



Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

## Questionnaire – Birth to 18-years-old

*Please note that we may contact you if your responses need to be clarified.*

1. a) **Today's date** : \_\_\_\_\_  
(Month) (Day) (Year)

b) Child/Participant's name: \_\_\_\_\_  
(First) (Last)

2. a) Parent/Guardian's name: \_\_\_\_\_ Ph #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(First) (Last)

b) Child/Participant's doctor's information:

Dr. \_\_\_\_\_ Ph #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Initial) (Last)

Doctor's mailing address *or* major intersection and city/town:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) Your mailing address (so we can send a copy of your signed consent form to you):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Child/Participant's **date of birth**: \_\_\_\_\_  
(Month) (Day) (Year)

4. Child/Participant is: ☐ female ☐ male

**\*\*Please be sure to read and sign the consent form attached to this questionnaire**

5. a) Was Child/Participant born in Canada?

☐ yes - In which province? \_\_\_\_\_

☐ no - In which country was Child/Participant born? \_\_\_\_\_

6. What are considered to be healthy & normal blood test results for one ethnic group may be different for other ethnic groups. For this reason, it is important for us to know Child/Participant's ethnic origin. Please check mark the ethnic origin(s) of Child/Participant's biological mother and biological father. You can select more than one answer.

biological mother

- |  |   |
|--|---|
| <input type="checkbox"/> Aboriginal      | <input type="checkbox"/> Korean           |
| <input type="checkbox"/> Arab/west Asian | <input type="checkbox"/> Latin American   |
| <input type="checkbox"/> Black           | <input type="checkbox"/> South Asian      |
| <input type="checkbox"/> Chinese         | <input type="checkbox"/> South east Asian |
| <input type="checkbox"/> Filipino        | <input type="checkbox"/> Caucasian        |
| <input type="checkbox"/> Japanese        | <input type="checkbox"/> Other: _____     |

biological father

- |  |   |
|--|---|
| <input type="checkbox"/> Aboriginal      | <input type="checkbox"/> Korean           |
| <input type="checkbox"/> Arab/west Asian | <input type="checkbox"/> Latin American   |
| <input type="checkbox"/> Black           | <input type="checkbox"/> South Asian      |
| <input type="checkbox"/> Chinese         | <input type="checkbox"/> South east Asian |
| <input type="checkbox"/> Filipino        | <input type="checkbox"/> Caucasian        |
| <input type="checkbox"/> Japanese        | <input type="checkbox"/> Other: _____     |

7. Is Child/Participant's biological mother considered to be healthy?

☐ yes

☐ no - please explain: \_\_\_\_\_

☐ unsure

8. Is Child/Participant's biological father considered to be healthy?

☐ yes

☐ no - please explain: \_\_\_\_\_

☐ unsure

9. Does Child/Participant have a long-term illness or health condition that has been confirmed by a doctor?

☐ yes - please explain: \_\_\_\_\_

☐ no

10. a) Does Child/Participant regularly take any prescribed medications?

☐ yes - please explain: \_\_\_\_\_

☐ no

**\*\*Please be sure to read and sign the consent form attached to this questionnaire.**

A) Has Child/Participant been ill within the past **7 days**?

- ☐ yes - please explain: \_\_\_\_\_  
☐ no

B) Please specify Child/Participant's diet in a **typical week**. Please check all that apply.

- ☐ red meat (beef, veal, pork, lamb, etc.)  
☐ poultry (chicken, turkey, duck, etc.)  
☐ fish (salmon, halibut, haddock, cod, tuna, etc.)  
☐ shellfish (lobster, crab, shrimp, etc.)  
☐ eggs  
☐ milk ☐ skim ☐ 1% ☐ 2% ☐ homo  
☐ cheese  
☐ yogurt  
☐ margarine  
☐ honey  
☐ vegetarian: do not eat any red meat, poultry, fish or shellfish  
☐ vegan: do not eat any red meat, poultry, fish, shellfish, eggs, dairy or honey  
  
☐ multi-vitamins  
☐ vitamin D  
☐ other vitamins/minerals – please explain: \_\_\_\_\_  
☐ Breastmilk  
☐ Infant Formula

C) Has Child/Participant taken any medication **prescribed by a doctor** in the past 2 weeks?

- ☐ yes - please explain: \_\_\_\_\_  
☐ no

D) Please check all non-prescribed medications or substances that Child/Participant has taken in the past 2 weeks.

- ☐ cold/flu medication  
☐ asprin/tylenol/ibuprofen ☐ allergy medication  
☐ other (i.e. cigarettes, alcohol, etc.)- please explain: \_\_\_\_\_

E) Has Child/Participant exercised heavily in the past 24 hours (e.g. running, cycling, swimming, etc.)?

- ☐ yes - please explain: \_\_\_\_\_  
☐ no

**This section is for females only.**

F) Is Child/Participant pregnant?

- ☐ yes  
☐ no

G) Does Child/Participant take birth control pills?

- ☐ yes  
☐ no

H) Has Child/Participant had her first period/menstruation?

- ☐ yes (if yes, please answer *questions H and I* below)  
☐ no

I) How many days does Child/Participant's period/menstruation usually last? \_\_\_\_\_ days

J) Is Child/Participant menstruating today?

- ☐ yes – this is Child/Participant's \_\_\_\_\_ day of menstruating (e.g. 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, etc.)  
☐ no – Child/Participant's last period/menstruation start date was \_\_\_\_\_ (Month) \_\_\_\_\_ (day) \_\_\_\_\_ (year)

K) Would you like us to notify you of future CALIPER follow-up studies?

- ☐ yes – e-mail address: \_\_\_\_\_  
☐ no

**Office Use Only**

**These measurements will be taken by a CALIPER team member at the appointment.**

L) fasting: \_\_\_\_\_ hrs

M) weight: \_\_\_\_\_ kg

N) height: \_\_\_\_\_ cm

O) waist: \_\_\_\_\_ cm

P) location: \_\_\_\_\_