**Yes for 1-2 episodes only**	**Yes for 3 or more episodes**	**If yes, please give full names of substances if you can**
a)	cough medicine	1	2	3	.....
b)	antibiotics/penicillin	1	2	3	.....
c)	throat medicine	1	2	3	.....
d)	vitamins	1	2	3	.....
e)	paracetamol/calpol	1	2	3	.....
f)	ointment for skin	1	2	3	.....
g)	eye ointment	1	2	3	.....
h)	diarrhoea mixture or pills	1	2	3	.....
i)	dimotapp/decongestant	1	2	3	.....
j)	ear drops	1	2	3	.....
k)	eye drops	1	2	3	.....
l)	iron	1	2	3	.....
m)	laxative	1	2	3	.....
n)	homeopathic medicine	1	2	3	.....
o)	herbal medicine	1	2	3	.....
p)	asthma medication	1	2	3	.....
q)	vaporiser	1	2	3	.....
r)	other (please tick and describe)		2	3	.....

.....

A9. 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, inhaler, laxatives as well as antibiotics, homeopathic and herbal remedies etc.)

Yes ☐ 1 No ☐ 2 → **If no, go to A10a below**

If yes,

b) please describe:

.....

.....

A10. a) **In the past year** has he had any periods when there was wheezing with whistling on his chest when he breathed?

Yes ☐ 1 No ☐ 2 → **If no, go to A10k on page 10**

If yes,

b) How many separate times has this happened in the past 12 months?

once ☐ 1 twice ☐ 2 3-4 times ☐ 3 5 or more times ☐ 4 don't know ☐ 9

c) How many days altogether would you say he has wheezed in the past 12 months?

1 day ☐ 1 2-3 days ☐ 2 4-9 days ☐ 3 10-19 days ☐ 4 20 or more days ☐ 5 don't know ☐ 9

d) Was he breathless during any of these times?

Yes for all ☐ 1 Yes for some ☐ 2 No not at all ☐ 3

e) Did he have a fever during any of these times?

Yes for all ☐ 1 Yes for some ☐ 2 No not at all ☐ 3

A10. f) How often, on average, has your child's sleep been disturbed due to wheezing <u>in the past 12 months</u>?

Never woken with wheezing [1] Less than one night per week [2] One or more nights per week [3]

g) Has wheezing ever been severe enough to limit your child's speech to only one or two words at a time between breaths <u>in the past 12 months</u>?

Yes [1] No [2]

h) Do you think the wheezing attacks are worse during any particular time of year?

yes, worse in spring and/or summer [1]

yes, worse in autumn and/or winter [2]

not particularly [3]

other (please tick & describe) [4]

……

j) What do you think brings on the wheezing attacks ?

		Yes	**No**
(i)	chest infection or bronchitis	1	2
(ii)	being in a smoky room	1	2
(iii)	cold weather	1	2
(iv)	I don't know	1	
(v)	other (please tick & describe)	1	2

.....……

k) <u>In the past 12 months</u> has your child's chest sounded wheezy during or after exercise?

Yes [1] No [2]

A10. l) In the past 12 months has your child had a dry cough at night, apart from a cough associated with a cold or chest infection?

Yes [1] No [2]

m) Have any of your other children ever had spells of wheezing with whistling on the chest?

Yes [1] No [2] have no other children [7]

A11. a) Has your child had any itchy, dry skin rash in the joints and creases of his body (e.g. behind the knees, elbows, under the arms) in the past year?

Yes [1] No [2] → **If no, go to A12a below**

If yes,

b) How bad was this?

very bad [1] quite bad [2] mild [3] no problem [4]

c) Does he have this sort of rash now?

Yes [1] No [2]

		Yes	**No**
d)	Did the rash ever become sore and oozy?	[1]	[2]
e)	Was it made worse by irritants such as bubble bath, soap, wool or nylon clothing?	[1]	[2]

A12. a) Has he had an itchy, dry, rash on his hands in the past year?

Yes [1] No [2]

b) Has he had an itchy, dry rash on his feet in the past year?

Yes [1] No [2] → **If no, go to A12c on page 12**

If yes, please describe which parts of his feet ……..

……

A12. c) In the past 12 months how often, on average, has your child been kept awake at night by an itchy rash?

Never in the past 12 months [1] Less than one night per week [2] One or more nights per week [3]

d) Does his skin get itchy when he gets sweaty? (e.g. in a hot room or when he has been playing?)

Yes [1] No [2]

A13. Has he had a skin reaction in the past year (e.g. redness or itching) which you thought was due to some food that he had eaten?

Yes [1] No [2] →**If no, go to A14 below**

If yes,

a) please describe the food(s) .....

b) how long after the food was eaten did the reaction appear?.....…

c) where was the reaction? mouth [1]

other part [2]

(please describe) .....……..

A14. This question is about problems which occur when your child **does not** have a cold or the flu.

a) Has your child ever had sneezing episodes, or a runny or blocked nose, when he did not have a cold or the flu?

Yes [1] No [2] → **If no, go to A14c below**

b) In the past 12 months, has your child had sneezing episodes, or a runny or blocked nose, when he did not have a cold or the flu?

Yes [1] No [2]

c) In the past 12 months, has he had itchy-watery eyes?

Yes [1] No [2]

A14. d) In which of the past 12 months did these nose and/or eye problems occur? (Please tick all that apply)

(i) Hasn't had a nose or eye problem ☐7 → **go to A15a below**

(ii)

January	☐1	May	☐1	September	☐1
February	☐1	June	☐1	October	☐1
March	☐1	July	☐1	November	☐1
April	☐1	August	☐1	December	☐1

e) In the past 12 months, how much did these nose and eye problems interfere with your child's activities?

Not at all	☐1	A little	☐2
A moderate amount	☐3	A lot	☐4

A15. a) Has he had vomiting spells in the past year?

Yes ☐1 No ☐2 →**If no, go to A16a on page 14**

If yes,

b) How many times?

once ☐1 twice ☐2 3-9 times ☐3 10 or more times ☐4

c) How often have these been associated with:

		Always	Frequently	Sometimes	Rarely	Never
(i)	diarrhoea	☐1	☐2	☐3	☐4	☐5
(ii)	chestiness (wheezing or coughing or grunting)	☐1	☐2	☐3	☐4	☐5

A16. a) In the past year has he had diarrhoea or gastro-enteritis?

Yes [1] No [2] **→If no, go to A17a below**

If yes,

b) how many times in the past 12 months? [ ][ ]

c) how many days did the worst attack last? [ ][ ]

A17. a) In the past year has your child ever had a time when he has coughed off and on for at least 2 days?

Yes [1] No [2] **→If no, go to A18 below**

If yes,

b) How many times has this happened in the past year?

once [1] twice [2] 3-9 times [3] 10 or more times [4]

c) Did he have a fever at any of these times?

Yes for all [1] Yes for some [2] No, not at all [3]

d) Did he have a runny nose during any of these spells?

Yes for all [1] Yes for some [2] No, not at all [3]

A18. Has pus or sticky mucus (not ear wax) leaked out of his ear in the past year?

never [1]

once [2]

more than once [3]

don't know [9]

A19. Does he breathe through his mouth rather than through his nose?

	(i) when asleep	(ii) when awake
all the time	1	1
much of the time	2	2
sometimes	3	3
rarely	4	4
never	5	5
don't know	9	9

A20. Does he snore for more than a few minutes at a time?

most nights	1
quite often	2
sometimes	3
only rarely	4
never	5
don't know	9

A21. a) Have there been times in the past year when he has had a pain in his stomach?

Yes 1 No 2 →**If <u>no</u>, go to A22a on page 16**

If <u>yes</u>,

b) How many separate times has this happened in the past year?

once 1 twice 2 3-4 times 3 5 or more times 4 don't know 9

A21. c) Did he have vomiting or diarrhoea at the same time as the pain?

yes every time [1] yes, for some of the times [2] no, not at all [3]

d) What do you think were the causes of his stomach pains? (Tick all that apply)

(i) something he ate [1]

(ii) an infection [1]

(iii) constipation [1]

(iv) other (please describe) [1] .....

(v) don't know [1]

A22. a) Does he often have aches and pains in his arms or legs?

yes arm(s) [1] yes leg(s) [2] yes both [3] no, not often [4]

↓

If <u>no</u>, go to A23a on page 17

If <u>yes</u>,

(i) does this happen especially when he is tired? Yes [1] No [2]

(ii) what do you think is the cause ?

.....

(iii) do you find any particular treatment helps ?

Yes [1] No [2]

If <u>yes</u>, please describe.....

A23. a) Since his 7th birthday has he had any form of convulsion, fit, seizure or other turn in which consciousness was lost or any part of the body made an abnormal movement?

Yes 1 No 2 Not known 9

If <u>no</u>, or <u>not known,</u> go to B1 on page 19

If <u>yes</u>,

. b) Please describe the <u>first</u> attack since his 7th birthday:

.....

.....

c) Did the child have a high temperature at the time?

Yes 1 No 2 Not known 9

d) How old was he at the time?

7 years 1 8 years 2 9 years 3

e) How many attacks has he had since his 7th birthday?

one 1 two 2 3-4 3 5 or more 4

. f) By whom was he seen for these attack(s)? (Tick all that apply)

		Yes
(i)	general practitioner at home	1
(ii)	general practitioner at surgery	1
(iii)	hospital outpatient department	1
(iv)	admitted to hospital	1

A23. g) What investigations, if any, have been carried out?

.....

h) Did later attacks differ from the first one?

yes 1 no 2 Has only had one attack since 7th birthday 7

go to (j) below

If <u>yes</u>, please describe

.....

.....

j) What was/were the attack(s) thought to be due to? (Tick all that apply)

(i)	febrile convulsions	1
(ii)	fainting and blackouts	1
(iii)	epilepsy	1
(iv)	breath holding	1
(v)	reaction to immunisation	1
(vi)	other (please describe)	1 .....
(vii)	don't know	1

Chloe

SECTION B: COMPLEMENTARY/ALTERNATIVE MEDICINE

We are interested to know if you have ever used complementary/alternative medicine for your child and how helpful you found it.

B1. Has your child **ever** received any of the following:

		Yes	No	
a)	Acupuncture	1	2	
b)	Aromatherapy	1	2	
c)	Bach/Flower essences	1	2	
d)	Cranial osteopathy	1	2	
e)	Herbal medicine	1	2	
f)	Homeopathy	1	2	
g)	Hypnosis	1	2	
h)	Osteopathy	1	2	
i)	Reflexology	1	2	
j)	Other (please tick and describe)	1	2	……

If none of these go to Section C

B2. Describe <u>each</u> treatment separately:

a) (i) **Name of 1st treatment** (e.g. acupuncture, reflexology etc.):

……..

(ii) If medicine or preparation was given, please state the name(s):

……...

(iii) Child's condition / illness: ……

(iv) Age of child when this treatment started: ☐ years
(put 0 for less than 1 year)

(v) If less than 1 year please state in months (put 00 for less than 1 month)

months ☐☐

B2.

a) (vi) How helpful did you find this treatment?

very helpful [1] somewhat helpful [2] not at all helpful [3] unsure [4]

b) (i) **Name of 2nd treatment** (e.g. acupuncture, reflexology etc.):

……..

(ii) If medicine or preparation was given, please state the name(s):

……...

(iii) Child's condition / illness: ……

(iv) Age of child when this treatment started: [ ] years
(put 0 for less than 1 year)

. (v) If less than 1 year please state in months (put 00 for less than 1 month)

months [ ][ ]

(vi) How helpful did you find this treatment?

very helpful [1] somewhat helpful [2] not at all helpful [3] unsure [4]

c) (i) **Name of 3rd treatment** (e.g. acupuncture, reflexology etc.):

……..

(ii) If medicine or preparation was given, please state the name(s):

……...

(iii) Child's condition / illness: ……

(iv) Age of child when this treatment started: [ ] years
(put 0 for less than 1 year)

(v) If less than 1 year please state in months (put 00 for less than 1 month)

months [ ][ ]

(vi) How helpful did you find this treatment?

very helpful [1] somewhat helpful [2] not at all helpful [3] unsure [4]

B2.

d) i) **Name of 4th treatment** (e.g. acupuncture, reflexology etc.):

……..

(ii) If medicine or preparation was given, please state the name(s):

……...

(iii) Child's condition / illness: ……

(iv) Age of child when this treatment started: ☐ years
(put 0 for less than 1 year)

(v) If less than 1 year please state in months (put 00 for less than 1 month)

months ☐☐

(vi) How helpful did you find this treatment?

very helpful ☐1 somewhat helpful ☐2 not at all helpful ☐3 unsure ☐4

e) i) **Name of 5th treatment** (e.g. acupuncture, reflexology etc.):

……..

(ii) If medicine or preparation was given, please state the name(s):

……...

(iii) Child's condition / illness: ……

(iv) Age of child when this treatment started: ☐ years
(put 0 for less than 1 year)

(v) If less than 1 year please state in months (put 00 for less than 1 month)

months ☐☐

(vi) How helpful did you find this treatment?

very helpful ☐1 somewhat helpful ☐2 not at all helpful ☐3 unsure ☐4

If there were more than 5 different types of treatment please list on a separate page describing them as above.

SECTION C: ALLERGIES

C1. Are there any foods or drinks that your child has had an allergic reaction to since his 7th birthday?

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

If no, or don't know go to C2a on page 23

If yes,

a) please describe which foods or drinks .....

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

eating/drinking 1 | touching 2 | both 3

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

(i) bright red rash 1 — **If yes**, over what part of body?

.....

(ii) hives (white raised bumps on skin) 1 — **If yes**, over what part of body?

.....

(iii) wheezing or whistling in the chest 1

(iv) vomiting 1

(v) diarrhoea 1

(vi) difficulty breathing 1

(vii) stop breathing 1

(viii) headache 1

(ix) swelling 1 — **If yes, describe where** ……..

(x) other reaction (please describe) 1 ……

C1. d) How long after eating or drinking or touching does this usually happen?

less than 1 hr [1] 1-2 hrs [2] 3-5 hrs [3]

6 hrs or more [4] don't know [9]

e) How many times has a reaction happened **in the past year**?

once [1] 2-3 times [2] 4-9 times [3]

10 or more times [4] don't know [9]

f) What have you done about these reactions? (Tick all that apply)

(i) Avoided the foods that caused them [1]

(ii) Took to GP to investigate [1]

(iii) Investigated in hospital [1]

(iv) Other (please describe) [1] ……

g) What treatment has your child been given for the problem?

None [1] Yes, some treatment [2] → Please describe ……

……

C2. a) Apart from food and drink are there any other things to which he is allergic?

Yes [1] No [2] **→If <u>no</u>, go to C3 on page 24**

If <u>yes</u>,

b) What is he allergic to? (Tick all that apply)

(i) pollen [1]

(ii) cat [1]

(iii) dog [1]

(iv) bee sting or wasp sting [1]

C2. b) (v) house dust 1

(vi) medicine 1 → **If <u>yes</u>**, please describe type of medicine

……..

(vii) other (please tick and describe) 1 …….

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

(i) wheezing 1

(ii) breathlessness 1

(iii) sneezing 1

(iv) rash 1

(v) other (please tick and describe) 1

.....

C3. Spring and Summer problems:

a) Does your child suffer from any of the following symptoms **during Spring or Summer**? (Please tick all that apply)

	Yes
(i) runny, red or itchy eyes	1
(ii) frequent sneezing bouts	1
(iii) constantly blocked, runny or itchy nose	1
(iv) nettle-like rash without obvious cause	1
(v) constant cold	1
(vi) none of the above	1

C3. b) Does your child take any of the following medication regularly at any time of year?

		Yes, in spring/ summer	Yes, in autumn/ winter	Yes, all year	No, not at all
(i)	Piriton	1	2	3	4
(ii)	Loratadine/Clarityn	1	2	3	4
(iii)	Flixonase	1	2	3	4
(iv)	Nasonex	1	2	3	4
(v)	Antihistamine eye drops	1	2	3	4
(vi)	Triludan	1	2	3	4
(vii)	Cetirizine/Zirtek	1	2	3	4
(viii)	Beconase	1	2	3	4
(ix)	Opticrom eye drops	1	2	3	4
(x)	Other antihistamine (please tick & describe	1	2	3	4

……..

SECTION D: PROBLEMS AND INVESTIGATIONS

D1. a) Since his 7th birthday has anyone thought there might be a problem with his hearing?

Yes [1] No [2]

b) Has your child been seen by a hearing specialist since he was 7?

Yes [1] No [2] **→If no, go to D2a below**

If yes,

c) At what age?

7 years old [1] 8 years old [2] 9 years old [3]

d) What was decided? .....

.....

D2. a) Has your child been referred to an eye specialist since his 7th birthday?

Yes [1] No [2] **→If no, go to D3a on page 28**

If yes,

b) at what age?

7 years old [1] 8 years old [2] 9 years old [3]

c) What was decided? .....

.....

d) What treatment was given? .....

.....

D3. a) Has anyone **ever** thought that there might be a problem with his talking?

Yes [1] No [2] →**If no, go to D4a below**

If yes,

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

Yes [1] No [2] →**If no, go to D3c below**

If yes,

(i) how old was he? [ ] years

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

.....

c) Are there still any worries about his talking?

Yes [1] No [2]

If yes, please describe .....

.....

D4. a) Has anyone **ever** thought he might have a problem with clumsiness, movement or coordination?

Yes [1] No [2] →**If no, go to D5a on page 29**

If yes,

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

Yes [1] No [2] →**If no, go to D4e on page 29**

If yes,

c) how old was he? [ ] years (If less than 12 months put 0)

d) what was decided?.....

.....

D4. e) Are there still worries about this?

Yes [1] No [2]

If <u>yes</u>, please describe.....

.....

D5. a) Has anyone **ever** thought there might be a problem with other aspects of his development?

Yes [1] No [2] →**If <u>no</u>, go to D6a below**

If <u>yes</u>,

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

Yes [1] No [2] →**If <u>no</u>, go to D5e below**

If <u>yes</u>,

c) how old was he? [ ] years (If less than 12 months put 0)

d) what was decided?.....

.....

e) Are there still worries about this?

Yes [1] No [2]

If <u>yes</u>, please describe.....

.....

D6. a) Has anyone **ever** thought there might be a problem with his behaviour or personality?

Yes [1] No [2] →**If <u>no</u>, go to D7a on page 30**

If <u>yes</u>,

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

Yes [1] No [2] →**If <u>no</u>, go to D6e on page 30**

If <u>yes</u>,

D6. c) how old was he? ☐ years (If less than 12 months put 0)

d) what was decided?.....

.....

e) Are there still worries about this?

Yes ☐1 No ☐2

If <u>yes</u>, please describe.....

.....

D7. a) Has anyone **<u>ever</u>** thought there might be a problem with aches and pains, including headache?

Yes ☐1 No ☐2 **→If <u>no</u>, go to D8a on page 31**

If <u>yes</u>,

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

Yes ☐1 No ☐2 **→If <u>no</u>, go to D7e below**

If <u>yes</u>,

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

d) what was decided?.....

.....

e) Are there still worries about this?

Yes ☐1 No ☐2

If <u>yes</u>, please describe.....

.....

D8. a) Have there been any **other** problems for which your child saw (or is going to see) a specialist since his 7th birthday?

Yes [1] No [2] →**If no, go to section E on page 32**

If yes,

b) For how many different problems? [ ][ ]

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)	Has he seen a specialist?	Yes [1] No [2] Not yet [3]	Yes [1] No [2] Not yet [3]	Yes [1] No [2] Not yet [3]
e)	What age was he the first time he was seen for this problem ? (put 0 if less than 12 months)	[ ] years	[ ] years	[ ] years
f)	What was decided?	....	....	....
g)	What treatment was given?	....	....	....

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

SECTION E: 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.

E1. a) Has he been burnt or scalded in the past 12 months?

Yes [1] No [2] →**If no, go to E2a on page 33**

If yes, b) how many times? [ ][ ]

For each accident please describe below what happened:

		1st accident	**2nd accident**	**3rd accident**
c)	Place accident happened (e.g.kitchen, park, school)	.....	.....	.....
d)	What was he burnt with? (e.g. tea, iron, electric fire, bonfire, fireworks)	.....	.....	.....
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	[1]	[1]	[1]
	Treated him themselves	[2]	[2]	[2]
	Took to doctor	[3]	[3]	[3]
	Took to hospital	[4]	[4]	[4]
	Other (please describe)	[5]	[5]	[5]
		.....	.....	.....
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.....

E2. a) Has he had an accident while playing sports or games in the past 12 months?

Yes [1] No [2] → **If no, go to E3a on page 34**

If yes, b) how many times? [ ][ ]

For each accident please describe below what happened:

		1st accident	**2nd accident**	**3rd accident**
c)	Place it happened (e.g.playground, street, school)	.....	.....	.....
d)	What happened (e.g. hit by ball, fell off trampoline)?	.....	.....	.....
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	[1]	[1]	[1]
	Treated him themselves	[2]	[2]	[2]
	Took to doctor	[3]	[3]	[3]
	Took to hospital	[4]	[4]	[4]
	Other (please describe)	[5]	[5]	[5]
		.....	.....	.....
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 .....

E3. a) Has he swallowed anything he shouldn't have (such as pills, buttons, disinfectant) in the past 12 months?

Yes [1] No [2] **→If no, go to E4a on page 35**

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, school, at friend's)	.....	.....	.....
d)	What did he swallow? (e.g. bleach, aspirin, marble)	.....	.....	.....
e)	Date of accident (month, year)	.....	.....	.....
f)	Who was with him?	.....	.....	.....
g)	What did the person with him do?			
	Nothing	[1]	[1]	[1]
	Treated him themselves	[2]	[2]	[2]
	Took to doctor	[3]	[3]	[3]
	Took to hospital	[4]	[4]	[4]
	Other (please describe)	[5]	[5]	[5]
		.....	.....	.....
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 .....

E4. a) Has he had any injuries involving traffic in the past 12 months?

Yes [1] No [2] →**If no, go to E5a on page 36**

If yes, b) how many times? [ ][ ]

For each accident or injury please describe below what happened:

		1st accident	**2nd accident**	**3rd accident**
c)	Where was he and what was he doing (e.g. sitting in car; riding a bicycle)?	.....	.....	.....
d)	What happened (e.g. car hit tree; fell off bike)	.....	.....	.....
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	[1]	[1]	[1]
	Treated him themselves	[2]	[2]	[2]
	Took to doctor	[3]	[3]	[3]
	Took to hospital	[4]	[4]	[4]
	Other (please describe)	[5]	[5]	[5]
		.....	.....	.....
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 .....

E5. a) Has he **ever** been injured by the action of another person (whether intentionally or not)?

Yes [1] No [2] →**If no, go to E6a on page 37**

If yes, b) how many times? [ ][ ]

For each time please describe below what happened:

		1st injury	**2nd injury**	**3rd injury**
c)	Person involved (e.g. stranger, sister, child's father)	.....	.....	.....
d)	What happened ?	.....	.....	.....
e)	Date of injury (month, year)	.....	.....	.....
f)	Who else was with him?	.....	.....	.....
g)	What did the person with him do?			
	Nothing	[1]	[1]	[1]
	Treated him themselves	[2]	[2]	[2]
	Took to doctor	[3]	[3]	[3]
	Took to hospital	[4]	[4]	[4]
	Other (please describe)	[5]	[5]	[5]
		.....	.....	.....
h)	What treatment did the person with him give?	.....	.....	.....
i)	What other treatment did he have?	.....	.....	.....

j) Please describe how each accident happened:

Injury 1 .....

Injury 2 .....

Injury 3 .....

E6. a) Has he had any other accidents or injuries in the past 12 months?

Yes [1] No [2] →**If no, go to E7 on page 38**

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. kitchen, garden, street, school)	.....	.....	.....
d)	What happened?	.....	.....	.....
e)	Date of accident (month, year)	.....	.....	.....
f)	Injuries caused (if no injury write none)	.....	.....	.....
g)	What did the person with him do?			
	Nothing	[1]	[1]	[1]
	Treated him themselves	[2]	[2]	[2]
	Took to doctor	[3]	[3]	[3]
	Took to hospital	[4]	[4]	[4]
	Other (please describe)	[5]	[5]	[5]
		.....	.....	.....
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 .....

E7. Has he had any of the following happen **since he was born**? (tick all questions and all time periods that apply)

		(i) Yes, aged 0 - 2 years	(ii) Yes, aged 3-4 years	(iii) Yes, aged 5-6 years	(iv) Yes, since 7th birthday
a)	Broken arm/hand	1	1	1	1
b)	Broken leg/foot	1	1	1	1
c)	Broken/cracked skull	1	1	1	1
d)	Other broken bone (please describe).....……	1	1	1	1
e)	Unconscious because of a head injury	1	1	1	1
f)	Cut(s) requiring stitches	1	1	1	1
g)	Burn or scald needing a skin graft	1	1	1	1
h)	A road traffic accident	1	1	1	1
i)	An accident in a playground	1	1	1	1
j)	An accident at school, nursery, crèche	1	1	1	1
k)	Stung by wasp or bee	1	1	1	1
l)	Bitten by animal or human (please tick and describe)	1	1	1	1
m)	Badly sunburnt	1	1	1	1
n)	Nearly drowned	1	1	1	1
o)	Front tooth (teeth) knocked out	1	1	1	1
p)	Front tooth (teeth) chipped or injured	1	1	1	1
q)	Other tooth/teeth knocked out or chipped	1	1	1	1

E8. Has the study child ever had an accident that has had effects that are still present? (Please tick all that apply)

a) yes, a scar [1]

b) yes, a behaviour difference [1]

c) yes, other [1]

For any of the above, please describe

.....

Louisa & Nicholas

Ellie

Donna

F1. This questionnaire was completed by: (tick all that apply)

a) mother [1]

b) father [1]

c) other (please tick and describe) [1] .....

F2. Please give the date on which you completed this questionnaire:

day [ ][ ] month [ ][ ] year [ ][ ][ ][ ]

F3. Please give the date of birth of your child:

day [ ][ ] month [ ][ ] 199 [ ]

THANK YOU VERY MUCH FOR YOUR HELP

Space for any additional comment you would like to make

NB Please remember we cannot reply to any comment unless you sign it.

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 928 5007

For office use only *coder* [ ][ ] *int* [ ][ ]