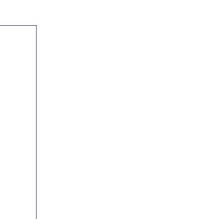
| Q20a If you have had allergies and/or hayfever, which of the following are you allergic to? Please tick all that apply. | | | | | | | |
|--|--|--|--|--|--|--|--|
| Pollen Dust Insect bites or stings Some food Animals/birds if yes, please continue to Ω20b Other | | | | | | | |
| Q20b If you have had all allergies and/or hayfever to animals/birds, which of the | | | | | | | |
| following are you allergic to? Please tick all that apply. | | | | | | | |
| Dog Guniea Pig, Rabbit, Mouse, Rat, Hamster Budgie or other type of bird Other type of animal | | | | | | | |
| Q21 Have you had any of the following in the past year? Please tick all that apply. | | | | | | | |
| Attacks of wheezing with whistling on the chest A dry itchy rash Urticaria (hives) | | | | | | | |
| Sneezing attacks Runny nose Watery eyes Cough often during the night | | | | | | | |
| Cough often when you wake up in the morning None of these | | | | | | | |
| Q22 How many pieces/ portions of fruit of any sort do you eat on a typical day? | | | | | | | |
| Q23 How many portions of vegetables (excluding potatoes) do you eat on a typical day? | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| do you eat on a typical day? | | | | | | | |
| do you eat on a typical day? QUESTIONS ABOUT YOUR HOME ENVIRONMENT | | | | | | | |
| do you eat on a typical day? QUESTIONS ABOUT YOUR HOME ENVIRONMENT Q24 How many other children (under 16) live with you and your baby? | | | | | | | |
| QUESTIONS ABOUT YOUR HOME ENVIRONMENT Q24 How many other children (under 16) live with you and your baby? Q25 How many other adults (older than 16) live with you in your household? | | | | | | | |
| QUESTIONS ABOUT YOUR HOME ENVIRONMENT Q24 How many other children (under 16) live with you and your baby? Q25 How many other adults (older than 16) live with you in your household? Q26a Does anyone in your household smoke? Yes No (please continue to Q27) | | | | | | | |





FOLLOW-UP QUESTIONNAIRE

The questionnaire asks about your baby and their environment, as well as some questions about you. It will probably take about 10 minutes to complete. Please complete it as fully as you can and return in the prepaid envelope provided.

| First name: | Surname: |
|---------------------|--|
| wing are not | correct for your baby in the sticker above |
| DD/ | MM/YYYY |
| / | First name: |

QUESTIONS ABOUT YOUR BABY:

| Q1 How is your baby's health in general? | | | | | | | | |
|---|---|------------------------|----------------|----------------------|--|--|--|--|
| Would you say it was: | | | | | | | | |
| Very good Good | Fair | Bad | | Very bad | | | | |
| | | | | | | | | |
| Ω2 Has your baby ever had any antibiotics* for an infection that were prescribed by a doctor or hospital? | | | | | | | | |
| Yes No | | | | | | | | |
| *Including antibiotic eye drops, and antibiotic creams/ ointments | | | | | | | | |
| f yes, please fill in the table below as fully as you can | | | | | | | | |
| Name of antibiotic | By mouth, cream/ ointment, injection | Approximate start date | Number of days | What was the reason? | | | | |
| | | | | | | | | |
| | | | | | | | | |

| Q3 Is your baby currently on any regular prescribed by a doctor or hospital? | nr* medication | Yes No | Q11a How old was your baby when s/he first had any food apart from milk? |
|---|---------------------------------------|----------------------|--|
| *regular = every day for two weeks or more | | | Age in weeks: |
| If yes, please fill in the table below as fully as you | u can | | |
| Name of medication | Approximate Number start date of days | What was the reason? | Q11b What was the first solid food given to your baby? Please tick only one: Fruit Vegetable Baby rice/baby cereal Rusk Yogurt Other, please specify: |
| | | | Q12 How much time in hours does your baby spend in sleep during the night (from 7pm to 7am)? |
| Q4 Are your baby's immunisations up to | o date? | Yes No | Q13 On average, how many times does your baby wake at night? |
| Q5 Has your baby <i>ever</i> been given breas (via syringe, bottle or cup etc) or have baby to the breast, even if this was o | e you put your | Yes No | Q14 How much do you feel that your baby cries in comparison with other babies of their age? Please tick only one: Cries more than other babies Is the same as other babies Cries less than other babies |
| Q6 How old* was your baby (in weeks) v Age in weeks: * If less than a week old, please write 1 | | en breast milk? | Q15 Has your baby ever had times when s/he appears to be in agony, screams, draws their legs up to their body and can't be calmed? Yes No |
| Q7 Has your baby <i>ever</i> been given infan even if this was only once? | t formula, | Yes No | QUESTIONS ABOUT YOU: |
| Q8 How old* was your baby (in weeks) Age in weeks: | when they <i>first</i> receive | ed infant formula? | Q16 Did you have the whooping cough vaccine during this pregnancy? |
| * If less than a week old, please write 1 | | | Q17 Did you have the flu vaccine during this pregnancy? |
| Q9 How would you describe your baby Please tick only one: My baby seems contented while feeding: Rarely | Sometimes Ofte | | Q18 How is your health in general? Would you say it was: Very good Good Bair Bad Very bad |
| Q10 Has your baby ever had any foods vegetables or any other kind of so Yes (please continue to Q11a) | | aby rice, fruit, | Q19 Has a doctor or other health professional ever told you that you have any of the conditions listed? Please tick all that apply: Asthma Eczema Allergies Hayfever None of these (continue to Q21) |