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)

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1. In the last year, has your child had an **ITCHY** skin condition - by *itchy* we mean scratching or rubbing the skin)? Yes ☐ No ☐

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 ☐ No ☐

1c. Has your child had this ITCHY skin condition in the last week? Yes ☐ No ☐

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 ☐ No ☐

2. In the last year, has your child suffered from a dry skin in general? Yes ☐ No ☐

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

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 ☐ No ☐

IF YOU HAVE ANSWERED 'NO' PLEASE SKIP TO QUESTION 12
IF YOU HAVE ANSWERED 'YES' PLEASE ANSWER THE QUESTIONS IN THE SHADED BOX BELOW:

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

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 ☐
- No ☐
- Don't know ☐

Contact with pets or other animals?
- Yes ☐
- No ☐
- Don't know ☐

Food or drinks?
- Yes ☐
- No ☐
- Don't know ☐

11. Looking back on the last year, do you think that your child had asthma?
- Yes ☐
- No ☐

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 12months, did the following things cause coughing in your child?

Feeding or playing?	Yes ☐ No ☐ Don't know ☐
laughing, crying or excitement?	Yes ☐ No ☐ Don't know ☐
contact with pets or other animals?	Yes ☐ No ☐ Don't know ☐
food or drinks?	Yes ☐ No ☐ Don't know ☐

17. How often did your child see the GP for coughing or wheezing during the last 12 months?

Never ☐
Once ☐
2-3 times ☐
4-6 times ☐
7 or more times ☐

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

being referred to a consultant in hospital	Yes ☐ No ☐
being admitted to hospital	Yes ☐ No ☐
attending the casualty (A and E) department	Yes ☐ No ☐
attending (or calling) the GP in an emergency	Yes ☐ No ☐

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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 ☐
- A little ☐
- A moderate amount ☐
- A lot ☐

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

- Yes ☐
- No ☐

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 ☐
- Sometimes even without a cold ☐
- Almost always ☐

25.b Did the snoring disturb your child's sleep?

- Not at all ☐
- A little ☐
- A moderate amount ☐
- A lot ☐

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

- No, never ☐
- Yes, once ☐
- Yes, more than once ☐

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

pneumonia?

- No, never ☐
- Yes, once ☐
- Yes, more than once ☐

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 ☐
No ☐

IF YOU HAVE ANSWERED 'NO' PLEASE SKIP TO QUESTION 32
IF YOU HAVE ANSWERED 'YES' PLEASE ANSWER THE QUESTIONS IN THE SHADED BOX BELOW:

31a. Does your child have a reaction to any of these foods? (PLEASE TICK ALL THAT APPLY)

If you have ticked 'other', please describe the type of food that causes the reaction:……..
……

- Peanuts ☐
- Cows milk ☐
- Egg ☐
- Gluten (eg wheat, oats) ☐
- Fruit ☐
- Other (please describe) ☐

31b. What type of reaction does the food cause? (PLEASE TICK ALL THAT APPLY)

If you have ticked 'other', please describe the type of reaction:……
……

- Breathing problems ☐
- Vomit ☐
- Diarrhea ☐
- Stomach pain ☐
- Rashes ☐
- Irritability ☐
- Other (please describe) ☐

31c.Has your child been treated by a doctor for allergies to any of these foods? (PLEASE TICK ALL THAT APPLY)

If you have ticked 'other', please describe the type of food allergy that has been treated:……..
……

- Peanuts ☐
- Cows milk ☐
- Egg ☐
- Gluten (eg wheat, oats) ☐
- Fruit ☐
- Other (please describe) ☐

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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 ☐

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

- Cat ☐
- Dog ☐
- Bird ☐
- Fish ☐
- Rat ☐
- Gerbil ☐
- Rabbit ☐
- Hamster ☐
- Guinea pig ☐
- Sheep ☐
- Pigs ☐
- Cows ☐
- Horses ☐

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

……..

42. Does the child's mother smoke cigarettes?

- Yes ☐
- No ☐

If yes, how many per day?

- 1 to 10 ☐
- 11 to 20 ☐
- More than 20 ☐

43. Do any other household members smoke cigarettes?

- Yes ☐
- No ☐

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

- 1 to 10 ☐
- 11 to 20 ☐
- More than 20 ☐

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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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