



The Influence of genetic and environmental factors on childhood diseases

Postal questionnaire to assess asthma/allergy: Year 1

Thank you for agreeing to participate in our study one year ago. Please fill out this questionnaire and return it in the pre-paid envelope that has been supplied.

How to complete the questionnaire: Please tick the appropriate box

Example: Person completing questionnaire (tick box please):

Mother Father Other

Name of Child:

Bar Code Sticker

Date of Birth:

- Person completing questionnaire (tick box please):

Mother Father Other

- Date questionnaire completed: day ____ month ____ year ____
(please fill in today's date)

1. In the last year, has your child had an **ITCHY** skin condition - by *itchy* we mean scratching or rubbing the skin)?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

IF YOU HAVE ANSWERED 'NO' PLEASE SKIP TO QUESTION 2

IF YOU HAVE ANSWERED 'YES' PLEASE ANSWER THE QUESTIONS IN THE SHADED BOX BELOW:

1b. Was this ITCHY skin condition coming and going for at least six months?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

1c. Has your child had this ITCHY skin condition in the last week?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

1d. How old was your child when this skin condition began? months old

1e. Has this skin condition ever affected the skin creases in the past – by skin creases we mean fronts of elbows, behind the knees, front of ankles, around the neck or around the eyes?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

2. In the last year, has your child suffered from a dry skin in general?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

3. In the last year, has your child suffered from any of the following skin complaints: (PLEASE TICK ALL THAT APPLY).

Eczema	<input type="checkbox"/>
Facial spots	<input type="checkbox"/>
Nappy rash	<input type="checkbox"/>

4. In the last year, has your child ever had wheezing or whistling in the chest? By “wheezing” we mean breathing that makes a high-pitched whistling or squeaking sound from the chest, not the throat

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

IF YOU HAVE ANSWERED 'NO' PLEASE SKIP TO QUESTION 12

IF YOU HAVE ANSWERED 'YES' PLEASE ANSWER THE QUESTIONS IN THE SHADED BOX BELOW:

4a. How old was your child when he/she first began to months wheeze?

5. In the last year, has your child had wheezing or whistling in the chest during or soon after a cold or flu? Yes
No

6. How many attacks of wheezing has your child had during the last 12 months? None
1 to 3
4 to 12
More than 12

7. Do these attacks cause him/her to be short of breath? Yes, always
Most of the time
Occasionally
No, never

8. Which of these two descriptions fits best your child's wheeze? (TICK ONE ONLY)

My child has only short attacks of wheeze, for example with colds. In between these attacks, he/she does not normally wheeze

My child wheezes always or a lot of the time. With colds he/she has attacks with more severe wheeze

9. In the last year, how often, on average, has your child's sleep been disturbed due to wheezing? never woken with wheezing
less than one night per week
one or more nights per week

10. In the last year, did any of the following things cause wheezing in your child? Feeding; playing? Yes
No
Don't know

laughing, crying or excitement?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
Contact with pets or other animals?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
Food or drinks?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
11. Looking back on the last year, do you think that your child had asthma?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>

12. Does your child usually have a cough with colds?

Yes

No

13. Does your child have a cough even without having a cold?

Yes, always

Yes, sometimes

No, never

14. Do you think that your child coughs more than other children?

Yes

No

15. In the last year, has your child had a dry cough at night, apart from a cough associated with a cold or a chest infection?

Yes

No

16. In the last 12 months, did the following things cause coughing in your child?

	Yes	<input type="checkbox"/>
Feeding or playing?	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

	Yes	<input type="checkbox"/>
laughing, crying or excitement?	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

	Yes	<input type="checkbox"/>
contact with pets or other animals?	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

	Yes	<input type="checkbox"/>
food or drinks?	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

	Never	<input type="checkbox"/>
17. How often did your child see the GP for coughing or wheezing during the last 12 months?	Once	<input type="checkbox"/>
	2-3 times	<input type="checkbox"/>
	4-6 times	<input type="checkbox"/>
	7 or more times	<input type="checkbox"/>

18. In the last 12 months, has wheezing or asthma resulted in your child:

	Yes	<input type="checkbox"/>
being referred to a consultant in hospital	No	<input type="checkbox"/>

	Yes	<input type="checkbox"/>
being admitted to hospital	No	<input type="checkbox"/>

	Yes	<input type="checkbox"/>
attending the casualty (A and E) department	No	<input type="checkbox"/>

	Yes	<input type="checkbox"/>
attending (or calling) the GP in an emergency	No	<input type="checkbox"/>

19. Did your child take any of the following drugs during the last 12 months?

Salbutamol, Ventolin, Bricanyl or other blue inhaler

Yes
 No
 Don't know

Pulmicort, Flixotide, Becotide or other brown inhaler

Yes
 No
 Don't know

Steroid tablets (prednisolone) for asthma attacks

Yes
 No
 Don't know

20. In the last year, did your child suffer from rattly breathing (rattles)?

Never
 Only with a cold
 Sometimes even without a cold
 Almost always

21. In the last year, how many times has your child had a cold or flu?

Never
 1-3 times
 4-6 times
 7-10 times
 More than 10 times

22. How long does a cold usually last in your child?

Less than 1 week
 1 to 2 weeks
 2 to 4 weeks
 More than 4 weeks

23. In the past year, has your child had a problem with sneezing, or a runny, or blocked nose when he/she did NOT have a cold or the flu?

Yes
 No

24. In the past year, how much did this nose problem interfere with your child's feeding, playing and other activities?

	Not at all	<input type="checkbox"/>
	A little	<input type="checkbox"/>
	A moderate amount	<input type="checkbox"/>
	A lot	<input type="checkbox"/>

25. Over the past 12 months, has your child snored at night?

	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>

IF YOU HAVE ANSWERED 'NO' PLEASE SKIP TO QUESTION 26

IF YOU HAVE ANSWERED 'YES' PLEASE ANSWER THE QUESTIONS IN THE SHADED BOX BELOW:

25.a. If yes, has he/she snored:	Only with a cold	<input type="checkbox"/>
	Sometimes even without a cold	<input type="checkbox"/>
	Almost always	<input type="checkbox"/>
25.b Did the snoring disturb your child's sleep?	Not at all	<input type="checkbox"/>
	A little	<input type="checkbox"/>
	A moderate amount	<input type="checkbox"/>
	A lot	<input type="checkbox"/>

26. In the past 12 months, has your child had any ear infections?

	No, never	<input type="checkbox"/>
	Yes, once	<input type="checkbox"/>
	Yes, more than once	<input type="checkbox"/>

27. Has your child ever suffered from any of the following conditions?

pneumonia?	No, never	<input type="checkbox"/>
	Yes, once	<input type="checkbox"/>
	Yes, more than once	<input type="checkbox"/>

whooping cough? No, never
Yes, once
Yes, more than once

bronchiolitis? No, never
Yes, once
Yes, more than once

croup? No, never
Yes, once
Yes, more than once

28. Does your child attend day care, childminder, nursery school or play school? Yes
No

29. Was your child breastfed? Yes
No

If yes, how long: less than a month
1-3 months
4-6 months
more than 6 months

30. During the first year of life, did your child posit or vomit? Not at all
A little
A lot

31. Do you think your child has a reaction to any food items?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

IF YOU HAVE ANSWERED 'NO' PLEASE SKIP TO QUESTION 32

IF YOU HAVE ANSWERED 'YES' PLEASE ANSWER THE QUESTIONS IN THE SHADED BOX BELOW:

<p>31a. Does your child have a reaction to any of these foods? (PLEASE TICK ALL THAT APPLY)</p> <p>If you have ticked 'other', please describe the type of food that causes the reaction:.....</p>	<p>Peanuts <input type="checkbox"/></p> <p>Cows milk <input type="checkbox"/></p> <p>Egg <input type="checkbox"/></p> <p>Gluten (eg wheat, oats) <input type="checkbox"/></p> <p>Fruit <input type="checkbox"/></p> <p>Other (please describe) <input type="checkbox"/></p>
<p>31b. What type of reaction does the food cause? (PLEASE TICK ALL THAT APPLY)</p> <p>If you have ticked 'other', please describe the type of reaction:.....</p>	<p>Breathing problems <input type="checkbox"/></p> <p>Vomit <input type="checkbox"/></p> <p>Diarrhea <input type="checkbox"/></p> <p>Stomach pain <input type="checkbox"/></p> <p>Rashes <input type="checkbox"/></p> <p>Irritability <input type="checkbox"/></p> <p>Other (please describe) <input type="checkbox"/></p>
<p>31c. Has your child been treated by a doctor for allergies to any of these foods? (PLEASE TICK ALL THAT APPLY)</p> <p>If you have ticked 'other', please describe the type of food allergy that has been treated:.....</p>	<p>Peanuts <input type="checkbox"/></p> <p>Cows milk <input type="checkbox"/></p> <p>Egg <input type="checkbox"/></p> <p>Gluten (eg wheat, oats) <input type="checkbox"/></p> <p>Fruit <input type="checkbox"/></p> <p>Other (please describe) <input type="checkbox"/></p>

32. Does your child have brothers and sisters who have the same mother and father as him/her? Yes
No

If yes, how many? (please fill in number)

If yes, how many have: -

Asthma or wheezing? (please fill in number)

Hay fever? (please fill in number)

Eczema? (please fill in number)

33. How many children under 16 live in your household?
(PLEASE FILL IN NUMBER)

34. How many adults over 16 usually live in your household?
(PLEASE FILL IN NUMBER)

35. How many rooms are there in your house, not counting kitchens, bathrooms and toilets? (PLEASE FILL IN NUMBER)

36. At what age did the child's mother finish full-time education? (PLEASE FILL IN AGE)

37. Which fuel is mainly used for cooking in your home? Electricity
Gas
Other fuel

38. How do you heat your home?
(PLEASE TICK AS MANY AS APPLY)

- Electric central heating
- Gas central heating
- Central heating with other fuel, e.g. oil
- Heaters in rooms
- Coal or wood fire

39. Is there visible damp within the house ?

- Yes
- No

If there is visible damp, which rooms is it in?
(PLEASE TICK ALL THAT APPLY)

- Kitchen
- Bathroom
- Child's bedroom
- Other living areas

40. What type of flooring does your child have in his/her bedroom?

- Carpet
- Laminate
- Laminate with rug
- Other hard flooring
- Other

41. Is your child exposed to animals?
(By exposed we mean do they come into close contact with any animals on a regular basis)

- Yes
- No

If yes, which of the following animals?
(PLEASE TICK ALL THAT APPLY)

If your child is exposed to other animals that are not on the list, please write which kind of animals in the space below:

.....

Cat	<input type="checkbox"/>
Dog	<input type="checkbox"/>
Bird	<input type="checkbox"/>
Fish	<input type="checkbox"/>
Rat	<input type="checkbox"/>
Gerbil	<input type="checkbox"/>
Rabbit	<input type="checkbox"/>
Hamster	<input type="checkbox"/>
Guinea pig	<input type="checkbox"/>
Sheep	<input type="checkbox"/>
Pigs	<input type="checkbox"/>
Cows	<input type="checkbox"/>
Horses	<input type="checkbox"/>

42. Does the child's mother smoke cigarettes?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If yes, how many per day?

1 to 10	<input type="checkbox"/>
11 to 20	<input type="checkbox"/>
More than 20	<input type="checkbox"/>

43. Do any other household members smoke cigarettes?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If yes, how many per day (total cigarettes smoked by household members other than mother)?

1 to 10	<input type="checkbox"/>
11 to 20	<input type="checkbox"/>
More than 20	<input type="checkbox"/>

44. How would you best describe the location of your house? (PLEASE TICK THE ONE THAT BEST APPLIES)

In a street with very dense traffic (main road)
In a street with moderate traffic (residential road)
In a quiet street with little or no traffic

45. Did you have any problems understanding this questionnaire?

Yes
No

Please write any comments you have about your child's health or about the questionnaire in the space below:

.....
.....
.....
.....
.....

Thank you for completing the questionnaire. It will cost you nothing to return it if you use the pre-paid envelope provided.

For any queries please do not hesitate to contact us:

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