OptEC Trial: Optimizing early child development in the primary care practice setting: Pragmatic randomized trial of iron treatment for young children with non-anemic iron deficiency

Follow-up Data Collection Form – Data linking sheet
(To be stored separately from study data)

ID String # __________________________ Date __________________________
Age _____ (months) Child’s Sex: Male [ ] Female [ ]
Home Telephone # __________________ Work/cell Tel # __________________
Name of caregiver interviewed ____________________________________________
Relationship to child ____________________________________________
OptEC Trial: Optimizing early child development in the primary care practice setting:  
Pragmatic randomized trial of iron treatment for young children with  
non-anemic iron deficiency (NAID)

Follow-up Data Collection Form

1. How many days last week did your child receive the provided study drug (circle one)?
   0  1  2  3  4  5  6  7

2. Since starting this study, has your child taken any iron supplements regularly other than the ones provided for this study (fill in all that apply)?
   - No
   - Iron: Ferinsol _______ ml per ____________ (day, week, month, year)
   - Iron: Other _______ ml per ____________ (day, week, month, year)
   - Multivitamin with iron _______ ml per ____________ (day, week, month, year)

3. Since starting this study, has your child taken any other vitamins or supplements regularly (fill in all that apply)?
   - No
   - Vitamin D: Drops _______ ml per ____________ (day, week, month, year)
   - Vitamin D: Liquid _______ ml per ____________ (day, week, month, year)
   - Multivitamin (without iron) _______ ml per ____________ (day, week, month, year)
   - Other—Please explain___________________________________________________

4. How hard or easy has it been to give the provided study drug?
   Easy Hard
   0   1   2   3   4   5

5. Did your child like taking the study drug (circle one)?
   - Yes
   - No
   - Indifferent

6. In a typical week, how many days did your child receive the study drug (please circle)?
   0  1  2  3  4  5  6  7

7. If your child received the study drug 6 days/week or less, please state the reason (circle all that apply)?
   - Takes too long  Yes  No
   - Too messy  Yes  No
   - My child didn’t like it  Yes  No
• Not convinced that it will benefit my child  Yes  No
• Too hard to give it  Yes  No
• Forgot  Yes  No
• Other reason(s)  Yes  No

8. Did your child experience any of the following while administering the study drug (circle all that apply)?

• Coughing  Yes  No
• Spitting up  Yes  No
• Choking, gagging  Yes  No
• Unhappy with the taste  Yes  No

9. Did your child experience any of the following during the past 4 months (circle all that apply)?

• Staining of the teeth  Yes  No
• Constipation  Yes  No
• Loose stool  Yes  No
• Passage of black stool  Yes  No

10. Is your child currently breastfeeding (please circle)?

• Yes
• No — at what age did you stop breastfeeding? ________________ months
• Not applicable, did not breastfeed

11. Please specify your child’s diet for the past 3 days. Please check all that apply.

☐ Breast milk
☐ Infant formula
☐ Red meat (beef, veal, pork, lamb, etc.)
☐ Poultry (chicken, turkey, duck, etc.)
☐ Fish (salmon, halibut, haddock, cod, tuna, etc.)
☐ Shellfish (lobster, crab, shrimp, etc.)
☐ Eggs
☐ Milk ☐ Skim ☐ 1% ☐ 2% ☐ Homo
☐ Fruits
☐ Vegetables
☐ Cheese
☐ Yogurt
☐ Margarine
☐ Honey
☐ Whole grain products (bread, bagel, bun, cereal, pasta, rice, roti, tortillas, etc.)
☐ Fast Food
☐ Infant cereal
☐ Vegetarian: does not eat red meat, poultry, fish or shellfish
☐ Vegan: does not eat red meat, poultry, fish, shellfish, eggs, dairy or honey

12. Circle how many cups of each drink your child has currently in a typical day. (1 cup = 8 ounces = 250 ml)
Cow’s milk 0 ½ 1 2 3 4 5+
Infant formula 0 ½ 1 2 3 4 5+
Infant cereal 0 ¼ ½ ¾ 1 2 3 4 5+
Soy milk 0 ½ 1 2 3 4 5+
Other milk (rice, goat etc) 0 ½ 1 2 3 4 5+
100% Juice (apple, orange etc) 0 ½ 1 2 3 4 5+
Sweetened drinks (Kool aid, Sunny D, etc.) 0 ½ 1 2 3 4 5+
Tea 0 ½ 1 2 3 4 5+
Soda or Pop 0 ½ 1 2 3 4 5+

13. Did your child’s diet include the following foods during the last 4 months? Please check all that apply?

- Whole grain products (example – iron enriched breakfast cereals, enriched pasta and rice, beans such as chick peas, kidney beans, lentils and canned baked beans)
  
  _______ times per ____________ (day, week, month)

- Tofu
  
  _______ times per ____________ (day, week, month)

- Citrus fruits (example - oranges, grapefruit, lemon juice, tomatoes, cantaloupe, kiwi fruit)
  
  _______ times per ____________ (day, week, month)

- Citrus vegetables (example – spinach, cabbage, broccoli, Brussels sprouts, bell pepper, cauliflower)
  
  _______ times per ____________ (day, week, month)

14. Has your child been ill within the past 4 months?

- No

- Yes. (complete all that apply below)
  
  - Colds or flus, how many times? _____
  
  - Asthma attack, how many times? _____
  
  - Pneumonia, how many times? _____
  
  - Ear infection, how many times? _____
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<thead>
<tr>
<th>For office use only</th>
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<tr>
<td>Height: __________ cm</td>
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<tr>
<td>Weight: __________ kg</td>
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<tr>
<td>BMI: __________ kg/m²</td>
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<tr>
<td>Waist circumference: __________ cm</td>
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