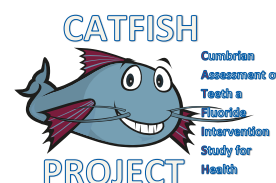


Project document 8 - Baseline Child questionnaire Birth Cohort

Page 1

ID Number «Child_CATFISH_IDa»

CATFISH STUDY



All questions relate to your child born in the last 6 months.

Today's date

1. Gender

☐ Male

☐ Female

2. Date of birth (DD MM YYYY)

3. Height (length)

(at birth or last measurement taken)

 cm

4. Weight

(at birth or last measurement taken)

 kg

☐ Yes [Go to 6]

☐ No [Go to 9]

5. Did you ever try to breastfeed?

☐ Yes [Go to 7]

☐ No [Go to 9]

6. Was your child ever able to breastfeed?

☐ Yes [Go to 9]

☐ No [Go to 8]

7. Is your child still breastfed?

<input type="radio"/> days	<input type="radio"/> weeks	<input type="radio"/> months
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8. How old were they when they completely stopped being breastfed? (Include expressed milk)

☐ Don't know

☐ Still breastfeeding

<input type="radio"/> days	<input type="radio"/> weeks	<input type="radio"/> months
----------------------------	-----------------------------	------------------------------

9. How old were they when they were first given baby milk formula to drink?

☐ Don't know

☐ **Not had formula**

Has your child had anything to drink other than breast or formula milk? If yes how old were they when they were first given drinks that contain sugar or are sugar free.

(e.g. SMA, Cow & Gate)

<input type="radio"/> days	<input type="radio"/> weeks	<input type="radio"/> months
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10. How old were they when they first had **drinks containing sugar**? (e.g. squash, fruit juice, cola, lemonade, sweetened tea)

☐ Don't know

☐ **Not had this drink**

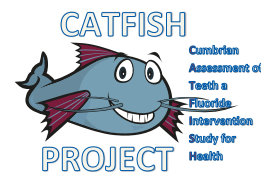
<input type="radio"/> days	<input type="radio"/> weeks	<input type="radio"/> months
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11. How old were they when they first had **sugar free drinks**? (e.g. water,

☐ Don't know

☐ **Not had sugar free drinks**

CATFISH STUDY



12. Is your child on any medications, supplements or vitamins? (Please list)

13. Please tick any birth, pre-natal or post-natal history for your child.

14. Does your child take any fluoride supplements?

15. Has your child had to attend a hospital for any reason since birth?

16. Has your child been diagnosed with any chronic conditions? (A chronic condition is one that is long lasting)

	6-7 times a week	3-5 times a week	1-2 times a week	Less than once a week	Rarely/ Never
17a. How often does your child sleep through the night?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17b. How often, on average, does your child eat sweets or chocolate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17c. How often, on average, does your child have fizzy drinks, fruit juice or soft drinks like squash? (excluding diet or sugar free drinks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. On a typical day, how much of the following does your child drink? (Glasses/baby bottles about 250ml)

Boiled tap water/tap water (unfiltered) glasses per day

Boiled tap water/tap water (filtered) glasses per day

Bottled water glasses per day

Drinks made with boiled tap water/tap water (e.g. formula) glasses per day

19. Does your child eat or drink anything in the hour before going to sleep?

Thank you. If you have other comments please use the box below, or the back if you need more space.