ELIGIBILITY ASSESSMENT

Instructions:
- This form is to be completed by research personnel prior to enrolment.

Date of eligibility assessment: [ ] / [ ] / [ ]

1. Are you planning to have a vaginal birth?
   - No → ineligible
   - Yes

2. Are you having a single baby (not twins or triplets)?
   - No → ineligible
   - Yes

3. Are you able to communicate in English?
   - No → ineligible
   - Yes

Does this woman meet all study eligibility criteria by answering “Yes” to all of the questions above?
   - Yes → eligible to enroll
   - No

Did this woman sign their Patient Informed Consent form, including date and witness signature?
   - Yes
   - No → do not enroll

Person must first meet all study eligibility criteria and sign consent form, before receiving Participant ID (PID). Obtain PID from Study Participant Tracking Sheet.

Participant ID: [ ] - [ ]

Version date: July 18, 2012
BASELINE INFORMATION

Instructions:
- This form is to be completed by study participants at enrolment.
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- If you do not understand a question, please ask a research staff member.
- All of your answers will remain confidential.

1. What is today’s date?  
   
2. What is your expected date of birth?  
   
3. What was your weight just before this pregnancy?  

4. Have you been regularly exposed to other people’s tobacco smoke during your pregnancy? (regularly is defined as most days or nights)
   - No
   - Yes
   - if yes, not counting yourself, how many people who live in your household smoke regularly?
     
   - if yes, do people smoke regularly in the room where you work?
     - No
     - Yes
     - if yes, how many hours per day are you exposed to other people’s tobacco smoke in total (at home, at work and elsewhere)?

5. Do you smoke cigarettes?
   - Never smoked
   - Smoked prior to pregnancy, but not now
   - Smoked earlier in pregnancy, but not now
   - Current smoker
   - if you are a current smoker, how many cigarettes do you usually smoke per day?
6. Do you, your baby’s father or your other child/children (if applicable) have any of the following: (check all that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yourself</th>
<th>Father of Baby</th>
<th>Your Child/Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma, wheezing</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Eczema</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Seasonal allergies</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Food allergies</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Other allergies</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Heart disease (heart attack, angina, bypass surgery)</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Obesity or overweight</td>
<td></td>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>

7. Please list any medications, health products (including vitamins, probiotics, supplements and nicotine replacement therapies like “the patch”), alcohol or street drugs that you have taken during this pregnancy.

- None

When during this pregnancy? (check both if it applies)

- Before 20 weeks
- After 20 weeks
- N/A, not yet 20 weeks
BASELINE INFORMATION UPDATE

Instructions:
- This form is to be completed by research personnel through telephone contact with participants.
- Refer to the participant’s Baseline Form for Question #9.
- Participants who were less than 36 weeks, 0 days gestation at enrolment are to be contacted between 36 weeks, 0 days gestation and 36 weeks, 6 days gestation (inclusive).

1. Was the baseline information update done?
   - No, because the participant was enrolled at or after 36 weeks, 0 days gestation
   - No, because the participant could not be contacted
   - Yes

2. Date of phone call: [ ] / [ ] / [ ]

3. Are you still pregnant?
   - No → ineligible for further follow-up
   - Yes

4. Are you still planning to have a vaginal birth?
   - No → ineligible for further follow-up
   - Yes

5. Are you having a single baby (not twins or triplets)?
   - No → ineligible for further follow-up
   - Yes

6. Is a midwife still your primary care provider?
   - No → ineligible for further follow-up
   - Yes

Script if they answer “no” to any of questions 3, 4, 5 or 6:
Researcher: “Ok that is all I need to know from you today. This study is going to continue to follow women after their births if they are not pre-term, planning a C-section, having multiples or high risk, so at this point, you have already provided us with as much information as we need. We really appreciate your participation in our study—thank you so much for your time. Do you have any questions for me?”
7. Have you been regularly exposed to other people’s tobacco smoke during your pregnancy? (regularly is defined as most days or nights)
   - [ ] No
   - [ ] Yes
   → if yes, not counting yourself, how many people who live in your household smoke regularly?
   - [ ] people

   → if yes, do people smoke regularly in the room where you work?
   - [ ] No
   - [ ] Yes

   → if yes, how many hours per day are you exposed to other people’s tobacco smoke in total (at home, at work and elsewhere)?
   - [ ] hours

8. Do you smoke cigarettes?
   - [ ] Never smoked
   - [ ] Smoked prior to pregnancy, but not now
   - [ ] Smoked earlier in pregnancy, but not now
   - [ ] Current smoker
     → if you are a current smoker, how many cigarettes do you usually smoke per day?
     - [ ] cigarettes per day
9. Please list any medications, health products (including vitamins, probiotics, supplements and nicotine replacement therapies like “the patch”), alcohol or street drugs that you have taken during this pregnancy and not told us about yet. **Note to interviewer:** refer to Baseline Form to review previously reported health products.

- [ ] None

**Name** | **When during this pregnancy?**<br>**(check both if it applies)** | **Before 20 weeks** | **After 20 weeks**
--- | --- | --- | ---

a. ________________________________ | | |  

b. ________________________________ | | |  

c. ________________________________ | | |  

d. ________________________________ | | |  

e. ________________________________ | | |  

f. ________________________________ | | |  

Instructions:
- This form is to be completed by the midwives using the birth record, nursing notes and newborn admission forms as needed.

1. Maternal height:   feet,   inches or   cm

2. Maternal weight at last prenatal visit:   lbs or   kg

3. Gravida:   

4. Term:   

5. Premature:   

6. Abortuses:   

7. Living:   

8. Was a 50 g oral glucose challenge test done?
   - No
   - Yes
     - if yes, what were the test results?
       60 minutes:   mmol/L   not done

9. Was a 75 g oral glucose tolerance test done?
   - No
   - Yes
     - if yes, what were the test results?
       Fasting:   mmol/L   not done
       60 minutes:   mmol/L   not done
       120 minutes:   mmol/L   not done
10. Was GBS screening performed?
   - Unknown
   - No
     - if no, was there a reason to treat with GBS prophylaxis?
       - No
       - Yes – GBS bacteriuria
       - Yes – previous baby with GBS septicemia
   - Yes
     - if yes, what was the test result?
       - Positive
       - Negative
       - Unknown

11. Actual place of birth
   - Hospital
   - Home
   - Other: ________________________________

12. Were any of the following antenatal risk factors present? (check all that apply)
   - None
   - Large for gestational age
   - Small for gestational age
   - Intrauterine growth restriction
   - PROM
   - PPROM
   - Pre-eclampsia
   - Gestational hypertension
   - Other: ________________________________

13. Were any maternal antibiotics administered during the intrapartum period prior to the baby being born?
   - No
   - Yes
     - if yes, please complete the table on the following page.
If antibiotics were administered, please indicate the following for each drug:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th>Indication:</th>
<th>Drug:</th>
<th>Dosage:</th>
<th>Date and time:</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 1</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 2</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 3</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 4</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 5</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>Indication:</th>
<th>Drug:</th>
<th>Dosage:</th>
<th>Date and time:</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 1</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 2</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 3</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 4</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose 5</td>
<td></td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral</td>
</tr>
<tr>
<td><strong>DRUG 3</strong></td>
<td>N/A</td>
<td><strong>Drug:</strong></td>
<td><strong>Dosage:</strong></td>
<td><strong>Date and time:</strong></td>
<td><strong>Route</strong></td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>-----------</td>
<td>--------------</td>
<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Indication:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Caesarean section</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IV Oral</td>
</tr>
<tr>
<td>☐ GBS prophylaxis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☑ ☑</td>
</tr>
<tr>
<td>☐ Signs and symptoms of maternal infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☑ ☑</td>
</tr>
<tr>
<td>☐ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☑ ☑</td>
</tr>
<tr>
<td>_____________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DRUG 4</strong></td>
<td>N/A</td>
<td><strong>Drug:</strong></td>
<td><strong>Dosage:</strong></td>
<td><strong>Date and time:</strong></td>
<td><strong>Route</strong></td>
</tr>
<tr>
<td>Indication:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Caesarean section</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IV Oral</td>
</tr>
<tr>
<td>☐ GBS prophylaxis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☑ ☑</td>
</tr>
<tr>
<td>☐ Signs and symptoms of maternal infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☑ ☑</td>
</tr>
<tr>
<td>☐ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☑ ☑</td>
</tr>
<tr>
<td>_____________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Version date:** September 25, 2014
14. Did the **mother** receive any antibiotics *after* the baby was born and *prior* to hospital discharge?

- [ ] No
- [ ] Yes

If yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary indication:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Drug:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Dosage:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Route:</td>
<td>[ ] IV [ ] Oral [ ] Other: ________________</td>
</tr>
<tr>
<td>Start date and time:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Stop date and time:</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary indication:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Drug:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Dosage:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Route:</td>
<td>[ ] IV [ ] Oral [ ] Other: ________________</td>
</tr>
<tr>
<td>Start date and time:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Stop date and time:</td>
<td>________________________________</td>
</tr>
</tbody>
</table>
15. Date and time of rupture of membranes:
   - year:
   - month:
   - day:
   - 24 hour clock:
   - unknown

16. Date and time of birth:
   - year:
   - month:
   - day:
   - 24 hour clock:

17. Presentation at delivery:
   - Cephalic
   - Breech
   - Transverse/oblique
   - Unknown

18. Mode of delivery:
   - Vaginal
   - Caesarean section without labour
   - Caesarean section with labour

   if Caesarean section with labour, what was the dilation at time of CS? cm

19. Status of baby at birth:
   - Alive
   - Stillborn

20. Gender:
   - Male
   - Female
   - Ambiguous

21. Apgar score: at 1 minute:
   - at 5 minutes:

22. Birthweight:
   - grams

23. Length:
   - . cm

24. Head circumference:
   - . cm
25. Was the baby admitted to the NICU or ICU?
   - ☐ No
   - ☐ Yes
   → if yes, what was the date and time of admission?
     
     
     
     year / month / day
     24 hour clock

   → if yes, what was the date and time of discharge?
     
     
     
     year / month / day
     24 hour clock

26. Was the baby tested for hypoglycemia?
   - ☐ No
   - ☐ Yes
   → if yes, were any glucose values less than 3.0 mmol/L?
     - ☐ No
     - ☐ Yes
27. Did the baby receive any antibiotics prior to discharge other than erythromycin prophylactic eye ointment?
   - [ ] No
   - [ ] Yes, if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary indication:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dosage:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start date and time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop date and time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary indication:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dosage:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start date and time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop date and time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Version date: September 25, 2014
28. What was the baby fed at first feeding?
   - Breast milk
   - Formula
   - Other: ____________________________
   - Unknown

29. Was the baby fed any formula during hospital stay?
   - No hospital stay
   - No formula fed during hospital stay
   - Yes formula fed during hospital stay
   - Unknown

30. Date/time of discharge of mother from hospital or midwife leaving home:
    - [ ] [ ] / [ ] / [ ]
    - [ ] : [ ]

31. Date/time of discharge of baby from hospital or midwife leaving home:
    - [ ] / [ ] / [ ]
    - [ ] : [ ]
Additional birth information

Instructions:
- This form is to be completed by research personnel by telephone or in person at 12 weeks or the earliest contact postpartum (after June 15, 2015).

1. Date: 

2. When you were in labour, did you spend any time immersed in water?
   - No
   - Yes
   - if yes, was your baby born in water?
     - No
     - Yes

3. During your baby’s first 3 months of life, were there other children living in your home (part-time or full-time)?
   - No
   - Yes
   - if yes, how many?
     - children
   - if yes, how many of the children attended school or daycare outside of your home during your baby’s first 3 months?
     - children
Day 3

Instructions:
- This form is to be completed when your baby is 3 days old.
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- Please use your study calendar to help you remember the information asked for.
- All of your answers will remain confidential.
- If you do not understand a question, please ask a research staff member by calling 905-525-9140 ext 22146 or by emailing babyandmistudy@gmail.com.
- Please return this form when you visit McMaster University Medical Center for your first study visit.

1. What is today’s date? 

   [ ] [ ] [ ] / [ ] [ ] [ ]

   year month day

2. How much did your baby weigh at your most recent visit with your midwife or doctor?

   [ ] [ ] [ ] grams or [ ] lbs, [ ] oz or [ ] I don’t know

3. Have you ever breast fed your baby?

   [ ] No
   [ ] Yes

   → if yes, do you still breastfeed your baby?

   [ ] No

      → if no, how old was your baby when you stopped breast feeding?

      [ ] [ ] days

   [ ] Yes

      → if yes, has your baby ever had anything other than breast milk or water?

      [ ] No
      [ ] Yes

         → if yes, how old was your baby when she or he first had anything other than breast milk or water?

         [ ] [ ] days
Day 3

4. Has your baby ever had any of the following?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goat’s milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another type of milk or formula:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Since you and your baby have been home, has your baby needed to stay in the hospital?

☐ No
☐ Yes
6. **Since you and your baby have been home,** has your baby had an infection that required antibiotic or antifungal (anti-yeast) treatment?
   - ☐ No
   - ☐ Yes ➔ if yes, please complete the following table:

| DRUG 1 | What was the type of infection? | ☐ Thrush ☐ Ear infection ☐ Chest infection ☐ Urinary tract infection ☐ Other: ____________________________ |
|        | What was the name of the drug?  | ________________________________________________ |
|        | How was it given?               | ☐ Topical ☐ Oral ☐ Other: ____________________________ |
|        | What was the start date?        | ☐ Still currently in use |
|        | What was the end date?          | or ☐ Still currently in use |

| DRUG 2 | ☐ Only one drug was given. (Do not complete the rest of the table) |
|        | What was the type of infection? | ☐ Thrush ☐ Ear infection ☐ Chest infection ☐ Urinary tract infection ☐ Other: ____________________________ |
|        | What was the name of the second drug? | ________________________________________________ |
|        | How was it given?               | ☐ Topical ☐ Oral ☐ Other: ____________________________ |
|        | What was the start date?        | ☐ Still currently in use |
|        | What was the end date?          | or ☐ Still currently in use |
7. Please list any other medications, vitamins, homeopathics or supplements that *your baby* has taken *since birth*.

- None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>b. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>c. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>d. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>e. _________________________________</td>
<td>☐</td>
</tr>
</tbody>
</table>
8. **Since you and your baby have been home**, have you taken any antibiotic or antifungal (anti-yeast) medications?
   - ☐ No
   - ☐ Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th>What was the name of the drug?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How was it given?</td>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other:</td>
</tr>
<tr>
<td>What was the start date?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the end date?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>Only one drug was taken. (Do not complete the rest of the table)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the name of the second drug?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other:</td>
</tr>
<tr>
<td>What was the start date?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the end date?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Date format is year/month/day.*
9. **If you are currently breastfeeding**, please list any other prescription medications that **you** have taken since your baby was born.

- ☐ Not currently breastfeeding
- ☑ None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
</tbody>
</table>
Instructions:
- This form is to be completed when your baby is 10 days old.
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- Please use your study calendar to help you remember the information asked for.
- All of your answers will remain confidential.
- If you do not understand a question, please ask a research staff member by calling 905-525-9140 ext 22146 or by emailing babyandmistudy@gmail.com.
- Please return this form when you visit McMaster University Medical Center for your first study visit.

1. What is today’s date?  
   [ ] [ ] / [ ] [ ] [ ]

2. How much did your baby weigh at your most recent visit with your midwife or doctor?  
   [ ] [ ] [ ] grams or [ ] [ ] lbs, [ ] [ ] oz or [ ] I don’t know

3. Have you ever breast fed your baby?  
   [ ] No
   [ ] Yes
   ➔ if yes, do you still breastfeed your baby?  
   [ ] No
   ➔ if no, how old was your baby when you stopped breast feeding?  
   [ ] [ ] days

   [ ] Yes
   ➔ if yes, has your baby ever had anything other than breast milk or water?  
   [ ] No
   [ ] Yes
   ➔ if yes, how old was your baby when she or he first had anything other than breast milk or water?  
   [ ] [ ] days
4. Has your baby ever had any of the following?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goat’s milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another type of milk or formula:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Since you and your baby have been home, has your baby needed to stay in the hospital?
   - No
   - Yes

6. How much time does your baby spend in sleep during the night (between 7 in the evening and 7 in the morning)?
   
   __________ hours, __________ minutes

7. How many times does your baby wake up during the night?
   __________ times

8. How much time during the night does your baby spend in wakefulness (from 10 in the evening to 6 in the morning)?
   
   __________ hours, __________ minutes

9. Do you consider your baby’s sleep to be a problem?
   - Not a problem at all
   - A small problem
   - A very serious problem
10. **Since you and your baby have been home**, has your baby had an infection that required antibiotic or antifungal (anti-yeast) treatment **that you haven’t told us about yet**?

- [ ] No
- [ ] Yes → if yes, please complete the following table:

**DRUG 1**

<table>
<thead>
<tr>
<th>What was the type of infection?</th>
<th>☐ Thrus</th>
<th>☐ Ear infection</th>
<th>☐ Chest infection</th>
<th>☐ Urinary tract infection</th>
<th>☐ Other: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the name of the drug?</td>
<td>____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other:</td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>What was the start date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] / [ ]</td>
<td>year</td>
<td>month</td>
<td>day</td>
<td></td>
</tr>
<tr>
<td>What was the end date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] / [ ]</td>
<td>or</td>
<td>☐ Still currently in use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DRUG 2**  ☐ Only one drug was given. (Do not complete the rest of the table)

<table>
<thead>
<tr>
<th>What was the type of infection?</th>
<th>☐ Thrus</th>
<th>☐ Ear infection</th>
<th>☐ Chest infection</th>
<th>☐ Urinary tract infection</th>
<th>☐ Other: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the name of the second drug?</td>
<td>____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other:</td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>What was the start date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] / [ ]</td>
<td>year</td>
<td>month</td>
<td>day</td>
<td></td>
</tr>
<tr>
<td>What was the end date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] / [ ]</td>
<td>or</td>
<td>☐ Still currently in use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Please list any other medications, vitamins, homeopathics or supplements that your baby has taken since birth.

☐ None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>b. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>c. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>d. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>e. _________________________________</td>
<td>☐</td>
</tr>
</tbody>
</table>
12. *Since you and your baby have been home,* have *you* taken any antibiotic or antifungal (anti-yeast) medications *that you haven’t told us about yet*?

- [ ] No
- [ ] Yes → if yes, please complete the following table:

### DRUG 1

<table>
<thead>
<tr>
<th>What was the name of the drug?</th>
<th>__________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>How was it given?</td>
<td>[ ] Topical [ ] Oral [ ] Other:</td>
</tr>
<tr>
<td>What was the start date?</td>
<td>[ ] [ ] / [ ] [ ] / [ ]</td>
</tr>
<tr>
<td>What was the end date?</td>
<td>[ ] [ ] / [ ] [ ] / [ ] or [ ] Still currently in use</td>
</tr>
</tbody>
</table>

### DRUG 2

- [ ] Only one drug was taken. (Do not complete the rest of the table)

<table>
<thead>
<tr>
<th>What was the name of the second drug?</th>
<th>__________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>How was it given?</td>
<td>[ ] Topical [ ] Oral [ ] Other:</td>
</tr>
<tr>
<td>What was the start date?</td>
<td>[ ] [ ] / [ ] [ ] / [ ]</td>
</tr>
<tr>
<td>What was the end date?</td>
<td>[ ] [ ] / [ ] [ ] / [ ] or [ ] Still currently in use</td>
</tr>
</tbody>
</table>
13. If you are currently breastfeeding, please list any other prescription medications that you have taken since your baby was born.

☐ Not currently breastfeeding
☐ None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a.</td>
<td>☐</td>
</tr>
<tr>
<td>b.</td>
<td>☐</td>
</tr>
<tr>
<td>c.</td>
<td>☐</td>
</tr>
<tr>
<td>d.</td>
<td>☐</td>
</tr>
<tr>
<td>e.</td>
<td>☐</td>
</tr>
</tbody>
</table>
6 WEEKS

Instructions:
- This form is to be completed when your baby is 6 weeks old.
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- Please use your study calendar to help you remember the information asked for.
- All of your answers will remain confidential.
- If you do not understand a question, please ask a research staff member by calling 905-525-9140 ext 22146 or by emailing babyandmistudy@gmail.com.
- Please return this form when you visit McMaster University Medical Center for your first study visit.

1. What is today’s date? 
   
   [ ] year
   [ ] month
   [ ] day

2. How much did your baby weigh at your most recent visit with your midwife or doctor?

   [ ] [ ] grams
   [ ] lbs, [ ] oz
   [ ] I don’t know

3. Have you ever breast fed your baby?

   [ ] No
   [ ] Yes
   => if yes, do you still breastfeed your baby?
   [ ] No
   => if no, how old was your baby when you stopped breast feeding?
   [ ] weeks
   (fill in “0” if your baby was less than 1 week old)

   [ ] Yes
   => if yes, has your baby ever had anything other than breast milk or water?
   [ ] No
   [ ] Yes
   => if yes, how old was your baby when he or she first had anything other than breast milk or water?
   [ ] weeks
   (fill in “0” if your baby was less than 1 week old)
4. Has your baby *ever* had any of the following?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goat’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another type of milk or formula:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Has your baby *ever* had any of the following foods or beverages?

<table>
<thead>
<tr>
<th>Food</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice cereal</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Other cereal</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Bread or toast</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Baby cookies</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Baked goods</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Dairy products</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Egg yolk</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Egg white</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Meat</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Raw vegetables</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Potato</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Cooked vegetables</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Legumes</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Soy products (i.e. tofu)</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Raw fruit</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Cooked fruit</td>
<td></td>
<td>☐</td>
<td>[ ] times per week</td>
</tr>
</tbody>
</table>
6 WEEKS

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other fizzy drinks</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Apple juice</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other fruit drinks</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Herbal drink</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Unpasteurized milk</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Gripe water</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tea (herbal)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tea (caffeinated)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Coffee</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>A little alcohol</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Potato chips</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other salty snacks</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Chocolate</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sweets</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Peanuts/ peanut butter</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tree nuts/ tree nut butter (i.e. almond, cashew)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
6. Please indicate if your baby **currently** has any of the following feeding behaviours:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No</th>
<th>Yes</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow feeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking only small quantities at each feed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hungry/ not satisfied</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused to take breast milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused to take other milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused to take solids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can not establish feeding routine</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Are you **currently** having difficulties feeding your baby?
   - □ No, no difficulties
   - □ Yes, some difficulties
   - □ Yes, great difficulties

8. Does your baby typically have **at least one** bowel movement every day?
   - □ No  
     ➔ if no, how many bowel movements does your baby have in a **typical week**?
     □□ bowel movements
   - □ Yes  
     ➔ if yes, how many bowel movements does your baby have in a **typical day**?
     □□ bowel movements
9. **Since your baby was 10 days old,** has **she or he** had an infection that required antibiotic or antifungal (anti-yeast) treatment?

- [ ] No
- [ ] Yes— if yes, please complete the following table:

### DRUG 1

<table>
<thead>
<tr>
<th>What was the type of infection?</th>
<th>☐ Thrush</th>
<th>☐ Ear infection</th>
<th>☐ Chest infection</th>
<th>☐ Urinary tract infection</th>
<th>☐ Other: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the name of the drug?</td>
<td>___________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other: ___________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the start date?</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the end date?</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td>or ☐ Still currently in use</td>
<td></td>
</tr>
</tbody>
</table>

### DRUG 2

- [ ] Only one drug was given. (Do not complete the rest of the table)

<table>
<thead>
<tr>
<th>What was the type of infection?</th>
<th>☐ Thrush</th>
<th>☐ Ear infection</th>
<th>☐ Chest infection</th>
<th>☐ Urinary tract infection</th>
<th>☐ Other: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the name of the second drug?</td>
<td>___________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other: ___________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the start date?</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the end date?</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
<td>or ☐ Still currently in use</td>
<td></td>
</tr>
</tbody>
</table>
10. Please list any other medications, vitamins, homeopathics or supplements that your baby has taken since he or she was 10 days old.

☐ None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. _________________________________</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>b. _________________________________</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>c. _________________________________</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>d. _________________________________</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>e. _________________________________</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

11. Since your baby was 10 days old, has she or he needed to stay in the hospital?

☐ No
☐ Yes
12. **Since your baby was 10 days old,** have you taken any antibiotic or antifungal (anti-yeast) medications?

- [ ] No
- [ ] Yes→ if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th>What was the name of the drug?</th>
<th>__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How was it given?</td>
<td>[ ] Topical  [ ] Oral  [ ] Other: __________________________</td>
</tr>
<tr>
<td></td>
<td>What was the start date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] [ ]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>year  month  day</td>
</tr>
<tr>
<td></td>
<td>What was the end date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] [ ]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>year  month  day</td>
</tr>
</tbody>
</table>

| DRUG 2 | [ ] Only one drug was taken. (Do not complete the rest of the table) |

<table>
<thead>
<tr>
<th></th>
<th>What was the name of the second drug?</th>
<th>__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How was it given?</td>
<td>[ ] Topical  [ ] Oral  [ ] Other: __________________________</td>
</tr>
<tr>
<td></td>
<td>What was the start date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] [ ]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>year  month  day</td>
</tr>
<tr>
<td></td>
<td>What was the end date?</td>
<td>[ ] [ ] [ ] / [ ] [ ] [ ]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>year  month  day</td>
</tr>
</tbody>
</table>
13. **If you are currently breastfeeding**, Please list any other prescription medications that you have taken since your baby was 10 days old.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>b. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>c. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>d. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>e. ___________________________</td>
<td>No</td>
</tr>
</tbody>
</table>

14. How much time does your baby spend in sleep during the night (between 7 in the evening and 7 in the morning)?

[ ] hours, [ ] minutes

15. How many times does your baby wake up during the night?

[ ] times

16. How much time during the night does your baby spend in wakefulness (from 10 in the evening to 6 in the morning)?

[ ] hours, [ ] minutes

17. Do you consider your baby’s sleep to be a problem?

- [ ] Not a problem at all
- [ ] A small problem
- [ ] A very serious problem

18. Has your baby been diagnosed with asthma or reactive airway disease by your doctor?

- [ ] Yes
- [ ] No
19. Does your baby take any puffers or breathing medications?
  - Yes
  - No

20. Have you been told by your doctor that your baby has eczema?
  - Yes
  - No

21. Has your baby ever experienced any of the following?: (check all that apply)
  - Itchy rashes
  - Itchy rashes that don’t go away on the face, knuckles, elbows or knees
  - Rash on the nose, mouth or diaper area
  - Dry, thickened or scaly skin or more skin creases in the palms than usual
  - Cracked skin around the ear
  - Scaly scalp that won’t go away
  - Red dots surrounding hair follicles
  - None of the above

22. Have you ever had any concerns that your baby may have an allergy?
  - No
  - Yes, I/we suspect(ed) an allergy
    - if yes, please describe what the allergic substance was thought to be and what made you suspect and allergy:
      __________________________________________________________
      __________________________________________________________
      __________________________________________________________
  - Yes, an allergy was confirmed by the doctor
    - if yes, please indicate what the allergic substance(s) is/are:
      __________________________________________________________
      __________________________________________________________
      __________________________________________________________
12 WEEKS – PART 1

Instructions:
- This form is to be completed by research personnel at the 12 week study visit.
- Record the measurements indicated below and attach this form to “Part 2” completed by the participant.

1. Date and time of visit: __________ / __________ / __________ __________:________
   - year
   - month
   - day
   - 24 hour clock

2. Head circumference: ________ . ________ cm

3. Tricep skinfold thickness:
   - Measurement 1: ________ . ________ cm
   - Measurement 2: ________ . ________ cm
   - Measurement 3: ________ . ________ cm

4. Subscapular skinfold thickness:
   - Measurement 1: ________ . ________ cm
   - Measurement 2: ________ . ________ cm
   - Measurement 3: ________ . ________ cm

5. Bicep skinfold thickness:
   - Measurement 1: ________ . ________ cm
   - Measurement 2: ________ . ________ cm
   - Measurement 3: ________ . ________ cm
12 WEEKS – PART 1

6. Mid-arm circumference:
   Measurement 1: □□□□ . □□ cm
   Measurement 2: □□□□ . □□ cm
   Measurement 3: □□□□ . □□ cm

7. Suprailiac skinfold thickness:
   Measurement 1: □□□□ . □□ cm
   Measurement 2: □□□□ . □□ cm
   Measurement 3: □□□□ . □□ cm

8. Hip circumference:
   Measurement 1: □□□□ . □□ cm
   Measurement 2: □□□□ . □□ cm
   Measurement 3: □□□□ . □□ cm

9. Abdominal circumference:
   Measurement 1: □□□□ . □□ cm
   Measurement 2: □□□□ . □□ cm
   Measurement 3: □□□□ . □□ cm

10. Length: □□□□ . □□ cm
12 WEEKS – PART 1

11. Percent fat: [ ] . [ ] %
12. Percent fat free mass: [ ] . [ ] %
13. Fat mass: [ ] . [ ] [ ] kg
14. Fat free mass: [ ] . [ ] [ ] kg
15. Body mass: [ ] . [ ] [ ] kg
16. Body volume: [ ] . [ ] [ ] L
17. Body density: [ ] . [ ] [ ] kg/L
18. Fat mass density: [ ] . [ ] [ ] kg/L
19. Fat free mass density: [ ] . [ ] [ ] kg/L
20. Body surface area: [ ] . [ ] [ ] cm²
21. Thoracic gas volume: [ ] . [ ] [ ] L

22. The PEA POD test was:
   ☐ Completed
   ☐ Begun but terminated early
   ☐ Not attempted because baby exceeded capacity
   ☐ Not attempted because parent declined

23. Were stool samples received?
   ☐ No
   ☐ Yes
      ➞ if yes, indicate the following:
      
      Date Collected
      
      Day 3 [ ] [ ] [ ] / [ ] [ ] [ ]
      Day 10 [ ] [ ] [ ] / [ ] [ ] [ ]
      6 Weeks [ ] [ ] [ ] / [ ] [ ] [ ]
      12 Weeks [ ] [ ] [ ] / [ ] [ ] [ ]
12 WEEKS – PART 2

Instructions:
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- Please use your study calendar to help you remember the information asked for.
- All of your answers will remain confidential.
- If you do not understand a question, please ask a research staff member.

1. Have you ever breast fed your baby?
   - No
   - Yes
     - if yes, do you still breastfeed your baby?
       - No
       - if no, how old was your baby when you stopped breast feeding?
         - weeks
         (fill in “0” if your baby was less than 1 week old)
       - Yes
         - if yes, has your baby ever had anything other than breast milk or water?
           - No
           - Yes
             - if yes, how old was your baby when he or she first had anything other than breast milk or water?
               - weeks
               (fill in “0” if your baby was less than 1 week old)

2. Has your baby ever had any of the following?

<table>
<thead>
<tr>
<th>Formula</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soy milk</td>
<td></td>
<td></td>
<td>times per week</td>
</tr>
<tr>
<td>Goat’s milk</td>
<td></td>
<td></td>
<td>times per week</td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td></td>
<td></td>
<td>times per week</td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
<td>times per week</td>
</tr>
<tr>
<td>Another type of milk or formula:</td>
<td></td>
<td></td>
<td>times per week</td>
</tr>
</tbody>
</table>
3. Has your baby ever had any of the following foods or beverages?

<table>
<thead>
<tr>
<th>Food Type</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice cereal</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Other cereal</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Bread or toast</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Baby cookies</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Baked goods</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Dairy products</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Egg yolk</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Egg white</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Meat</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Raw vegetables</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Potato</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Cooked vegetables</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Legumes</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Soy products (i.e. tofu)</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Raw fruit</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>Cooked fruit</td>
<td></td>
<td>☐ →</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Current Use</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Pop</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Other fizzy drinks</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Apple juice</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Other fruit drinks</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Herbal drink</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Unpasteurized milk</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Gripe water</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Tea (herbal)</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Tea (caffeinated)</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Coffee</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>A little alcohol</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Potato chips</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Other salty snacks</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Chocolate</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Sweets</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Peanuts/ peanut butter</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
<tr>
<td>Tree nuts/ tree nut butter (i.e. almond, cashew)</td>
<td>☐</td>
<td>☐ →</td>
<td>[ ] times per week</td>
</tr>
</tbody>
</table>
4. Please indicate if your baby currently has any of the following feeding behaviours:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No</th>
<th>Yes</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow feeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking only small quantities at each feed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hungry/ not satisfied</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused to take breast milk</td>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Refused to take other milk</td>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Refused to take solids</td>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Can not establish feeding routine</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Are you currently having difficulties feeding your baby?
   - No, no difficulties
   - Yes, some difficulties
   - Yes, great difficulties

6. During the past week, how often did your baby usually spit-up (anything coming out of the mouth) during a 24-hour period?
   - Less than once
   - 1 to 3 times
   - 4 to 6 times
   - More than 6 times

7. During the past week, how much did your baby usually spit-up (anything coming out of the mouth) during a typical episode?
   - Did not spit up
   - Less than 1 tablespoonful
   - 1 tablespoonful to 2 ounces
   - More than 2 ounces to half the feeding
   - More than half the feeding
8. **During the past week**, how often did spitting up (anything coming out of the mouth) seem to be uncomfortable for your baby, for example, crying, fussing, irritability, etc?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

9. **During the past week**, how often did your baby refuse a feeding even when hungry?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

10. **During the past week**, how often did your baby stop eating soon after starting even when hungry?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

11. **During the past week**, did your baby cry a lot during or within 1 hour after feedings?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

12. **During the past week**, did your baby cry or fuss more than usual?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always
13. **During the past week**, on average how long did your baby cry or fuss during a 24 hour period?
   - [ ] Less than 10 minutes
   - [ ] 10 minutes to 1 hour
   - [ ] More than 1 hour but less than 3 hours
   - [ ] 3 or more hours

14. **During the past week**, how often did your baby have hiccups?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Often
   - [ ] Always

15. **During the past week**, how often did your baby have episodes of arching back?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Often
   - [ ] Always

16. **During the past week**, has your baby stopped breathing while awake or struggled to breathe?
   - [ ] No
   - [ ] Yes

17. **During the past week**, has your baby turned blue or purple?
   - [ ] No
   - [ ] Yes
18. **In the last month**, have you noted your baby straining for 10 minutes or longer before successful passage of stool?
   - No
   - Yes
   - if yes, how many times per week?
     - times

19. Does your baby typically have at least one bowel movement every day?
   - No
     - if no, how many bowel movements does your baby have in a typical week?
       - bowel movements
   - Yes
     - if yes, how many bowel movements does your baby have in a typical day?
       - bowel movements

20. **In the last month**, has your baby had any episodes of abdominal pain or discomfort?
   - No
   - Yes

21. **Since your last study visit**, has your baby needed to stay in the hospital?
   - No
   - Yes
22. *Since your last study visit,* has your baby had an infection that required antibiotic or antifungal (anti-yeast) treatment?
   - [ ] No
   - [x] Yes→ if yes, please complete the following table:

### DRUG 1

<table>
<thead>
<tr>
<th>What was the type of infection?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Thrush</td>
<td>☐ Ear infection</td>
<td>☐ Chest infection</td>
<td></td>
</tr>
<tr>
<td>☐ Urinary tract infection</td>
<td>☐ Other: ________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the name of the drug?</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How was it given?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other: ________________________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the start date?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
<td>day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the end date?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
<td>day</td>
<td>or ☐ Still currently in use</td>
</tr>
</tbody>
</table>

### DRUG 2

- [x] Only one drug was given. (Do not complete the rest of the table)

<table>
<thead>
<tr>
<th>What was the type of infection?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Thrush</td>
<td>☐ Ear infection</td>
<td>☐ Chest infection</td>
<td></td>
</tr>
<tr>
<td>☐ Urinary tract infection</td>
<td>☐ Other: ________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the name of the second drug?</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How was it given?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Topical</td>
<td>☐ Oral</td>
<td>☐ Other: ________________________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the start date?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
<td>day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the end date?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
<td>day</td>
<td>or ☐ Still currently in use</td>
</tr>
</tbody>
</table>
23. Please list any other medications, vitamins, homeopathics or supplements that your baby has taken since your last study visit.

- None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>b. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>c. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>d. _________________________________</td>
<td>☐</td>
</tr>
<tr>
<td>e. _________________________________</td>
<td>☐</td>
</tr>
</tbody>
</table>
24. **Since your last study visit**, have you taken any antibiotic or antifungal (anti-yeast) medications?

- [ ] No
- [ ] Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the name of the drug?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was it given?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Topical</td>
<td>☐ Oral</td>
</tr>
<tr>
<td>What was the start date?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
<tr>
<td>What was the end date?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Only one drug was taken. (Do not complete the rest of the table)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the name of the second drug?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was it given?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Topical</td>
<td>☐ Oral</td>
</tr>
<tr>
<td>What was the start date?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
<tr>
<td>What was the end date?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
</tbody>
</table>
25. **If you are currently breastfeeding**, please list any other prescription medications that you have taken since your last study visit.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ________________</td>
<td>No</td>
</tr>
<tr>
<td>b. ________________</td>
<td>No</td>
</tr>
<tr>
<td>c. ________________</td>
<td>No</td>
</tr>
<tr>
<td>d. ________________</td>
<td>No</td>
</tr>
<tr>
<td>e. ________________</td>
<td>No</td>
</tr>
</tbody>
</table>

26. How much time does your baby spend in sleep during the night (between 7 in the evening and 7 in the morning)?

[ ] [ ] hours, [ ] [ ] minutes

27. How many times does your baby wake up during the night?

[ ] [ ] times

28. How much time during the night does your baby spend in wakefulness (from 10 in the evening to 6 in the morning)?

[ ] [ ] hours, [ ] [ ] minutes

29. Do you consider your baby’s sleep to be a problem?

- [ ] Not a problem at all
- [ ] A small problem
- [ ] A very serious problem

30. Has your baby been diagnosed with asthma or reactive airway disease by your doctor?

- [ ] Yes
- [ ] No
31. Does your baby take any puffers or breathing medications?
   - Yes
   - No

32. Have you been told by your doctor that your baby has eczema?
   - Yes
   - No

33. **In the last month**, has your baby experienced any of the following?: (check all that apply)
   - Itchy rashes
   - Itchy rashes that don’t go away on the face, knuckles, elbows or knees
   - Rash on the nose, mouth or diaper area
   - Dry, thickened or scaly skin or more skin creases in the palms than usual
   - Cracked skin around the ear
   - Scaly scalp that won’t go away
   - Red dots surrounding hair follicles
   - None of the above

34. Have you **ever** had any concerns that your baby may have an allergy?
   - No
   - Yes, I/we suspect(ed) an allergy
     - if yes, please describe what the allergic substance was thought to be and what made you suspect an allergy:

     ________________________________________________________________

     ________________________________________________________________

     ________________________________________________________________

   - Yes, an allergy was confirmed by the doctor
     - if yes, please indicate what the allergic substance(s) is/are:

     ________________________________________________________________

     ________________________________________________________________

     ________________________________________________________________
PEA POD QUESTIONNAIRE

Instructions:
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- If you do not understand a question, please ask a research staff member.

1. What were your feelings about the PEA POD prior to its use?
   - I was concerned/worried
   - I was curious/interested
   - I was indifferent
   - I was uncomfortable
   - Other: ____________________________

2. Is your experience with the PEA POD what you expected based on the information that we provided to you?
   - Yes
   - No
   - I had no expectations about the PEA POD

3. How comfortable were you during the use of the PEA POD?
   - Very comfortable
   - Comfortable
   - Neither comfortable nor uncomfortable
   - Uncomfortable
   - Very uncomfortable

4. How comfortable do you think your baby was while inside the PEA POD?
   - Very comfortable
   - Comfortable
   - Neither comfortable nor uncomfortable
   - Uncomfortable
   - Very uncomfortable

5. Additional comments, questions or concerns about the PEA POD:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Version date: July 18, 2012
4 MONTHS

Instructions:
- This form is to be completed by research personnel through telephone contact with participants at 4 months postpartum.
- Please refer to previous forms to appropriately prompt and ensure consistency for questions 3-5, 9, 12 and 21.

1. Was the 4 month follow up completed?
   - [ ] No
   - [x] Yes

2. Date: [ ] /[ ] / [ ]
   - year
   - month
   - day

3. Have you **ever** breast fed your baby?
   - [ ] No
   - [x] Yes
   - If yes, **do you still** breastfeed your baby?
     - [ ] No
     - If no, how old was your baby when you stopped breast feeding?
       - [ ] weeks
       - (fill in “0” if your baby was less than 1 week old)
   - [x] Yes
   - If yes, has your baby **ever** had anything other than breast milk or water?
     - [ ] No
     - [ ] Yes
     - If yes, how old was your baby when he or she first had anything other than breast milk or water?
       - [ ] weeks
       - (fill in “0” if your baby was less than 1 week old)
4. Has your baby *ever* had any of the following?

<table>
<thead>
<tr>
<th>Milk Type</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goat’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another type of milk or formula</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Formula: [ ] [ ] [ ] times per week
- Soy milk: [ ] [ ] [ ] times per week
- Goat’s milk: [ ] [ ] [ ] times per week
- Hypo-allergenic formula: [ ] [ ] [ ] times per week
- Cow’s milk: [ ] [ ] [ ] times per week
- Another type of milk or formula: [ ] [ ] [ ] times per week
5. Has your baby *ever* had any of the following foods or beverages?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice cereal</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Other cereal</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Bread or toast</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Baby cookies</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Baked goods</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Dairy products</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Egg yolk</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Egg white</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Meat</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Fish</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Raw vegetables</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Potato</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Cooked vegetables</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Legumes</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Soy products (i.e. tofu)</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Raw fruit</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Cooked fruit</td>
<td>☐</td>
<td>☐ →</td>
</tr>
<tr>
<td>Item</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>Pop</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Other fizzy drinks</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Apple juice</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Other fruit drinks</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Herbal drink</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Unpasteurized milk</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Gripe water</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Tea (herbal)</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Tea (caffeinated)</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Coffee</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>A little alcohol</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Potato chips</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Other salty snacks</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Chocolate</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Sweets</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Peanuts/ peanut butter</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Tree nuts/ tree nut butter (i.e. almond, cashew)</td>
<td></td>
<td>☐</td>
</tr>
</tbody>
</table>
6. Please indicate if your baby currently has any of the following feeding behaviours:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow feeding</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Taking only small quantities at each feed</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Choking</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hungry/ not satisfied</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Refused to take breast milk</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Refused to take other milk</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Refused to take solids</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Can not establish feeding routine</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

7. Are you currently having difficulties feeding your baby?
   - ☐ No, no difficulties
   - ☐ Yes, some difficulties
   - ☐ Yes, great difficulties
8. **Since your last study visit**, has your baby had an infection that required antibiotic or antifungal (anti-yeast) treatment?
   - [ ] No
   - [ ] Yes ➔ if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What was the type of infection?</td>
<td>Thruh</td>
<td>Ear infection</td>
<td>Chest infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urinary tract infection</td>
<td>Other: ____________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What was the name of the drug?</td>
<td>____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How was it given?</td>
<td>Topical</td>
<td>Oral</td>
<td>Other: ____________________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>What was the start date?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>year</td>
<td>month</td>
<td>day</td>
</tr>
<tr>
<td></td>
<td>What was the end date?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>year</td>
<td>month</td>
<td>day</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td>[ ] Still currently in use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>Only one drug was given. (Do not complete the rest of the table)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What was the type of infection?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What was the name of the second drug?</td>
</tr>
<tr>
<td></td>
<td>How was it given?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What was the start date?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What was the end date?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>or</td>
</tr>
</tbody>
</table>
9. Please list any other medications, vitamins, homeopathics or supplements that your baby has taken since your last study visit.

   None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a.</td>
<td>☐</td>
</tr>
<tr>
<td>b.</td>
<td>☐</td>
</tr>
<tr>
<td>c.</td>
<td>☐</td>
</tr>
<tr>
<td>d.</td>
<td>☐</td>
</tr>
<tr>
<td>e.</td>
<td>☐</td>
</tr>
</tbody>
</table>

10. Since your last study visit, has your baby needed to stay in the hospital?

   No
   Yes
11. *Since your last study visit*, have **you** taken any antibiotic or antifungal (anti-yeast) medications?

- [ ] No
- [ ] Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What was the name of the drug?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How was it given?</strong></td>
<td>[ ] Topical</td>
</tr>
<tr>
<td><strong>What was the start date?</strong></td>
<td></td>
</tr>
<tr>
<td>[ ]/ [ ]/ [ ]</td>
<td>year</td>
</tr>
<tr>
<td><strong>What was the end date?</strong></td>
<td></td>
</tr>
<tr>
<td>[ ]/ [ ]/ [ ]</td>
<td>year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Only one drug was taken. (Do not complete the rest of the table)</td>
<td></td>
</tr>
</tbody>
</table>

| **What was the name of the second drug?** |  |
| **How was it given?** | [ ] Topical | [ ] Oral | [ ] Other: |
| **What was the start date?** |  |
| [ ]/ [ ]/ [ ] | year | month | day |
| **What was the end date?** |  |
| [ ]/ [ ]/ [ ] | year | month | day | or [ ] Still currently in use |
12. **If you are currently breastfeeding**, please list any other prescription medications that **you** have taken since your last study visit.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. _______________</td>
<td>[ ]</td>
</tr>
<tr>
<td>b. _______________</td>
<td>[ ]</td>
</tr>
<tr>
<td>c. _______________</td>
<td>[ ]</td>
</tr>
<tr>
<td>d. _______________</td>
<td>[ ]</td>
</tr>
<tr>
<td>e. _______________</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

13. How much time does your baby spend in sleep during the night (between 7 in the evening and 7 in the morning)?

- [ ] hours, [ ] minutes

14. How many times does your baby wake up during the night?

- [ ] times

15. How much time during the night does your baby spend in wakefulness (from 10 in the evening to 6 in the morning)?

- [ ] hours, [ ] minutes

16. Do you consider your baby’s sleep to be a problem?

- [ ] Not a problem at all
- [ ] A small problem
- [ ] A very serious problem

17. Has your baby been diagnosed with asthma or reactive airway disease by your doctor?

- [ ] Yes
- [ ] No
18. Does your baby take any puffers or breathing medications?
   - Yes
   - No

19. Have you been told by your doctor that your baby has eczema?
   - Yes
   - No

20. **In the last month**, has your baby experienced any of the following?: (check all that apply)
   - Itchy rashes
   - Itchy rashes that don’t go away on the face, knuckles, elbows or knees
   - Rash on the nose, mouth or diaper area
   - Dry, thickened or scaly skin or more skin creases in the palms than usual
   - Cracked skin around the ear
   - Scaly scalp that won’t go away
   - Red dots surrounding hair follicles
   - None of the above

21. Have you **ever** had any concerns that your baby may have an allergy?
   - No
   - Yes, I/we suspect(ed) an allergy
     - if yes, please describe what the allergic substance was thought to be and what made you suspect and allergy:

     __________________________________________________
     __________________________________________________
     __________________________________________________

   - Yes, an allergy was confirmed by the doctor
     - if yes, please indicate what the allergic substance(s) is/are:

     __________________________________________________
     __________________________________________________
     __________________________________________________
Instructions:
- This form is to be completed by research personnel at the 5 month study visit.
- Record the measurements indicated below and attach this form to “Part 2” completed by the participant.

1. Date and time of visit: [ ] / [ ] / [ ] [ ] : [ ]
   - year
   - month
   - day
   - 24 hour clock

2. Head circumference: [ ] . [ ] cm

3. Tricep skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm

4. Subscapular skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm

5. Bicep skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm
5 MONTHS – PART 1

6. Mid-arm circumference:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

7. Suprailiac skinfold thickness:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

8. Hip circumference:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

9. Abdominal circumference:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

10. Length: [ ] . [ ] cm
5 MONTHS – PART 1

11. Percent fat: □ □ □ %

12. Percent fat free mass: □ □ □ %

13. Fat mass: □ □ □ kg

14. Fat free mass: □ □ □ kg

15. Body mass: □ □ □ kg

16. Body volume: □ □ □ L

17. Body density: □ □ □ kg/L

18. Fat mass density: □ □ □ kg/L

19. Fat free mass density: □ □ □ kg/L

20. Body surface area: □ □ □ cm²

21. Thoracic gas volume: □ □ □ L

22. The PEA POD test was:
   □ Completed without interruption
   □ Begun but terminated early
   □ Not attempted because baby exceeded capacity
   □ Not attempted because parent declined

23. Were stool samples received?
   □ No
   □ Yes
      □ if yes, indicate the following:

      Date Collected

      Day 3 □ □ □ / □ □ / □ □
      Day 10 □ □ □ / □ □ / □ □
      6 Weeks □ □ □ / □ □ / □ □
      12 Weeks □ □ □ / □ □ / □ □
      5 Months □ □ □ / □ □ / □ □
Instructions:
  o Mark only one box with an “X” for each question, unless instructed to do otherwise.
  o Please use your study calendar to help you remember the information asked for.
  o All of your answers will remain confidential.
  o If you do not understand a question, please ask a research staff member.

1. Have you ever breast fed your baby?
   □ No
   □ Yes
       ⇒ if yes, do you still breastfeed your baby?
   □ No
       ⇒ if no, how old was your baby when you stopped breast feeding?
       □ □ . □ months
       (fill in “0” if your baby was less than 1 month old)
   □ Yes
       ⇒ if yes, has your baby ever had anything other than breast milk or water?
   □ No
   □ Yes
       ⇒ if yes, how old was your baby when he or she first had anything other than breast milk or water?
       □ □ . □ months
       (fill in “0” if your baby was less than 1 month old)

2. Has your baby ever had any of the following?

<table>
<thead>
<tr>
<th>Formula</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Formula</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Goat’s milk</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Another type of milk or</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>formula:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Has your baby *ever* had any of the following foods or beverages?

<table>
<thead>
<tr>
<th>Food Type</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice cereal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other cereal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bread or toast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby cookies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baked goods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dairy products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egg yolk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egg white</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raw vegetables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potato</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooked vegetables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legumes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy products (i.e. tofu)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raw fruit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooked fruit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 5 MONTHS – PART 2

<table>
<thead>
<tr>
<th>Item</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other fizzy drinks</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Apple juice</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other fruit drinks</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Herbal drink</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Unpasteurized milk</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Gripe water</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Tea (herbal)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Tea (caffeinated)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Coffee</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>A little alcohol</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Potato chips</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other salty snacks</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Chocolate</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Sweets</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Peanuts/ peanut butter</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Tree nuts/ tree nut butter (i.e. almond, cashew)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
4. Please indicate if your baby currently has any of the following feeding behaviours:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No</th>
<th>Yes</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow feeding</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Taking only small quantities at each feed</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Choking</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Hungry/ not satisfied</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Refused to take breast milk</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Refused to take other milk</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Refused to take solids</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Can not establish feeding routine</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

5. Are you currently having difficulties feeding your baby?
   - No, no difficulties
   - Yes, some difficulties
   - Yes, great difficulties

6. During the past week, how often did your baby usually spit-up (anything coming out of the mouth) during a 24-hour period?
   - Less than once
   - 1 to 3 times
   - 4 to 6 times
   - More than 6 times

7. During the past week, how much did your baby usually spit-up (anything coming out of the mouth) during a typical episode?
   - Did not spit up
   - Less than 1 tablespoonful
   - 1 tablespoonful to 2 ounces
   - More than 2 ounces to half the feeding
   - More than half the feeding
8. **During the past week**, how often did spitting up (anything coming out of the mouth) seem to be uncomfortable for your baby, for example, crying, fussing, irritability, etc?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

9. **During the past week**, how often did your baby refuse a feeding even when hungry?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

10. **During the past week**, how often did your baby stop eating soon after starting even when hungry?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

11. **During the past week**, did your baby cry a lot during or within 1 hour after feedings?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

12. **During the past week**, did your baby cry or fuss more than usual?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always
13. **During the past week**, on average how long did your baby cry or fuss during a 24 hour period?
   - [ ] Less than 10 minutes
   - [ ] 10 minutes to 1 hour
   - [ ] More than 1 hour but less than 3 hours
   - [ ] 3 or more hours

14. **During the past week**, how often did your baby have hiccups?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Often
   - [ ] Always

15. **During the past week**, how often did your baby have episodes of arching back?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Often
   - [ ] Always

16. **During the past week**, has your baby stopped breathing while awake or struggled to breathe?
   - [ ] No
   - [ ] Yes

17. **During the past week**, has your baby turned blue or purple?
   - [ ] No
   - [ ] Yes
18. **In the last month**, have you noted your baby straining for 10 minutes or longer before successful passage of stool?
   - No
   - Yes
     - if yes, how many times per week?
       - [ ] times

19. Does your baby typically have **at least one** bowel movement every day?
   - No
     - if no, how many bowel movements does your baby have in a **typical week**?
       - [ ] bowel movements
   - Yes
     - if yes, how many bowel movements does your baby have in a **typical day**?
       - [ ] bowel movements

20. **In the last month**, has your baby had any episodes of abdominal pain or discomfort?
   - No
   - Yes

21. **Since your last study visit or phone call**, has your baby needed to stay in the hospital?
   - No
   - Yes
 pid:

mother's date of birth: ___/___/___

5 months – part 2

22. Since your last study visit or phone call, has your baby had an infection that required antibiotic or antifungal (anti-yeast) treatment?

- No
- Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th>What was the type of infection?</th>
<th>☐ Thrus</th>
<th>☐ Ear infection</th>
<th>☐ Chest infection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Urinary tract infection</td>
<td>☐ Other: __________________________</td>
<td></td>
</tr>
</tbody>
</table>

What was the name of the drug? ____________________________________________

How was it given?

- ☐ Topical
- ☐ Oral
- ☐ Other: __________________________

What was the start date? ___/___/___

What was the end date? ___/___/___ or ☐ Still currently in use

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>Only one drug was given. (Do not complete the rest of the table)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What was the type of infection?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What was the name of the second drug? ____________________________________________

How was it given?

- ☐ Topical
- ☐ Oral
- ☐ Other: __________________________

What was the start date? ___/___/___

What was the end date? ___/___/___ or ☐ Still currently in use
23. Please list any other medications, vitamins, homeopathics or supplements that *your baby* has taken *since your last study visit or phone call*.

- None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
</tbody>
</table>
5 MONTHS – PART 2

24. *Since your last study visit or phone call*, have you taken any antibiotic or antifungal (anti-yeast) medications?
   - [ ] No
   - [ ] Yes → if yes, please complete the following table:

### DRUG 1

- **What was the name of the drug?**
  
  - __________________________

- **How was it given?**
  - [ ] Topical
  - [ ] Oral
  - [ ] Other: __________________________

- **What was the start date?**
  - [ ] [ ] / [ ] / [ ]
  - [ ] year
  - [ ] month
  - [ ] day

- **What was the end date?**
  - [ ] [ ] / [ ] / [ ]
  - [ ] year
  - [ ] month
  - [ ] day
  - or [ ] Still currently in use

### DRUG 2

- [ ] Only one drug was taken. (Do not complete the rest of the table)

- **What was the name of the second drug?**
  
  - __________________________

- **How was it given?**
  - [ ] Topical
  - [ ] Oral
  - [ ] Other: __________________________

- **What was the start date?**
  - [ ] [ ] / [ ] / [ ]
  - [ ] year
  - [ ] month
  - [ ] day

- **What was the end date?**
  - [ ] [ ] / [ ] / [ ]
  - [ ] year
  - [ ] month
  - [ ] day
  - or [ ] Still currently in use
25. If you are currently breastfeeding, please list any other prescription medications that you have taken since your last study visit or phone call.

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. ______________</td>
<td>☐</td>
</tr>
<tr>
<td>b. ______________</td>
<td>☐</td>
</tr>
<tr>
<td>c. ______________</td>
<td>☐</td>
</tr>
<tr>
<td>d. ______________</td>
<td>☐</td>
</tr>
<tr>
<td>e. ______________</td>
<td>☐</td>
</tr>
</tbody>
</table>

26. How much time does your baby spend in sleep during the night (between 7 in the evening and 7 in the morning)?

   [ ] hours, [ ] minutes

27. How many times does your baby wake up during the night?

   [ ] times

28. How much time during the night does your baby spend in wakefulness (from 10 in the evening to 6 in the morning)?

   [ ] hours, [ ] minutes

29. Do you consider your baby’s sleep to be a problem?

   ☐ Not a problem at all
   ☐ A small problem
   ☐ A very serious problem

30. Has your baby been diagnosed with asthma or reactive airway disease by your doctor?

   ☐ Yes
   ☐ No
5 MONTHS – PART 2

31. Does your baby take any puffers or breathing medications?
   - Yes
   - No

32. Have you been told by your doctor that your baby has eczema?
   - Yes
   - No

33. In the last month, Has your baby experienced any of the following?: (check all that apply)
   - Itchy rashes
   - Itchy rashes that don’t go away on the face, knuckles, elbows or knees
   - Rash on the nose, mouth or diaper area
   - Dry, thickened or scaly skin or more skin creases in the palms than usual
   - Cracked skin around the ear
   - Scaly scalp that won’t go away
   - Red dots surrounding hair follicles
   - None of the above

34. Have you ever had any concerns that your baby may have an allergy?
   - No
   - Yes, I/we suspect(ed) an allergy
     - if yes, please describe what the allergic substance was thought to be and what made you suspect and allergy:
       ____________________________________________________________
       ____________________________________________________________
       ____________________________________________________________

   - Yes, an allergy was confirmed by the doctor
     - if yes, please indicate what the allergic substance(s) is/are:
       ____________________________________________________________
       ____________________________________________________________
       ____________________________________________________________

Version date: September 25, 2014
6, 8 AND 10 MONTHS - TELEPHONE

Instructions:
- This form is to be completed by research personnel through telephone contact with participants at 6, 8 and 10 months postpartum.
- Please refer to previous forms to appropriately prompt and ensure consistency for questions 3-5, 9, 12 and 21.

1. Was the follow up contact completed?
   - No
   - Yes

2. Date: __________ / __________ / __________
   - year
   - month
   - day

3. Have you ever breast fed your baby?
   - No
   - Yes
     - if yes, do you still breastfeed your baby?
       - No
       - if no, how old was your baby when you stopped breast feeding?
         - __________ . __________ months
           (fill in “0” if your baby was less than 1 month old)
       - Yes
       - if yes, has your baby ever had anything other than breast milk or water?
         - No
         - Yes
         - if yes, how old was your baby when he or she first had anything other than breast milk or water?
           - __________ . __________ months
             (fill in “0” if your baby was less than 1 month old)
4. Has your baby *ever* had any of the following?

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goat’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another type of milk or formula</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has your baby ever had any of the following:

- **Formula**
- **Soy milk**
- **Goat’s milk**
- **Hypo-allergenic formula**
- **Cow’s milk**
- **Another type of milk or formula:**

**Current Use**

- Times per week
5. Has your baby ever had any of the following foods or beverages?

<table>
<thead>
<tr>
<th>Food</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice cereal</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Other cereal</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Bread or toast</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Baby cookies</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Baked goods</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Dairy products</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Egg yolk</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Egg white</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Meat</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Fish</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Raw vegetables</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Potato</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Cooked vegetables</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Legumes</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Soy products (i.e. tofu)</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Raw fruit</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
<tr>
<td>Cooked fruit</td>
<td>0</td>
<td>1</td>
<td>times per week</td>
</tr>
</tbody>
</table>
### 6, 8 AND 10 MONTHS - TELEPHONE

<table>
<thead>
<tr>
<th>Item</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Other fizzy drinks</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Apple juice</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Other fruit drinks</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Herbal drink</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Unpasteurized milk</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Gripe water</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Tea (herbal)</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Tea (caffeinated)</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Coffee</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>A little alcohol</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Potato chips</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Other salty snacks</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Chocolate</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Sweets</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Peanuts/ peanut butter</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
<tr>
<td>Tree nuts/ tree nut butter (i.e. almond, cashew)</td>
<td>☐</td>
<td>☐</td>
<td>☐ → times per week</td>
</tr>
</tbody>
</table>
6. Please indicate if your baby currently has any of the following feeding behaviours:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No</th>
<th>Yes</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow feeding</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Taking only small quantities at each feed</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Choking</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Hungry/ not satisfied</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Refused to take breast milk</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Refused to take other milk</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Refused to take solids</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Can not establish feeding routine</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

7. Are you currently having difficulties feeding your baby?
   ☐ No, no difficulties
   ☐ Yes, some difficulties
   ☐ Yes, great difficulties
8. **Since your last study visit or phone call,** has your baby had an infection that required antibiotic or antifungal (anti-yeast) treatment?

- No
- Yes \(\rightarrow\) if yes, please complete the following table:

### DRUG 1

- What was the type of infection? [ ] Thrush [ ] Ear infection [ ] Chest infection [ ] Urinary tract infection [ ] Other: __________________________

- What was the name of the drug? __________________________________________

- How was it given? [ ] Topical [ ] Oral [ ] Other: __________________________

- What was the start date? [ ] [ ] [ ] / [ ] [ ] [ ]

- What was the end date? [ ] [ ] [ ] / [ ] [ ] [ ] or [ ] Still currently in use

### DRUG 2

- Only one drug was given. (Do not complete the rest of the table)

- What was the type of infection? [ ] Thrush [ ] Ear infection [ ] Chest infection [ ] Urinary tract infection [ ] Other: __________________________

- What was the name of the second drug? ______________________________________

- How was it given? [ ] Topical [ ] Oral [ ] Other: __________________________

- What was the start date? [ ] [ ] [ ] / [ ] [ ] [ ]

- What was the end date? [ ] [ ] [ ] / [ ] [ ] [ ] or [ ] Still currently in use
9. Please list any other medications, vitamins, homeopathics or supplements that your baby has taken since your last study visit or phone call.

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. ___________________________________</td>
<td>□</td>
</tr>
<tr>
<td>b. ___________________________________</td>
<td>□</td>
</tr>
<tr>
<td>c. ___________________________________</td>
<td>□</td>
</tr>
<tr>
<td>d. ___________________________________</td>
<td>□</td>
</tr>
<tr>
<td>e. ___________________________________</td>
<td>□</td>
</tr>
</tbody>
</table>

10. Since your last study visit or phone call, has your baby needed to stay in the hospital?

- No
- Yes
11. *Since your last study visit or phone call*, have you taken any antibiotic or antifungal (anti-yeast) medications?
   - [ ] No
   - [ ] Yes→ if yes, please complete the following table:

**DRUG 1**
- What was the name of the drug?
- How was it given?
  - [ ] Topical
  - [ ] Oral
  - [ ] Other: ______________________
- What was the start date? __________/_________/_________
- What was the end date? __________/_________/_________ or [ ] Still currently in use

**DRUG 2** [ ] Only one drug was taken. (Do not complete the rest of the table)
- What was the name of the second drug?
- How was it given?
  - [ ] Topical
  - [ ] Oral
  - [ ] Other: ______________________
- What was the start date? __________/_________/_________
- What was the end date? __________/_________/_________ or [ ] Still currently in use
12. If you are currently breastfeeding, please list any other prescription medications that you have taken since your last study visit or phone call.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ___________________</td>
<td>No</td>
</tr>
<tr>
<td>b. ___________________</td>
<td>No</td>
</tr>
<tr>
<td>c. ___________________</td>
<td>No</td>
</tr>
<tr>
<td>d. ___________________</td>
<td>No</td>
</tr>
<tr>
<td>e. ___________________</td>
<td>No</td>
</tr>
</tbody>
</table>

13. How much time does your baby spend in sleep during the night (between 7 in the evening and 7 in the morning)?

   [ ] hours, [ ] minutes

14. How many times does your baby wake up during the night?

   [ ] times

15. How much time during the night does your baby spend in wakefulness (from 10 in the evening to 6 in the morning)?

   [ ] hours, [ ] minutes

16. Do you consider your baby’s sleep to be a problem?

- [ ] Not a problem at all
- [ ] A small problem
- [ ] A very serious problem

17. Has your baby been diagnosed with asthma or reactive airway disease by your doctor?

- [ ] Yes
- [ ] No
18. Does your baby take any puffers or breathing medications?
   - Yes
   - No

19. Have you been told by your doctor that your baby has eczema?
   - Yes
   - No

20. **In the last month,** has your baby experienced any of the following?: (check all that apply)
   - Itchy rashes
   - Itchy rashes that don’t go away on the face, knuckles, elbows or knees
   - Rash on the nose, mouth or diaper area
   - Dry, thickened or scaly skin or more skin creases in the palms than usual
   - Cracked skin around the ear
   - Scaly scalp that won’t go away
   - Red dots surrounding hair follicles
   - None of the above

21. Have you ever had any concerns that your baby may have an allergy?
   - No
   - Yes, I/we suspect(ed) an allergy
     - if yes, please describe what the allergic substance was thought to be and what made you suspect and allergy:
       __________________________________________________________
       __________________________________________________________
       __________________________________________________________

   - Yes, an allergy was confirmed by the doctor
     - if yes, please indicate what the allergic substance(s) is/are:
       __________________________________________________________
       __________________________________________________________
       __________________________________________________________
1 YEAR – PART 1

Instructions:
- This form is to be completed by research personnel at the 1 year study visit.
- Record the measurements indicated below and attach this form to “Part 2” completed by the participant.

1. Date and time of visit: [ ] / [ ] / [ ] : [ ]
   - year
   - month
   - day
   - 24 hour clock

2. Head circumference: [ ] . [ ] cm

3. Tricep skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm

4. Subscapular skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm

5. Bicep skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm
1 YEAR – PART 1

6. Mid-arm circumference:
   Measurement 1: [ ] cm
   Measurement 2: [ ] cm
   Measurement 3: [ ] cm

7. Suprailiac skinfold thickness:
   Measurement 1: [ ] cm
   Measurement 2: [ ] cm
   Measurement 3: [ ] cm

8. Hip circumference:
   Measurement 1: [ ] cm
   Measurement 2: [ ] cm
   Measurement 3: [ ] cm

9. Abdominal circumference:
   Measurement 1: [ ] cm
   Measurement 2: [ ] cm
   Measurement 3: [ ] cm

10. Length: [ ] cm

11. Body mass: [ ] kg
12. Were stool samples received?

- [ ] No
- [ ] Yes

If yes, indicate the following:

<table>
<thead>
<tr>
<th>Date Collected</th>
<th>Year</th>
<th>Month</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1 YEAR – PART 2

Instructions:
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- Please use your study diary to help you remember the information asked for.
- All of your answers will remain confidential.
- If you do not understand a question, please ask a research staff member.

1. Have you ever breast fed your baby?
   - No
   - Yes
     - if yes, **do you still** breastfeed your baby?
       - No
         - if no, how old was your baby when you stopped breast feeding?
           - ___________ . _______ months
             (fill in “0” if your baby was less than 1 month old)
       - Yes
         - if yes, has your baby ever had anything other than breast milk or water?
           - No
           - Yes
             - if yes, how old was your baby when she or he first had anything other than breast milk or water?
               - ___________ . _______ months
                 (fill in “0” if your baby was less than 1 month old)

2. Has your baby ever had any of the following?

<table>
<thead>
<tr>
<th>Formula</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goat’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypo-allergenic formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another type of milk or formula:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

...
3. Has your baby *ever* had any of the following foods or beverages?

<table>
<thead>
<tr>
<th>Food</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice cereal</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Other cereal</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Bread or toast</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Baby cookies</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Baked goods</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Dairy products</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Egg yolk</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Egg white</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Meat</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Raw vegetables</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Potato</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Cooked vegetables</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Legumes</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Soy products (i.e. tofu)</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Raw fruit</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
<tr>
<td>Cooked fruit</td>
<td></td>
<td>☐</td>
<td>times per week</td>
</tr>
</tbody>
</table>
1 YEAR – PART 2

<table>
<thead>
<tr>
<th>Item</th>
<th>No</th>
<th>Yes</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other fizzy drinks</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Apple juice</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other fruit drinks</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Herbal drink</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Unpasteurized milk</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Gripe water</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Tea (herbal)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Tea (caffeinated)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Coffee</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>A little alcohol</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Potato chips</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other salty snacks</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Chocolate</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Sweets</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Peanuts/ peanut butter</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Tree nuts/ tree nut butter (i.e. almond, cashew)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
4. Please indicate if your baby *currently* has any of the following feeding behaviours:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No</th>
<th>Yes</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow feeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking only small quantities at each feed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hungry/ not satisfied</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused to take breast milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused to take other milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused to take solids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can not establish feeding routine</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Are you *currently* having difficulties feeding your baby?
   - No, no difficulties
   - Yes, some difficulties
   - Yes, great difficulties

6. *During the past week*, how often did your baby usually spit-up (anything coming out of the mouth) during a 24-hour period?
   - Less than once
   - 1 to 3 times
   - 4 to 6 times
   - More than 6 times

7. *During the past week*, how much did your baby usually spit-up (anything coming out of the mouth) during a typical episode?
   - Did not spit up
   - Less than 1 tablespoonful
   - 1 tablespoonful to 2 ounces
   - More than 2 ounces to half the feeding
   - More than half the feeding
8. **During the past week**, how often did spitting up (anything coming out of the mouth) seem to be uncomfortable for your baby, for example, crying, fussing, irritability, etc?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

9. **During the past week**, how often did your baby refuse a feeding even when hungry?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

10. **During the past week**, how often did your baby stop eating soon after starting even when hungry?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

11. **During the past week**, did your baby cry a lot during or within 1 hour after feedings?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

12. **During the past week**, did your baby cry or fuss more than usual?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always
13. **During the past week**, on average how long did your baby cry or fuss during a 24 hour period?
   - [ ] Less than 10 minutes
   - [ ] 10 minutes to 1 hour
   - [ ] More than 1 hour but less than 3 hours
   - [ ] 3 or more hours

14. **During the past week**, how often did your baby have hiccups?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Often
   - [ ] Always

15. **During the past week**, how often did your baby have episodes of arching back?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Often
   - [ ] Always

16. **During the past week**, has your baby stopped breathing while awake or struggled to breathe?
   - [ ] No
   - [ ] Yes

17. **During the past week**, has your baby turned blue or purple?
   - [ ] No
   - [ ] Yes
18. In the last month, have you noted your baby straining for 10 minutes or longer before successful passage of stool?
   - No
   - Yes
     - if yes, how many times per week?
       - [ ] times

19. Does your baby typically have at least one bowel movement every day?
   - No
     - if no, how many bowel movements does your baby have in a typical week?
       - [ ] bowel movements
   - Yes
     - if yes, how many bowel movements does your baby have in a typical day?
       - [ ] bowel movements

20. In the last month, has your baby had any episodes of abdominal pain or discomfort?
   - No
   - Yes
21. *Since your last study visit or phone call,* has your baby had an infection that required antibiotic or antifungal (anti-yeast) treatment?

- [ ] No
- [ ] Yes→ if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the type of infection?</td>
<td>☐ Thrush ☐ Ear infection ☐ Chest infection ☐ Urinary tract infection ☐ Other: __________________________</td>
</tr>
<tr>
<td>What was the name of the drug?</td>
<td>__________________________</td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical ☐ Oral ☐ Other: __________________________</td>
</tr>
<tr>
<td>What was the start date?</td>
<td>☐ Still currently in use</td>
</tr>
<tr>
<td>What was the end date?</td>
<td>☐ Still currently in use</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>☐ Only one drug was given. (Do not complete the rest of the table)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the type of infection?</td>
<td>☐ Thrush ☐ Ear infection ☐ Chest infection ☐ Urinary tract infection ☐ Other: __________________________</td>
</tr>
<tr>
<td>What was the name of the second drug?</td>
<td>__________________________</td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical ☐ Oral ☐ Other: __________________________</td>
</tr>
<tr>
<td>What was the start date?</td>
<td>☐ Still currently in use</td>
</tr>
<tr>
<td>What was the end date?</td>
<td>☐ Still currently in use</td>
</tr>
</tbody>
</table>
22. Please list any other medications, vitamins, homeopathics or supplements that *your baby* has taken *since your last study visit or phone call*.

- [ ] None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. _________________________________</td>
<td></td>
</tr>
<tr>
<td>b. _________________________________</td>
<td></td>
</tr>
<tr>
<td>c. _________________________________</td>
<td></td>
</tr>
<tr>
<td>d. _________________________________</td>
<td></td>
</tr>
<tr>
<td>e. _________________________________</td>
<td></td>
</tr>
</tbody>
</table>

23. *Since your last study visit or phone call*, has your baby needed to stay in the hospital?

- [ ] No
- [ ] Yes
24. *Since your last study visit or phone call,* have **you** taken any antibiotic or antifungal (anti-yeast) medications?

- [ ] No
- [ ] Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What was the name of the drug?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How was it given?</strong></td>
<td>☐ Topical</td>
<td>☐ Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What was the start date?</strong></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
<tr>
<td><strong>What was the end date?</strong></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
<tr>
<td>or</td>
<td>☐ Still currently in use</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Only one drug was taken. (Do not complete the rest of the table)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What was the name of the second drug?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How was it given?</strong></td>
<td>☐ Topical</td>
<td>☐ Oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What was the start date?</strong></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
<tr>
<td><strong>What was the end date?</strong></td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>year</td>
<td>month</td>
</tr>
<tr>
<td>or</td>
<td>☐ Still currently in use</td>
<td></td>
</tr>
</tbody>
</table>
25. **If you are currently breastfeeding**, please list any other prescription medications that you have taken since your last study visit or phone call.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>b. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>c. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>d. ___________________________</td>
<td>No</td>
</tr>
<tr>
<td>e. ___________________________</td>
<td>No</td>
</tr>
</tbody>
</table>

26. How much time does your baby spend in sleep during the night (between 7 in the evening and 7 in the morning)?

[ ] hours, [ ] minutes

27. How many times does your baby wake up during the night?

[ ] times

28. How much time during the night does your baby spend in wakefulness (from 10 in the evening to 6 in the morning)?

[ ] hours, [ ] minutes

29. Do you consider your baby’s sleep to be a problem?

- [ ] Not a problem at all
- [ ] A small problem
- [ ] A very serious problem
30. Has your baby been diagnosed with asthma or reactive airway disease by your doctor?
   ☐ Yes
   ☐ No

31. Has your baby ever had wheezing?
   ☐ Yes
   ☐ No

32. Has your baby ever had a problem with sneezing or a runny nose or a blocked nose when he/she did not have a cold or flu?
   ☐ Yes
   ☐ No

33. Does your baby take any puffers or breathing medications?
   ☐ Yes
   ☐ No

34. Have you been told by your doctor that your baby has “hay fever”?
   ☐ Yes
   ☐ No

35. Have you been told by your doctor that your baby has eczema?
   ☐ Yes
   ☐ No

36. In the last month, has your baby experienced any of the following?: (check all that apply)
   ☐ Itchy rashes
   ☐ Itchy rashes that don’t go away on the face, knuckles, elbows or knees
   ☐ Rash on the nose, mouth or diaper area
   ☐ Dry, thickened or scaly skin or more skin creases in the palms than usual
   ☐ Cracked skin around the ear
   ☐ Scalpy scalp that won’t go away
   ☐ Red dots surrounding hair follicles
   ☐ None of the above
37. Have you ever had any concerns that your baby may have an allergy?
   - No
   - Yes, I/we suspect(ed) an allergy
     if yes, please describe what the allergic substance was thought to be and what made you suspect and allergy:
       ________________________________________________________________
       ________________________________________________________________
       ________________________________________________________________

   - Yes, an allergy was confirmed by the doctor
     if yes, please indicate what the allergic substance(s) is/are:
       ________________________________________________________________
       ________________________________________________________________
       ________________________________________________________________

38. Since your baby was born, has he/she been regularly exposed to tobacco smoke? (regularly is defined as most days or nights)
   - No
   - Yes
39. Has your baby ever travelled outside of Canada or the United States?
   □ No
   □ Yes → if yes, please indicate the country, date and duration of stay of each trip:

<table>
<thead>
<tr>
<th>Country</th>
<th>Date of arrival</th>
<th>Duration of visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

40. What type of water does your child drink most often?
   □ Well water
   □ Bottled water
   □ Municipal water
   □ Municipal water with home filtration system
41. Does your child attend daycare or preschool?
   - No
     - if no, who cares for your child? (check all that apply)
       - Parent
       - Grandparent / other extended family member
       - Nanny / babysitter
   - Yes
     - if yes, how old was your child when they first attended?
       - ________ months
     - if yes, please indicate the type of care:
       - Home daycare
       - Centre-based daycare
       - Preschool
     - if yes, please indicate the frequency of attendance:
       - Part-time
       - Full-time
1.5 YEARS

Instructions:
- This form is to be completed by research personnel through telephone contact with participants when their child 1.5 years old.
- Please refer to previous forms to appropriately prompt and ensure consistency for questions 3, 5, 6, 8, 9 and 14-21.

1. Was the follow up contact completed?
   - No
   - Yes

2. Date: [ ] / [ ] / [ ]
   year  month  day

3. Have you ever breast fed your child?
   - No
   - Yes
   ➞ if yes, do you still breastfeed your child?
     - No
     ➞ if no, how old was your child when you stopped breast feeding?
       [ ] , [ ] months
       (fill in “0” if your child was less than 1 month old)
     - Yes

4. Does your child eat a special diet?
   - No
   - Yes
   ➞ if yes, check all that apply:
     - Vegetarian
     - Vegan
     - Gluten free
     - Dairy free
     - Other: __________________________

Mother’s Date of Birth:
[ ] / [ ] / [ ]
year  month  day

PID: [ ] - [ ] - [ ]
5. *Since your last study visit or phone call,* has your child had an infection that required antibiotic or antifungal (anti-yeast) treatment?

- [ ] No
- [ ] Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>What was the type of infection?</strong></td>
<td>[ ] Thrush</td>
<td>[ ] Ear infection</td>
<td>[ ] Chest infection</td>
</tr>
<tr>
<td></td>
<td><strong>What was the name of the drug?</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td><strong>How was it given?</strong></td>
<td>[ ] Topical</td>
<td>[ ] Oral</td>
<td>[ ] Other:</td>
</tr>
<tr>
<td></td>
<td><strong>What was the start date?</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td><strong>What was the end date?</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>[ ] N/A (Do not complete the rest of the table)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>What was the type of infection?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>What was the name of the second drug?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>How was it given?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>What was the start date?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>What was the end date?</strong></td>
</tr>
</tbody>
</table>

---

**Mother’s Date of Birth:**

- [ ] year
- [ ] month
- [ ] day
6. Please list any other medications, vitamins, homeopathics or supplements that *your child* has taken *since your last study visit or phone call*.

- [ ] None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. _________________________________</td>
<td></td>
</tr>
<tr>
<td>b. _________________________________</td>
<td></td>
</tr>
<tr>
<td>c. _________________________________</td>
<td></td>
</tr>
<tr>
<td>d. _________________________________</td>
<td></td>
</tr>
<tr>
<td>e. _________________________________</td>
<td></td>
</tr>
<tr>
<td>f. _________________________________</td>
<td></td>
</tr>
<tr>
<td>g. _________________________________</td>
<td></td>
</tr>
</tbody>
</table>

7. *Since your last study visit or phone call*, has your child needed to stay in the hospital?

- [ ] No
- [ ] Yes
8. **If you are currently breastfeeding**, have you taken any antibiotic or antifungal (anti-yeast) medications *since your last study visit or phone call*?

   - [ ] Not currently breastfeeding
   - [ ] No
   - [ ] Yes → if yes, please complete the following table:

### DRUG 1

**What was the name of the drug?**

**How was it given?**
- [ ] Topical
- [ ] Oral
- [ ] Other: ____________________________

**What was the start date?**

- [ ] Year: __________ / Month: __________ / Day: __________

**What was the end date?**

- [ ] Year: __________ / Month: __________ / Day: __________

   - [ ] Still currently in use

### DRUG 2

- [ ] Only one drug was taken. (Do not complete the rest of the table)

**What was the name of the second drug?**

**How was it given?**
- [ ] Topical
- [ ] Oral
- [ ] Other: ____________________________

**What was the start date?**

- [ ] Year: __________ / Month: __________ / Day: __________

**What was the end date?**

- [ ] Year: __________ / Month: __________ / Day: __________

   - [ ] Still currently in use
9. *If you are currently breastfeeding*, please list any other prescription medications that *you* have taken *since your last study visit or phone call*.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>[ ] No  [ ] Yes</td>
</tr>
<tr>
<td>b.</td>
<td>[ ] No  [ ] Yes</td>
</tr>
<tr>
<td>c.</td>
<td>[ ] No  [ ] Yes</td>
</tr>
<tr>
<td>d.</td>
<td>[ ] No  [ ] Yes</td>
</tr>
<tr>
<td>e.</td>
<td>[ ] No  [ ] Yes</td>
</tr>
<tr>
<td>f.</td>
<td>[ ] No  [ ] Yes</td>
</tr>
<tr>
<td>g.</td>
<td>[ ] No  [ ] Yes</td>
</tr>
</tbody>
</table>

10. How much time does your child spend in sleep during the night (between 7 in the evening and 7 in the morning)?

   [ ] hours, [ ] minutes

11. How many times does your child wake up during the night?

   [ ] times

12. How much time during the night does your child spend in wakefulness (from 10 in the evening to 6 in the morning)?

   [ ] hours, [ ] minutes

13. Do you consider your child’s sleep to be a problem?
- [ ] Not a problem at all
- [ ] A small problem
- [ ] A very serious problem
14. Has your child been diagnosed with asthma or reactive airway disease by your doctor?
   - Yes
   - No

15. Has your child ever had wheezing?
   - Yes
   - No

16. Has your child ever had a problem with sneezing or a runny nose or a blocked nose when he/she did not have a cold or flu?
   - Yes
   - No

17. Does your child take any puffers or breathing medications?
   - Yes
   - No

18. Have you been told by your doctor that your child has “hay fever”?
   - Yes
   - No

19. Have you been told by your doctor that your child has eczema?
   - Yes
   - No

20. Has your child ever had an itchy rash which was coming and going for at least 6 months?
   - No
   - Yes
     - if yes, has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck ears or eyes?
       - Yes
       - No

21. Have you ever been told by your doctor that your child has an allergy?
   - No
   - Yes
     - if yes, please specify the allergic substance(s):
       __________________________________________________________
       __________________________________________________________
2 YEARS – PART 1

Instructions:
- This form is to be completed by research personnel at the 2 year study visit.
- Record the measurements indicated below and attach this form to “Part 2” completed by the participant.

1. Date and time of visit: [ ]/ [ ]/ [ ] [ ] : [ ]

2. Head circumference: [ ] . [ ] cm

3. Tricep skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm

4. Subscapular skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm

5. Bicep skinfold thickness:
   - Measurement 1: [ ] . [ ] cm
   - Measurement 2: [ ] . [ ] cm
   - Measurement 3: [ ] . [ ] cm
2 YEARS – PART 1

6. Mid-arm circumference:
   Measurement 1: \[ \square \] \[ \square \] cm
   Measurement 2: \[ \square \] \[ \square \] cm
   Measurement 3: \[ \square \] \[ \square \] cm

7. Suprailiac skinfold thickness:
   Measurement 1: \[ \square \] \[ \square \] cm
   Measurement 2: \[ \square \] \[ \square \] cm
   Measurement 3: \[ \square \] \[ \square \] cm

8. Hip circumference:
   Measurement 1: \[ \square \] \[ \square \] cm
   Measurement 2: \[ \square \] \[ \square \] cm
   Measurement 3: \[ \square \] \[ \square \] cm

9. Abdominal circumference:
   Measurement 1: \[ \square \] \[ \square \] cm
   Measurement 2: \[ \square \] \[ \square \] cm
   Measurement 3: \[ \square \] \[ \square \] cm

10. Length: \[ \square \] \[ \square \] cm

11. Body mass: \[ \square \] \[ \square \] kg
12. Were stool samples received?
   - [ ] No
   - [ ] Yes
      - if yes, indicate the following:

```
<table>
<thead>
<tr>
<th>Date Collected</th>
<th>Year</th>
<th>Month</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```
2 YEARS – PART 2

Instructions:
- Mark only one box with an “X” for each question, unless instructed to do otherwise.
- Please use your study diary to help you remember the information asked for.
- All of your answers will remain confidential.
- If you do not understand a question, please ask a research staff member.

1. Have you ever breast fed your child?
   - [ ] No
   - [ ] Yes
     - If yes, do you still breastfeed your child?
       - [ ] No
         - If no, how old was your child when you stopped breast feeding?
           - [ ] . months
             (If fill in “0” if your child was less than 1 month old)
             - [ ] Yes

2. Does your child eat a special diet?
   - [ ] No
   - [ ] Yes
     - If yes, check all that apply:
       - Vegetarian
         - [ ]
       - Vegan
         - [ ]
       - Gluten free
         - [ ]
       - Dairy free
         - [ ]
       - Other: ____________________________
3. Are you currently having difficulties feeding your child?
   - No, no difficulties
   - Yes, some difficulties
   - Yes, great difficulties

4. Does your child typically have at least one bowel movement every day?
   - No
     - if no, how many bowel movements does your child have in a typical week?
       - bowel movements
   - Yes
     - if yes, how many bowel movements does your child have in a typical day?
       - bowel movements

5. In the last month, has your child had any episodes of abdominal pain or discomfort?
   - No
   - Yes
6. **Since your last study visit or phone call, has your child** had an infection that required antibiotic or antifungal (anti-yeast) treatment?
   - [ ] No
   - [ ] Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th>What was the type of infection?</th>
<th>☐ Thrush ☐ Ear infection ☐ Chest infection ☐ Urinary tract infection ☐ Other: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What was the name of the drug?</td>
<td>_____________________________________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>How was it given?</td>
<td>☐ Topical ☐ Oral ☐ Other: ___________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>What was the start date?</td>
<td>□ □ □ / □ □ □ / □ □ □ year month day</td>
</tr>
<tr>
<td></td>
<td>What was the end date?</td>
<td>□ □ □ / □ □ □ / □ □ □ year month day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>☐ N/A (Do not complete the rest of the table)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the type of infection?</td>
<td>☐ Thrush ☐ Ear infection ☐ Chest infection ☐ Urinary tract infection ☐ Other: ________________________________</td>
</tr>
<tr>
<td>What was the name of the second drug?</td>
<td>_____________________________________________________________________________________________</td>
</tr>
<tr>
<td>How was it given?</td>
<td>☐ Topical ☐ Oral ☐ Other: ___________________________________________________________________</td>
</tr>
<tr>
<td>What was the start date?</td>
<td>□ □ □ / □ □ □ / □ □ □ year month day</td>
</tr>
<tr>
<td>What was the end date?</td>
<td>□ □ □ / □ □ □ / □ □ □ year month day</td>
</tr>
</tbody>
</table>
7. Please list any other medications, vitamins, homeopathics or supplements that your child has taken since your last study visit or phone call.

- **None**

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ___________________________________</td>
<td>No ☐ Yes ☑</td>
</tr>
<tr>
<td>b. ___________________________________</td>
<td>No ☐ Yes ☑</td>
</tr>
<tr>
<td>c. ___________________________________</td>
<td>No ☐ Yes ☑</td>
</tr>
<tr>
<td>d. ___________________________________</td>
<td>No ☐ Yes ☑</td>
</tr>
<tr>
<td>e. ___________________________________</td>
<td>No ☐ Yes ☑</td>
</tr>
<tr>
<td>f. ___________________________________</td>
<td>No ☐ Yes ☑</td>
</tr>
<tr>
<td>g. ___________________________________</td>
<td>No ☐ Yes ☑</td>
</tr>
</tbody>
</table>

8. Since your last study visit or phone call, has your child needed to stay in the hospital?

- No ☐
- Yes ☑
2 YEARS – PART 2

9. If you are currently breastfeeding, have you taken any antibiotic or antifungal (anti-yeast) medications since your last study visit or phone call?
   - Not currently breastfeeding
   - No
   - Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th>What was the name of the drug? ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How was it given?</td>
</tr>
<tr>
<td></td>
<td>- Topical</td>
</tr>
<tr>
<td></td>
<td>- Oral</td>
</tr>
<tr>
<td></td>
<td>- Other: ____________________________</td>
</tr>
<tr>
<td></td>
<td>What was the start date? year / month / day</td>
</tr>
<tr>
<td></td>
<td>What was the end date? year / month / day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>Only one drug was taken. (Do not complete the rest of the table)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What was the name of the second drug? ________________________</td>
</tr>
<tr>
<td></td>
<td>How was it given?</td>
</tr>
<tr>
<td></td>
<td>- Topical</td>
</tr>
<tr>
<td></td>
<td>- Oral</td>
</tr>
<tr>
<td></td>
<td>- Other: ____________________________</td>
</tr>
<tr>
<td></td>
<td>What was the start date? year / month / day</td>
</tr>
<tr>
<td></td>
<td>What was the end date? year / month / day</td>
</tr>
</tbody>
</table>

- Still currently in use
10. **If you are currently breastfeeding**, please list any other prescription medications that *you* have taken *since your last study visit or phone call*.

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td></td>
</tr>
</tbody>
</table>

11. How much time does your child spend in sleep during the night (between 7 in the evening and 7 in the morning)?

   [ ] hours, [ ] minutes

12. How many times does your child wake up during the night?

   [ ] times

13. How much time during the night does your child spend in wakefulness (from 10 in the evening to 6 in the morning)?

   [ ] hours, [ ] minutes

14. Do you consider your child’s sleep to be a problem?

   - [ ] Not a problem at all
   - [ ] A small problem
   - [ ] A very serious problem
15. Has your child been diagnosed with asthma or reactive airway disease by your doctor?
   - Yes
   - No

16. Has your child ever had wheezing?
   - Yes
   - No

17. Has your child ever had a problem with sneezing or a runny nose or a blocked nose when he/she did not have a cold or flu?
   - Yes
   - No

18. Does your child take any puffers or breathing medications?
   - Yes
   - No

19. Have you been told by your doctor that your child has “hay fever”?
   - Yes
   - No

20. Have you been told by your doctor that your child has eczema?
   - Yes
   - No

21. Has your child ever had an itchy rash which was coming and going for at least 6 months?
   - No
   - Yes
     - if yes, has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck ears or eyes?
       - Yes
       - No
22. Have you *ever* been told by your doctor that your child has an allergy?

☐ No
☐ Yes

⇒ if yes, please specify the allergic substance(s):

________________________________________________________________________
________________________________________________________________________

23. *In the last year*, has your child been regularly exposed to tobacco smoke? (regularly is defined as most days or nights)

☐ No
☐ Yes

24. *In the last year*, has your child travelled outside of Canada or the United States?

☐ No
☐ Yes ⇒ if yes, please indicate the country, date and duration of stay of each trip:

<table>
<thead>
<tr>
<th>Country</th>
<th>Date of arrival</th>
<th>Duration of visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25. What type of water does your child drink most often?

☐ Well water
☐ Bottled water
☐ Municipal water
☐ Municipal water with home filtration system
26. Does your child attend daycare or preschool?

☐ No

⇒ if no, who cares for your child? (check all that apply)

☐ Parent

☐ Grandparent / other extended family member

☐ Nanny / babysitter

☐ Yes

⇒ if yes, how old was your child when they first attended?

☐ ☐ ☐ . ☐ months

⇒ if yes, please indicate the type of care:

☐ Home daycare

☐ Centre-based daycare

☐ Preschool

⇒ if yes, please indicate the frequency of attendance:

☐ Part-time

☐ Full-time
2.5 YEARS

Instructions:
- This form is to be completed by research personnel through telephone contact with participants when their child 2.5 years old.
- Please refer to previous forms to appropriately prompt and ensure consistency for questions 3, 5, 6, 8, 9 and 14-21.

1. Was the follow up contact completed?
   - [ ] No
   - [ ] Yes

2. Date: [__] / [__] / [__]
   - year
   - month
   - day

3. Have you ever breast fed your child?
   - [ ] No
   - [ ] Yes
     ➔ if yes, do you still breastfeed your child?
     - [ ] No
       ➔ if no, how old was your child when you stopped breast feeding?
         - [__] . [__] months
       (fill in “0” if your child was less than 1 month old)
     - [ ] Yes

4. Does your child eat a special diet?
   - [ ] No
   - [ ] Yes
     ➔ if yes, check all that apply:
       - Vegetarian
       - [ ]
       - Vegan
       - [ ]
       - Gluten free
       - [ ]
       - Dairy free
       - [ ]
       - Other: ________________________________
5. *Since your last study visit or phone call*, has *your child* had an infection that required antibiotic or antifungal (anti-yeast) treatment?  
   ☐ No  
   ☐ Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What was the type of infection?</strong></td>
<td>☐ Thrush  ☐ Ear infection  ☐ Chest infection</td>
</tr>
<tr>
<td><strong>What was the name of the drug?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How was it given?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>What was the start date?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>What was the end date?</strong></td>
<td></td>
</tr>
<tr>
<td><em>year</em> / <em>month</em> / <em>day</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th>☐ N/A (Do not complete the rest of the table)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What was the type of infection?</strong></td>
<td>☐ Thrush  ☐ Ear infection  ☐ Chest infection</td>
<td>☐ Urinary tract infection  ☐ Other: _______________________________</td>
</tr>
<tr>
<td><strong>What was the name of the second drug?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How was it given?</strong></td>
<td></td>
<td>☐ Topical  ☐ Oral  ☐ Other: _______________________________</td>
</tr>
<tr>
<td><strong>What was the start date?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What was the end date?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>year</em> / <em>month</em> / <em>day</em></td>
<td></td>
<td>or ☐ Still currently in use</td>
</tr>
</tbody>
</table>
6. Please list any other medications, vitamins, homeopathics or supplements that your child has taken since your last study visit or phone call.

- None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>No</td>
</tr>
<tr>
<td>b.</td>
<td>No</td>
</tr>
<tr>
<td>c.</td>
<td>No</td>
</tr>
<tr>
<td>d.</td>
<td>No</td>
</tr>
<tr>
<td>e.</td>
<td>Yes</td>
</tr>
<tr>
<td>f.</td>
<td>No</td>
</tr>
<tr>
<td>g.</td>
<td>No</td>
</tr>
</tbody>
</table>

7. Since your last study visit or phone call, has your child needed to stay in the hospital?

- No
- Yes
8. **If you are currently breastfeeding**, have you taken any antibiotic or antifungal (anti-yeast) medications since your last study visit or phone call?

   - [ ] Not currently breastfeeding
   - [ ] No
   - [ ] Yes → if yes, please complete the following table:

<table>
<thead>
<tr>
<th>DRUG 1</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What was the name of the drug?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How was it given?</td>
<td>Topical</td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td>What was the start date?</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>What was the end date?</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG 2</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What was the name of the second drug?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How was it given?</td>
<td>Topical</td>
<td>Oral</td>
</tr>
<tr>
<td></td>
<td>What was the start date?</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>What was the end date?</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

- [ ] Only one drug was taken. (Do not complete the rest of the table)
9. **If you are currently breastfeeding**, please list any other prescription medications that **you** have taken since your last study visit or phone call.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ____________________________</td>
<td>No</td>
</tr>
<tr>
<td>b. ____________________________</td>
<td>No</td>
</tr>
<tr>
<td>c. ____________________________</td>
<td>No</td>
</tr>
<tr>
<td>d. ____________________________</td>
<td>No</td>
</tr>
<tr>
<td>e. ____________________________</td>
<td>No</td>
</tr>
<tr>
<td>f. ____________________________</td>
<td>No</td>
</tr>
<tr>
<td>g. ____________________________</td>
<td>No</td>
</tr>
</tbody>
</table>

10. How much time does your child spend in sleep during the night (between 7 in the evening and 7 in the morning)?

   [ ] hours, [ ] minutes

11. How many times does your child wake up during the night?

   [ ] times

12. How much time during the night does your child spend in wakefulness (from 10 in the evening to 6 in the morning)?

   [ ] hours, [ ] minutes

13. Do you consider your child’s sleep to be a problem?

   - [ ] Not a problem at all
   - [ ] A small problem
   - [ ] A very serious problem
14. Has your child been diagnosed with asthma or reactive airway disease by your doctor?
   ☐ Yes  ☐ No

15. Has your child *ever* had wheezing?
   ☐ Yes  ☐ No

16. Has your child *ever* had a problem with sneezing or a runny nose or a blocked nose when he/she did not have a cold or flu?
   ☐ Yes  ☐ No

17. Does your child take any puffers or breathing medications?
   ☐ Yes  ☐ No

18. Have you been told by your doctor that your child has “hay fever”?
   ☐ Yes  ☐ No

19. Have you been told by your doctor that your child has eczema?
   ☐ Yes  ☐ No

20. Has your child *ever* had an itchy rash which was coming and going for at least 6 months?
   ☐ No  ☐ Yes
   ➞ if yes, has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck ears or eyes?
   ☐ Yes  ☐ No

21. Have you *ever* been told by your doctor that your child has an allergy?
   ☐ No  ☐ Yes
   ➞ if yes, please specify the allergic substance(s):
   ____________________________________________________________________________
   ____________________________________________________________________________
Instructions:
- This form is to be completed by research personnel at the 3 year study visit.
- Record the measurements indicated below and attach this form to “Part 2” completed by the participant.

1. Date and time of visit: [ ] [ ] / [ ] / [ ] [ ] : [ ]

2. Head circumference: [ ] . [ ] cm

3. Tricep skinfold thickness:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

4. Subscapular skinfold thickness:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

5. Bicep skinfold thickness:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm
3 YEARS – PART 1

6. Mid-arm circumference:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

7. Suprailiac skinfold thickness:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

8. Hip circumference:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

9. Abdominal circumference:
   Measurement 1: [ ] . [ ] cm
   Measurement 2: [ ] . [ ] cm
   Measurement 3: [ ] . [ ] cm

10. Length: [ ] . [ ] cm

11. Body mass: [ ] . [ ] kg
3 YEARS – PART 1

12. Were stool samples received?
   - ☐ No
   - ☐ Yes

   > if yes, indicate the following:

   Date Collected
   - Day 3
     - ☐ [ ] / [ ] / [ ]
     - ☐ [ ] / [ ] / [ ]
   - Day 10
     - ☐ [ ] / [ ] / [ ]
   - 6 Weeks
     - ☐ [ ] / [ ] / [ ]
   - 12 Weeks
     - ☐ [ ] / [ ] / [ ]
   - 5 Months
     - ☐ [ ] / [ ] / [ ]
   - 1 Year
     - ☐ [ ] / [ ] / [ ]
   - 2 Year
     - ☐ [ ] / [ ] / [ ]
   - 3 Year
     - ☐ [ ] / [ ] / [ ]

13. What is the child’s ethnicity?
   - ☐ Asian
   - ☐ Black
   - ☐ Hispanic
   - ☐ White
   - ☐ Other
14. Was a blood sample taken?  
   - No  
     - if no, indicate the following:  
       - Not attempted  
       - Attempted, not able to obtain a sample  
       - Parent declined  
       - Child declined  
   - Yes  
     - if yes, indicate the following:  
       - Date Collected: [ ] [] / [ ] [] / [ ] []  
       - if yes, when did your child last eat or drink anything except water?  
         - < 1 hour before  
         - 1-3 hours before  
         - > 3 hours before  
         - Overnight  
     - if yes, did your child experience any of the following in the 48 hours prior to blood collection?  
       - Fever: No [ ] Yes [ ]  
       - Runny/stuffy nose: No [ ] Yes [ ]  
       - Cough: No [ ] Yes [ ]  
       - Diarrhea or vomiting: No [ ] Yes [ ]
15. Was a DXA scan performed?

☐ No  
⇒ if no, indicate the following:

☐ Not attempted
☐ Attempted, not able to obtain a reading
☐ Parent declined
☐ Child declined

☐ Yes
⇒ if yes, indicate the following:

Date Performed

[ ] [ ] / [ ] [ ] [ ]

year   month   day

⇒ if yes, indicate the following:

a) Bone (Ancillary Results [Total Body] page, Summary Sheet)

i. BA

[ ] [ ] [ ] . [ ] cm²

ii. BMC

[ ] [ ] [ ] . [ ] g

iii. BMD

[ ] [ ] [ ] g/cm²

iv. BMD z-score (age-matched)

[ ] [ ] [ ] (+/-)

b) Fat and Lean Mass (Body Composition page)

i. Fat

[ ] [ ] [ ] . [ ] g

ii. Lean

[ ] [ ] [ ] . [ ] g

iii. % Fat

[ ] [ ] . [ ] %

iv. Total Mass

[ ] [ ] . [ ] kg
c) Fat Distribution – Trunk (Body Composition page)

i. Android (% fat) □□□□□□□□ □□

ii. Gynoid (% fat) □□□□□□□□ □□

iii. Trunk (% fat) □□□□□□□□ □□

iv. Fat (trunk total) □□□□□□□□ □□ g

v. Lean (trunk total) □□□□□□□□ □□ g

d) Fat Mass Ratio (Body Composition page)

vi. Trunk/Total □□□□□□□□

vii. Legs/Total □□□□□□□□

viii. Arms+Legs/Total □□□□□□□□
1. Have you ever breast fed your child?
   - No
   - Yes
     ➞ if yes, do you still breastfeed your child?
       - No
       ➞ if no, how old was your child when you stopped breast feeding?
         □  □  □ months
         (fill in “0” if your child was less than 1 month old)
       - Yes

2. Does your child eat a special diet?
   - No
   - Yes
     ➞ if yes, check all that apply:
       - Vegetarian
       - Vegan
       - Gluten free
       - Dairy free
       - Other: __________________________________________
3. Are you currently having difficulties feeding your child?
   - No, no difficulties
   - Yes, some difficulties
   - Yes, great difficulties

4. Does your child typically have at least one bowel movement every day?
   - No
     - if no, how many bowel movements does your child have in a typical week?
       - bowel movements
   - Yes
     - if yes, how many bowel movements does your child have in a typical day?
       - bowel movements

5. In the last month, has your child had any episodes of abdominal pain or discomfort?
   - No
   - Yes
Below are questions about your child’s eating and other habits. Think about your child’s every day habits when answering. Check only one answer for each question.

6. My child usually eats grain products (examples are bread, bagel, bun, cereal, pasta, rice, roti and tortillas):
   - More than 5 times a day
   - 4 to 5 times a day
   - 2 to 3 times a day
   - Less than 2 times a day

7. My child usually has milk products (examples are white or chocolate milk, cheese, yogurt, milk puddings or milk substitutes, such as fortified soy beverages):
   - More than 3 times a day
   - 3 times a day
   - 2 times a day
   - Once a day or less

8. My child usually eats fruit:
   - More than 3 times a day
   - 3 times a day
   - 2 times a day
   - Once a day
   - Not at all

9. My child usually eats vegetables:
   - More than 2 times a day
   - 2 times a day
   - Once a day
   - Not at all

10. My child usually eats meat, fish, poultry or alternatives (alternatives can be eggs, peanut butter, tofu, nuts or fried beans, peas and lentils):
    - More than 2 times a day
    - 2 times a day
    - Once a day
    - A few times a week
    - Not at all
3 YEARS – PART 2

11. My child usually eats “fast food“:
   - ☐ 4 or more times a week
   - ☐ 2 to 3 times a week
   - ☐ Once a week
   - ☐ A few times a month
   - ☐ Once a month or less

12. I have difficulty buying food to feed my child because food is expensive:
   - ☐ Most of the time
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

13. My child has problems chewing, swallowing, gagging or choking when eating:
   - ☐ Most of the time
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

14. My child is not hungry at mealtimes because he/she drinks all day:
   - ☐ Most of the time
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

15. My child usually eats:
   - ☐ Less than 2 times a day
   - ☐ 2 times a day
   - ☐ 3 to 4 times a day
   - ☐ 5 times a day
   - ☐ More than 5 times a day

16. I let my child decide how much to eat:
   - ☐ Always
   - ☐ Most of the time
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
17. My child eats meals while watching TV:
   - Always
   - Most of the time
   - Sometimes
   - Rarely
   - Never

18. My child usually takes supplements: (Examples are multivitamins, iron drops, cod liver oil)
   - Always
   - Most of the time
   - Sometimes
   - Rarely
   - Never

19. My child:
   - Needs more physical activity
   - Gets enough physical activity

20. My child usually watches TV, uses the computer or plays video games:
   - 5 or more hours a day
   - 4 hours a day
   - 3 hours a day
   - 2 hours a day
   - 1 hour or less a day

21. I am comfortable with how my child is growing:
   - Yes
   - No

22. My child:
   - Should weight more
   - Is about the right weight
   - Should weigh less
23. *Since your last study visit or phone call*, has *your child* had an infection that required antibiotic or antifungal (anti-yeast) treatment?  
- [ ] No  
- [ ] Yes → if yes, please complete the following table:

**DRUG 1**

- **What was the type of infection?**  
  - [ ] Thrush  
  - [ ] Ear infection  
  - [ ] Chest infection  
  - [ ] Urinary tract infection  
  - [ ] Other: ______________________________

- **What was the name of the drug?**  
  __________________________________________

- **How was it given?**  
  - [ ] Topical  
  - [ ] Oral  
  - [ ] Other: ______________________________

- **What was the start date?**  
  [ ] [ ] [ ] / [ ] [ ] [ ]  
  year month day  

- **What was the end date?**  
  [ ] [ ] [ ] / [ ] [ ] [ ]  
  year month day  
  or  
  - [ ] Still currently in use

**DRUG 2**  
- [ ] N/A (Do not complete the rest of the table)

- **What was the type of infection?**  
  - [ ] Thrush  
  - [ ] Ear infection  
  - [ ] Chest infection  
  - [ ] Urinary tract infection  
  - [ ] Other: ______________________________

- **What was the name of the second drug?**  
  __________________________________________

- **How was it given?**  
  - [ ] Topical  
  - [ ] Oral  
  - [ ] Other: ______________________________

- **What was the start date?**  
  [ ] [ ] [ ] / [ ] [ ] [ ]  
  year month day  

- **What was the end date?**  
  [ ] [ ] [ ] / [ ] [ ] [ ]  
  year month day  
  or  
  - [ ] Still currently in use
24. Please list any other medications, vitamins, homeopathics or supplements that your child has taken since your last study visit or phone call.

- None

<table>
<thead>
<tr>
<th>Medication, vitamin or supplement name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. _________________________________</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>b. _________________________________</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>c. _________________________________</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>d. _________________________________</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>e. _________________________________</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>f. _________________________________</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>g. _________________________________</td>
<td>☐ No ☐ Yes</td>
</tr>
</tbody>
</table>

25. Since your last study visit or phone call, has your child needed to stay in the hospital?

- No
- Yes
26. **If you are currently breastfeeding**, have you taken any antibiotic or antifungal (anti-yeast) medications since your last study visit or phone call?

- ☐ Not currently breastfeeding
- ☐ No
- ☐ Yes → if yes, please complete the following table:

### DRUG 1

<table>
<thead>
<tr>
<th>What was the name of the drug?</th>
<th>____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How was it given?</th>
<th>☐ Topical</th>
<th>☐ Oral</th>
<th>☐ Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the start date?</th>
<th>□ □ □ / □ □ □ / □ □ □</th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the end date?</th>
<th>□ □ □ / □ □ □ / □ □ □</th>
<th>or ☐ Still currently in use</th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
<td>day</td>
</tr>
</tbody>
</table>

### DRUG 2

☐ Only one drug was taken. (Do not complete the rest of the table)

<table>
<thead>
<tr>
<th>What was the name of the second drug?</th>
<th>____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How was it given?</th>
<th>☐ Topical</th>
<th>☐ Oral</th>
<th>☐ Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the start date?</th>
<th>□ □ □ / □ □ □ / □ □ □</th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What was the end date?</th>
<th>□ □ □ / □ □ □ / □ □ □</th>
<th>or ☐ Still currently in use</th>
</tr>
</thead>
<tbody>
<tr>
<td>year</td>
<td>month</td>
<td>day</td>
</tr>
</tbody>
</table>
27. **If you are currently breastfeeding**, please list any other prescription medications that **you** have taken since your last study visit or phone call.

- [ ] Not currently breastfeeding
- [ ] None

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Currently in Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td></td>
</tr>
</tbody>
</table>

28. How much time does your child spend in sleep during the night (between 7 in the evening and 7 in the morning)?

[   ] hours, [   ] minutes

29. How many times does your child wake up during the night?

[   ] times

30. How much time during the night does your child spend in wakefulness (from 10 in the evening to 6 in the morning)?

[   ] hours, [   ] minutes

31. Do you consider your child’s sleep to be a problem?

- [ ] Not a problem at all
- [ ] A small problem
- [ ] A very serious problem
32. Has your child been diagnosed with asthma or reactive airway disease by your doctor?
   ☐ Yes
   ☐ No

33. Has your child ever had wheezing?
   ☐ Yes
   ☐ No

34. Has your child ever had a problem with sneezing or a runny nose or a blocked nose when he/she did not have a cold or flu?
   ☐ Yes
   ☐ No

35. Does your child take any puffers or breathing medications?
   ☐ Yes
   ☐ No

36. Have you been told by your doctor that your child has “hay fever”?
   ☐ Yes
   ☐ No
37. Has your child *ever* had an itchy rash which was coming and going for at least 6 months?
   - [ ] No
   - [ ] Yes
      - If yes, has your child has this itchy rash at any time in the last 12 months?
        - [ ] No
        - [ ] Yes
           - If yes, has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck ears or eyes?
             - [ ] Yes
             - [ ] No
      
      - If yes, at what age did this itchy rash first occur?
        - One year of age or less
          - [ ] Under 1 year
          - [ ] Age 1 to 2
          - [ ] Age 2 or more
      
      - If yes, has this rash cleared completely at any time during the last 12 months?
        - [ ] Yes
        - [ ] No
      
      - If yes, in the last 12 months, how often, on average, has your child been kept awake at night by this itchy rash?
        - [ ] Never in the last 12 months
        - [ ] Less than one night per week
        - [ ] One or more nights per week

38. Has your child *ever* had eczema?
   - [ ] Yes
   - [ ] No
39. Have you ever been told by your doctor that your child has an allergy?

☐ No
☐ Yes

→ if yes, please specify the allergic substance(s):
________________________________________________________________________
________________________________________________________________________

40. In the last year, has your child been regularly exposed to tobacco smoke? (regularly is defined as most days or nights)

☐ No
☐ Yes

41. In the last year, has your child travelled outside of Canada or the United States?

☐ No
☐ Yes → if yes, please indicate the country, date and duration of stay of each trip:

<table>
<thead>
<tr>
<th>Country</th>
<th>Date of arrival</th>
<th>Duration of visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

42. What type of water does your child drink most often?

☐ Well water
☐ Bottled water
☐ Municipal water
☐ Municipal water with home filtration system
3 YEARS – PART 2

43. Does your child attend daycare or preschool?
   □ No
      ➔ if no, who cares for your child? (check all that apply)
         □ Parent
         □ Grandparent / other extended family member
         □ Nanny / babysitter
   □ Yes
      ➔ if yes, how old was your child when they first attended?
         □ [ ] months
      ➔ if yes, please indicate the type of care:
         □ Home daycare
         □ Centre-based daycare
         □ Preschool
      ➔ if yes, please indicate the frequency of attendance:
         □ Part-time
         □ Full-time

44. We are interested in knowing about your child’s exposure to household animals at your home or the home of a regular care provider. If your child has been regularly exposed (most days or nights) to animals during any of the age ranges listed below, please indicate it by checking the boxes that apply.

<table>
<thead>
<tr>
<th>Animals that stayed inside the house.</th>
<th>Never</th>
<th>Less than 3 months old</th>
<th>3 months to 6 months old</th>
<th>6 months to 1 year old</th>
<th>1 year to 2 years old</th>
<th>2 years to 3 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Animals that went outside and inside the house</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Animals that stayed outside the house</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

Page 13 of 22
Version date: October 6, 2015
For each of the items below please mark the box for “Not True”, “Somewhat True” or “Certainly True” based on your child’s behaviour over the last 6 months. Please answer all items as best as you can even if you are not absolutely certain.

45. Considerate of other people’s feelings
46. Restless, overactive, cannot stay still for long
47. Often complains of headaches, stomach-aches or sickness
48. Shares readily with other children, for example toys, treats, pencils
49. Often loses temper
50. Rather solitary, prefers to play alone
51. Generally well behaved, usually does what adults request
52. Many worries or often seems worried
53. Helpful if someone is hurt, upset or feeling ill
54. Constantly fidgeting or squirming
55. Has at least one good friend
56. Often fights with other children or bullies them
57. Often unhappy, depressed or tearful
58. Generally liked by other children
59. Easily distracted, concentration wanders
60. Nervous or clingy in new situations, easily loses confidence
61. Kind to younger children
62. Often argumentative with adults
63. Picked on or bullied by other children
64. Often offers to help others (parents, teachers, other children)
65. Can stop and think things out before acting
66. Can be spiteful to others
67. Gets along better with adults than with other children
68. Many fears, easily scared
69. Good attention span, sees work through to the end
70. Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour, or being able to get along with other people?

- No
- Yes, minor difficulties
- Yes, definite difficulties
- Yes, severe difficulties

If yes, how long have these difficulties been present?

- Less than a month
- 1 to 5 months
- 6 to 12 months
- Over a year

If yes, do the difficulties upset or distress your child?

- Not at all
- Only a little
- A medium amount
- A great deal

If yes, do the difficulties interfere with your child’s everyday life in the following areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>Not at all</th>
<th>Only a little</th>
<th>A medium amount</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, do the difficulties put a burden on you or the family as a whole?

- Not at all
- Only a little
- A medium amount
- A great deal
On the next pages you will see a set of statements that describe children’s reactions to a number of situations. We would like you to tell us what *your child’s* reaction is likely to be in those situations. There are of course no “correct” ways of reacting; children differ widely in their reactions and it is these differences that we are trying to learn about. Please read each statement and decide whether it is a “true” or “untrue” description of your child’s reaction *within the past six months*. Use the following scale to indicate how well a statement describes your child:

1. extremely untrue of your child
2. quite untrue of your child
3. slightly untrue of your child
4. neither true nor untrue of your child
5. slightly true of your child
6. quite true of your child
7. extremely true of your child

If you cannot answer one of the items because you have never seen the child in that situation, then circle NA (not applicable). Please be sure to circle a number or NA for every item.
### 3 YEARS – PART 2

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extremely untrue</td>
<td>Quite untrue</td>
<td>Slightly untrue</td>
<td>Neither true nor untrue</td>
<td>Slightly true</td>
<td>Quite true</td>
<td>Extremely true</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**My child:**

71. Seems always in a big hurry to get from one place to another.  
   1  2  3  4  5  6  7  NA

72. Gets quite frustrated when prevented from doing something s/he wants to do.  
   1  2  3  4  5  6  7  NA

73. When drawing or colouring in a book, shows strong concentration.  
   1  2  3  4  5  6  7  NA

74. Likes going down high slides or other adventurous activities.  
   1  2  3  4  5  6  7  NA

75. Is quite upset by a little cut or bruise.  
   1  2  3  4  5  6  7  NA

76. Prepares for trips and outings by planning things s/he will need.  
   1  2  3  4  5  6  7  NA

77. Often rushes into new situations.  
   1  2  3  4  5  6  7  NA

78. Tends to become sad if the family's plans don't work out.  
   1  2  3  4  5  6  7  NA

79. Likes being sung to.  
   1  2  3  4  5  6  7  NA

80. Seems to be at ease with almost any person.  
   1  2  3  4  5  6  7  NA

81. Is afraid of burglars or the "boogie man".  
   1  2  3  4  5  6  7  NA
### 3 YEARS – PART 2

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Extremely untrue</td>
<td>Quite untrue</td>
<td>Slightly untrue</td>
<td>Neither true nor untrue</td>
<td>Slightly true</td>
<td>Quite true</td>
<td>Extremely true</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**My child:**

82. Notices it when parents are wearing new clothing.

   1 2 3 4 5 6 7 NA

83. Prefers quiet activities to active games.

   1 2 3 4 5 6 7 NA

84. When angry about something, s/he tends to stay upset for ten minutes or longer.

   1 2 3 4 5 6 7 NA

85. When building or putting something together, becomes very involved in what s/he is doing and works for long periods.

   1 2 3 4 5 6 7 NA

86. Likes to go high and fast when pushed on a swing.

   1 2 3 4 5 6 7 NA

87. Seems to feel depressed when unable to accomplish some task.

   1 2 3 4 5 6 7 NA

88. Is good at following instructions.

   1 2 3 4 5 6 7 NA

89. Takes a long time in approaching new situations.

   1 2 3 4 5 6 7 NA

90. Hardly ever complains when ill with a cold.

   1 2 3 4 5 6 7 NA

91. Likes the sound of words, such as nursery rhymes.

   1 2 3 4 5 6 7 NA

92. Is sometimes shy even around people s/he has known a long time.

   1 2 3 4 5 6 7 NA
### 3 YEARS – PART 2

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Extremely untrue</td>
<td>Quite untrue</td>
<td>Slightly untrue</td>
<td>Neither true nor untrue</td>
<td>Slightly true</td>
<td>Quite true</td>
<td>Extremely true</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**My child:**

93. Is very difficult to soothe when s/he has become upset.
   1   2   3   4   5   6   7   NA

94. Is quickly aware of some new item in the living room.
   1   2   3   4   5   6   7   NA

95. Is full of energy, even in the evening.
   1   2   3   4   5   6   7   NA

96. Is not afraid of the dark.
   1   2   3   4   5   6   7   NA

97. Sometimes becomes absorbed in a picture book and looks at it for a long time.
   1   2   3   4   5   6   7   NA

98. Likes rough and rowdy games.
   1   2   3   4   5   6   7   NA

99. Is not very upset at minor cuts or bruises.
   1   2   3   4   5   6   7   NA

100. Approaches places s/he has been told are dangerous slowly and cautiously.
    1   2   3   4   5   6   7   NA

101. Is slow and unhurried in deciding what to do next.
    1   2   3   4   5   6   7   NA

102. Gets angry when s/he can’t find something s/he wants to play with.
    1   2   3   4   5   6   7   NA

103. Enjoys gentle rhythmic activities such as rocking or swaying.
    1   2   3   4   5   6   7   NA
### 3 YEARS – PART 2

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Extremely untrue</td>
<td>Quite untrue</td>
<td>Slightly untrue</td>
<td>Neither true nor false</td>
<td>Slightly true</td>
<td>Quite true</td>
<td>Extremely true</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**My child:**

104. Sometimes turns away shyly from new acquaintances.
    1 2 3 4 5 6 7 NA

105. Becomes upset when loved relatives or friends are getting ready to leave following a visit.
    1 2 3 4 5 6 7 NA

106. Comments when a parent has changed his/her appearance.
    1 2 3 4 5 6 7 NA
3 YEARS – PART 2

107. Have you, your child’s father, or your other child/children (if applicable) experienced any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yourself</th>
<th>Father of Child</th>
<th>Other child/children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory Bowel Disease</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Autoimmune Disease</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
<tr>
<td>Depression (only since your child was born)</td>
<td>No</td>
<td>Yes</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

108. What is your annual household income?
- [ ] Less than $25,000
- [ ] $25,000 to $49,999
- [ ] $50,000 to $74,999
- [ ] $75,000 to $99,999
- [ ] $100,000 to $124,999
- [ ] $125,000 or more

109. What is the highest level of education that you have completed?
- [ ] Elementary school
- [ ] High school / secondary school
- [ ] College diploma
- [ ] Postsecondary apprenticeship or training certificate
- [ ] University undergraduate degree
- [ ] Graduate degree
- [ ] Postgraduate degree

110. If you were to join a similar study in the future, how would you like to be reminded to collect diaper samples?
- [ ] Email
- [ ] Telephone call
- [ ] Cell phone text message
- [ ] By my midwife, doctor or other care provider
- [ ] I wouldn’t like to be reminded
3 YEARS – PART 2

111. What did you find to be the most challenging throughout your participation in this study?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

112. What did you enjoy the most about participating in this study?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

113. Would you choose to participate in a similar study, if you were invited to do so in the future?
   □ No
   □ Yes
**VACCINATION RECORD**

| Vaccination Date | DTAP (Diphtheria, Tetanus, Pertussis) | IPV (Inactivated Polio Vaccine) | OPV (Oral Polio Vaccine) | Hib (Haemophilus influenzae Type b) | Rotavirus | Pneumococcal | Meningococcal | MMR (Mumps, Measles, Rubella) | Varicella | Influenza | Other #1 | Other #2 | Other #3 | Other #4 | Other #5 |
|------------------|--------------------------------------|---------------------------------|--------------------------|----------------------------------|----------|-------------|--------------|-------------------------------|-----------|---------|---------|---------|---------|---------|---------|---------|
| YYYY / MM / DD   | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ | __________ / __________ / __________ |