PREGNANCY, HEREDITY, AND ENVIRONMENT

✉
SAM-prosjektet
Medisinsk fødselsregister
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Welcome to this nation wide research project on newborns and their parents.

This project is being conducted jointly with the Medical Birth Registration center in Norway and the National Institute of Environmental Health Sciences in the United States (an American institute for environment and health).

Is the name and address on the address form correct?

Cross off: ☐ **Yes** ☐ **No**

If you answered no, use the space below for corrections:

Name:

Address:

Postnr/adr:

- Your information is confidential
- We are going to remove this page with your name and store it separately from the rest of the questionnaire, henceforth, the information will not be able to be traced back to you.

Introduction:

The purpose of this questionnaire is to learn more about what can cause birth defects. The questions are related to you, your newborn child, and the child's father. In most instances, it shouldn't take more than 45 to 60 minutes to fill out the form.

In some questions we ask you to remember the first three months of your pregnancy, the earliest developmental period for your child. We will refer to this time as months **1 - 2 - 3**.

Instructions:

You answer the questions by putting a cross in a box. For some of the questions you will continue with the next one or jump to another one. You will get help from arrows and messages concerning "skip to". By other questions there is open space to write the answer.

Please answer all the questions unless you are instructed to skip.
Example:

93. Did you undergo other operations or medical treatment wherein you received anesthetics during months 1 - 2 - 3? (not including dental work)

1 ☐ Yes
2 ☐ No → Skip to question 95

94. Which months did you receive this anesthetization? (answer for each month)

Month 1 1 ☐ Yes
2 ☐ No
Month 2 1 ☐ Yes
2 ☐ No
Month 3 1 ☐ Yes
2 ☐ No

- **Since the answer to question 93 is "Yes", there needs to be an answer for each month in question 94.**
- **If the answer to question 93 had been "No", question 94 would have been left blank.**

If you don't know what you should answer or if the question doesn't concern your situation, you are welcome to write comments about the question. Please do not write in the left or middle margin because they are to be used for the coding of the answers. If you need more room, you can use the back side of the cover for your comments.
Use the enclosed pen or any black ink pen.

Call our project office number 55 97 4707/09 if you have questions!

The office hours are 9 am - 3 pm, Monday through Friday. You can call at any time and leave a message on the answering machine. We will call you back to save you the telephone charges.

YOU AND THE CHILD'S FATHER

1. When were you born?

day mo yr

2. When was your mother born?

Yr: 19

3. When was your father born?

Yr: 19

4. What is your current marital status?

1 ☐ Married
2 ☐ Live - in (with a boyfriend)
3 ☐ Single
4 ☐ Separated/Divorced
5 ☐ Widowed

5. What type of education have you completed?

1 ☐ Elementary/Junior High School
2 ☐ High School
3 ☐ Technical College (Vocational School)
4 ☐ 2 - 4 College (Technical School, Nursing School, District [community] College)
5 ☐ University (including: Technical College of Norway, Norwegian Business School)
6 ☐ Other:
Describe: _____

6. Were you born in Norway?

1 ☐ Yes → Skip to question 9
2 ☐ No

7. What country were you born in?

_____

8. What year did you move to Norway?

Yr:

9. When was the child's father born?

day mo yr

10. When was the child's paternal grandmother born?

Yr: 19

11. When was the child's paternal grandfather born?

Yr: 19

12. What type of education has the child's father completed?

1 ☐ Elementary/Junior High School
2 ☐ High School
3 ☐ Technical College (Vocational School)
4 ☐ 2 - 4 College (Technical School, Nursing School, District [community] College)
5 ☐ University (including: Technical College of Norway, Norwegian Business School)
6 ☐ Other:
Describe:_____

13. Was he born in Norway?

1 ☐ Yes → Skip to question 16
2 ☐ No

14. What country was he born in?

_____

15. When did he move to Norway?

Yr: ____

16. Are you and the child's father related?

1 ☐ Yes
2 ☐ No → Skip to question 18

17. If so, how are you related?

_____

18. How long have you lived in your current residence? If it is less than one year, give the number of months.

# of years ____ # of months: ____

19. About what year was your residence built?

Year: ____

20. Do you go on vacation to a cottage or summer place?

1 ☐ Yes
2 ☐ No

21. Have you or the child's father stayed in a foreign country in the past year?

1 ☐ Yes
2 ☐ No

22. What is <u>your</u> current gross yearly income?

01 ☐ No income
02 ☐ Less than 150.000 kr
03 ☐ 151 - 200.000 kr
04 ☐ 201 - 250.000 kr
05 ☐ 251 - 300.000 kr
06 ☐ 301 - 400.000 kr
07 ☐ More than 401.000 kr

23. What is your <u>husband's/live in's</u> current gross yearly income?

01 ☐ No income
02 ☐ Less than 150.000 kr
03 ☐ 151 - 200.000 kr
04 ☐ 201 - 250.000 kr
05 ☐ 251 - 300.000 kr
06 ☐ 301 - 400.000 kr
07 ☐ More than 401.000 kr

24. How many people are fully supported by these incomes?

Number: ____

YOUR HEALTH AND REPRODUCTIVE HISTORY

25. How old were you when you had your first period?

Age: ____

26. How many days do you normally bleed during your period?
(Do count days with spotting. Do not include the times when you used birth control pills)

Number of days: ____

27. How long does your menstrual cycle last?
(*Count how many days there are from the beginning of one period to the beginning of the next. Do not include times when you were using birth control pills)*

Number of days: ____
<u>Describe</u> if the irregularities are too large to estimate the number of days:

_____

28. Approximately how many times per year do you have your period?

Number of times: ____

29. Have you, in any twelve-month period, had regular intercourse without protection and not gotten pregnant?

1 ☐ Yes
2 ☐ No

30. Have you ever visited the doctor because you had difficulties getting pregnant?

1 ☐ Yes
2 ☐ No → Skip to question 34

31. During what year was the first time you visited the doctor for this?

Year: ⌊_⌊_⌊_⌊_⌋

32. Did you receive any medical treatment or medication to help you get pregnant with your newborn child?

1 ☐ Yes
2 ☐ No → Skip to question 34

33. If treatment:
What type of treatment did you receive to help you get pregnant?

_____

_____

_____

If medication(s):
What medication(s) did you use to help you get pregnant?

_____

_____

_____

34. When was your child born?

Date: ⌊_⌊_⌋ ⌊_⌊_⌋ ⌊_⌊_⌊_⌊_⌋
day mo yr

35. Was your baby born on time?

1 ☐ Yes → Skip to question 36
2 ☐ No

If early:
How many days early? ⌊_⌊_⌋ days

If late:
How many days late? ⌊_⌊_⌋ days

36. Were you pregnant with one child or several children during this pregnancy?

1 ☐ one child
2 ☐ twins
3 ☐ triplets
4 ☐ quadruplets

More than one child: *Turn to page 30 question 198 and give details on the page with the heading "Multiple births". Then return to question 40 on the next page*

37. What sex is the new child?

1 ☐ Boy
2 ☐ Girl

38. Was the child born with deformities?

1 ☐ Yes
2 ☐ No

39. If yes, describe the child's deformities.

_____

_____

_____

40. Are you pregnant again now?

1 ☐ Yes
2 ☐ No

41. How many times in total have you been pregnant?
(*Count all of your pregnancies, including those which ended in an abortion. If you are pregnant again now, do not include this pregnancy in the count).*

Total number of pregnancies: ⌊__⌋⌊__⌋
If you have only been pregnant one time, skip to page 9 question 64.

42. Have you given birth to live-born children before you became pregnant with your newborn child?

1 ☐ Yes
2 ☐ No → Skip to question 52

43. How many liveborn children have you given birth to before you became pregnant with your newborn child?

Number: ⌊__⌋⌊__⌋

Fill out for each live-born child. ***If you have had more than 3 live-born children, continue to page 31. Do not include your new child.***

	First child	Second child	Third child
44. When was the child born?	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ day mo yr	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ day mo yr	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ day mo yr
45. Was the child a single birth, twin, or triplet?	1 ☐ single birth 2 ☐ twins 3 ☐ triplets	1 ☐ single birth 2 ☐ twins 3 ☐ triplets	1 ☐ single birth 2 ☐ twins 3 ☐ triplets
46. Did you breastfeed this child?	1 ☐ Yes 2 ☐ No → Skip to Q48	1 ☐ Yes 2 ☐ No → Skip to Q48	1 ☐ Yes 2 ☐ No → Skip to Q48
47. When did you stop breast-feeding this child <u>at least once a day</u>?	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ mo yr	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ mo yr	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ mo yr
48. Was the father to the new child also father to this child?	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know
49. Does this child live with you?	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
50. Was the child born with deformities?	1 ☐ Yes 2 ☐ No If "Yes" describe:	1 ☐ Yes 2 ☐ No If "Yes" describe:	1 ☐ Yes 2 ☐ No If "Yes" describe:
51. Is this child still living?	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

52. Have you ever had a miscarriage or given birth to a stillborn child? (Do not include provoked or elective abortions or tubal pregnancies)

1 ☐ Yes
2 ☐ No → Skip to question 58

53. How many miscarriages or stillbirths have you had?

Total number : ⌊__⌋

Fill out for each of the miscarriages/stillbirths. ***If you have had more than three, just include the first three.***

	First	Second	Third
54. What month/year did the miscarriage/stillbirth occur?	⌊__⌋ ⌊____⌋ mo yr	⌊__⌋ ⌊____⌋ mo yr	⌊__⌋ ⌊____⌋ mo yr
55. How many weeks did this pregnancy last?	Number of weeks: ⌊__⌋	Number of weeks: ⌊__⌋	Number of weeks: ⌊__⌋
56. Did the child you lost have any deformities?	1 ☐ Yes 2 ☐ No 8 ☐ Don't know If "Yes", describe:	1 ☐ Yes 2 ☐ No 8 ☐ Don't know If "Yes", describe:	1 ☐ Yes 2 ☐ No 8 ☐ Don't know If "Yes", describe:
57. Was the father of the new child also the father of the child in this case?	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know

58. Have you ever had an induced (provoked) abortion?
(Do not include tubal pregnancies)

1 ☐ Yes
2 ☐ No

If "Yes":
How many induced (provoked) abortions?

Number: ⌊__⌋⌊__⌋

59. Have you ever had a tubal pregnancy?

1 ☐ Yes
2 ☐ No

If "Yes":
How many tubal pregnancies?

Number: ⌊__⌋⌊__⌋

Fill out for each induced (provoked) abortion and tubal pregnancy. Only include the first three.

	First	Second	Third
60. What month/year did the pregnancy end?	⌊__⌋⌊__⌋ mo ⌊__⌋⌊__⌋⌊__⌋⌊__⌋ yr	⌊__⌋⌊__⌋ mo ⌊__⌋⌊__⌋⌊__⌋⌊__⌋ yr	⌊__⌋⌊__⌋ mo ⌊__⌋⌊__⌋⌊__⌋⌊__⌋ yr
61. How many weeks did the pregnancy last?	Number of weeks: ⌊__⌋⌊__⌋	Number of weeks: ⌊__⌋⌊__⌋	Number of weeks: ⌊__⌋⌊__⌋
62. Was the father of the new child also the father of this child?	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know
63. Did the fetus have any deformities?	1 ☐ Yes 2 ☐ No 8 ☐ Don't know If "Yes", describe:	1 ☐ Yes 2 ☐ No 8 ☐ Don't know If "Yes", describe:	1 ☐ Yes 2 ☐ No 8 ☐ Don't know If "Yes", describe:

PREVENTION

64. Have you ever used any of the following methods to prevent pregnancy?

	Yes	No	
	1 ☐	2 ☐	condoms
	1 ☐	2 ☐	long intervals without intercourse
	1 ☐	2 ☐	IUD
	1 ☐	2 ☐	coitus interruptus
	1 ☐	2 ☐	birth control pills
	1 ☐	2 ☐	intercourse only during "safe periods"
	1 ☐	2 ☐	shots
	1 ☐	2 ☐	female sterilization
	1 ☐	2 ☐	male sterilization
	1 ☐	2 ☐	diaphragm
	1 ☐	2 ☐	spermicide
	1 ☐	2 ☐	contraceptive sponge
	1 ☐	2 ☐	any other methods of birth control?

Describe:

_____

_____

1 ☐ Never used any method → Skip to question 68

65. Which of the above method(s) you have already marked did you use at the very end before you became pregnant with your newborn child?

Last method(s) to prevent pregnancy:

_____

_____

_____

66. Did you stop using this method before you became pregnant with your new baby?

1 ☐ Yes

2 ☐ No

We are interested in finding out when you stopped using this method, even if you were still using it when you became pregnant.

67. When did you stop using this method? (Try to estimate month and year the best you can)

mo ____ yr ____

68. Were you planning to get pregnant?

1 ☐ Yes

2 ☐ No → Skip to question 70

69. For how many months were you trying to get pregnant?

1 ☐ Less than 2 months

2 ☐ 2 months

3 ☐ 3 months

4 ☐ more than 3 months

Number, if more than 3 months. ____

70. Did you use birth control pills (regardless of the reason) during the course of the last three months before you became pregnant with your newborn child?

1 ☐ Yes

2 ☐ No

71. When did you realize that you were pregnant?

1 ☐ Before the next period

2 ☐ When the next period should have come

3 ☐ After the next period should have come

Number of days after ____

72. How many weeks pregnant were you when you went to your first pregnancy counseling?

Number of weeks: ____

73. How much did you weigh before you were pregnant?

Number of kilos: ____

74. How tall are you?

cm: ____

MONTHS 1 - 2 - 3

We will ask you questions about the first three calendar months you were pregnant. The next questions will help you to decide which calendar months these were (for example Feb/Mar/April)

75. Which month did your last period before pregnancy begin?

01 ☐	january	05 ☐	may	09 ☐	september
02 ☐	february	06 ☐	june	10 ☐	october
03 ☐	march	07 ☐	july	11 ☐	november
04 ☐	april	08 ☐	august	12 ☐	december

Year: ☐☐☐☐

76. How sure are you about this month?

1 ☐ Positive
2 ☐ Quite sure
3 ☐ Not so sure

77. Did you have the majority of bleeding in this month or the next month?

1 ☐ this month
2 ☐ the next month

We are counting that month you had the majority of the bleeding as the pregnancy's first month. Write down this and the 2 following months. Do this as well as you can even if you are unsure. We are calling these months 1 - 2 - 3.

1. Month with most bleeding: _____
2. Month after: _____
3. Month after: _____

REMEMBER!
Use the three months you have written above when you answer the questions regarding months 1 - 2 - 3 in your pregnancy.

YOUR HEALTH IN MONTHS 1 - 2 - 3 (THE START OFYOUR PREGNANCY)

78. Did you experience nausea, either with or without vomiting, during the course of months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 82

79. Which of these months did you have nausea? (answer for each month)

Month 1 — 1 ☐ Yes 2 ☐ No
Month 2 — 1 ☐ Yes 2 ☐ No
Month 3 — 1 ☐ Yes 2 ☐ No

80. Which of these months did you have nausea <u>with</u> vomiting? (answer for each month)

Month 1 — 1 ☐ Yes 2 ☐ No
Month 2 — 1 ☐ Yes 2 ☐ No
Month 3 — 1 ☐ Yes 2 ☐ No

81. Did you take prescribed or over-the-counter medicines for this nausea during months 1 - 2 - 3? (answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes _____
2 ☐ No

Month 2
1 ☐ Yes _____
2 ☐ No

Month 3
1 ☐ Yes _____
2 ☐ No

82. Did you ever have a fever during the course of months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 87

83. What was the cause of the fever?
(state if possible what kind of infection)

_____

_____

_____

_____

84. All together, how many days did you have a fever during months 1 - 2 - 3?

Number of days: ☐☐

85. Which months did you have a fever?
(answer for each month)

Month 1 1 ☐ Yes
2 ☐ No

Month 2 1 ☐ Yes
2 ☐ No

Month 3 1 ☐ Yes
2 ☐ No

86. Did you take any medications to lower the fever during months 1 - 2 - 3? (with or without prescription)

If "Yes", state the medication:

Month 1

1 ☐ Yes_____
2 ☐ No

Month 2

1 ☐ Yes_____
2 ☐ No

Month 3

1 ☐ Yes_____
2 ☐ No

87. Did you have any other infections which did <u>not</u> give you a fever during months 1 - 2 - 3? (for example, colds, sinus infection, urinary tract infection, or others)

1 ☐ Yes
2 ☐ No → Skip to question 89

State the illness or infection:

_____

_____

_____

_____

88. Did you take any medications for these problems during months 1 - 2 - 3? (both prescription and over-the-counter)
(answer for each month)

If "Yes", state the medication

Month 1

1 ☐ Yes _____
2 ☐ No

Month 2

1 ☐ Yes _____
2 ☐ No

Month 3

1 ☐ Yes _____
2 ☐ No

89. Did you get any new amalgam fillings in your teeth during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 91

90. Which month did you get the new fillings?
(answer for each month)

Month 1 1 ☐ Yes
2 ☐ No

Month 2 1 ☐ Yes
2 ☐ No

Month 3 1 ☐ Yes
2 ☐ No

91. Did you get laughing gas or full narcotics in connection with dental treatment during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 93

92. Which months did you receive laughing gas or full narcotics during dental work? (answer for each month)

Month 1 1 ☐ Yes
2 ☐ No
Month 2 1 ☐ Yes
2 ☐ No
Month 3 1 ☐ Yes
2 ☐ No

93. Did you undergo other operations or medical treatment wherein you received anesthetics during months 1 - 2 - 3? (not including dental work)

1 ☐ Yes
2 ☐ No → Skip to question 95

94. Which months did you receive this anesthetization? (answer for each month)

Month 1 1 ☐ Yes
2 ☐ No
Month 2 1 ☐ Yes
2 ☐ No
Month 3 1 ☐ Yes
2 ☐ No

95. Did you take sleeping pills during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 97

96. Which months did you take sleeping pills? (answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes _____
2 ☐ No

Month 2
1 ☐ Yes _____
2 ☐ No

Month 3
1 ☐ Yes _____
2 ☐ No

97. Did you take sedatives during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 99

98. Which months did you take sedatives? (answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes _____
2 ☐ No

Month 2
1 ☐ Yes _____
2 ☐ No

Month 3
1 ☐ Yes _____
2 ☐ No

99. Did you have pain during months 1 - 2 - 3? (for example, headaches or toothaches) (answer for each month)

Month 1
1 ☐ Yes
2 ☐ No

Month 2
1 ☐ Yes
2 ☐ No

Month 3
1 ☐ Yes
2 ☐ No

100. Did you take pain relieving medication during months 1 - 2 - 3? (for example, Paracet, Paralgin Forte) (answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes_____
2 ☐ No

Month 2
1 ☐ Yes_____
2 ☐ No

Month 3
1 ☐ Yes_____
2 ☐ No

101. Did you have problems with pimples or other skin problems during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 103

102. Did you use medications against pimples or blemishes during months 1 - 2 - 3? (pills or creams, prescription or over-the-counter) (answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes _____
2 ☐ No

Month 2
1 ☐ Yes _____
2 ☐ No

Month 3
1 ☐ Yes _____
2 ☐ No

103. Do you have sugar sickness, diabetes? (do not include gestational diabetes)

1 ☐ Yes
2 ☐ No → Skip to question 106

104. Which type of diabetes do you have?

1 ☐ Insulin dependent
2 ☐ Not insulin dependent

105. Did you take any medications for diabetes during months 1 - 2 - 3?
(answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes _____
2 ☐ No

Month 2
1 ☐ Yes _____
2 ☐ No

Month 3
1 ☐ Yes _____
2 ☐ No

106. Do you have epilepsy or do you get other types of fits?

1 ☐ Yes
2 ☐ No → Skip to question 109

107. Describe the type of epilepsy or fits:

108. Did you take medications for epilepsy or other types of fits during months 1 - 2 - 3?
(answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes_____
2 ☐ No

Month 2
1 ☐ Yes_____
2 ☐ No

Month 3
1 ☐ Yes_____
2 ☐ No

109. Do you have chronic medical conditions or handicaps which are not included in the previous questions?

1 ☐ Yes
2 ☐ No → Skip to question 112

110. Describe these chronic medical conditions or handicaps:

111. Did you take medications for these problems during months 1 - 2 - 3? (prescription or over-the-counter) (answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes _____
2 ☐ No

Month 2
1 ☐ Yes _____
2 ☐ No

Month 3
1 ☐ Yes _____
2 ☐ No

YOUR HEALTH DURING MONTHS 1 - 2 - 3 - 4 - 5 - 6

112. Did you get any type of seizure or convulsion with or without spasms during months 1 - 2 - 3 - 4 - 5 - 6?

1 ☐ Yes
2 ☐ No → Skip to question 115

113. Which months did you have seizures like these?
(answer for each month)

Month 1 — 1 ☐ Yes 2 ☐ No
Month 2 — 1 ☐ Yes 2 ☐ No
Month 3 — 1 ☐ Yes 2 ☐ No
Month 4 — 1 ☐ Yes 2 ☐ No
Month 5 — 1 ☐ Yes 2 ☐ No
Month 6 — 1 ☐ Yes 2 ☐ No

114. Did you take medications because of these seizures or to prevent these seizures?
(answer for each month)

If "Yes", state the medication:

Month 1
1 ☐ Yes_____
2 ☐ No

Month 2
1 ☐ Yes_____
2 ☐ No

Month 3
1 ☐ Yes_____
2 ☐ No

Month 4
1 ☐ Yes_____
2 ☐ No

Month 5
1 ☐ Yes_____
2 ☐ No

Month 6
1 ☐ Yes_____
2 ☐ No

115. During months 1 - 2 - 3 - 4 - 5 - 6 did you ever receive notice that there was danger that you could lose the child?
(answer for each month)

Month 1 1 ☐ Yes 2 ☐ No
Month 2 1 ☐ Yes 2 ☐ No
Month 3 1 ☐ Yes 2 ☐ No
Month 4 1 ☐ Yes 2 ☐ No
Month 5 1 ☐ Yes 2 ☐ No
Month 6 1 ☐ Yes 2 ☐ No

116. Did you have signs of vaginal bleeding during months 1 - 2 - 3 - 4 - 5 - 6?

1 ☐ Yes
2 ☐ No → Skip to question 118

117. State which months you bled or had spotting.
(answer for each month)

Month 1 1 ☐ Yes 2 ☐ No
Month 2 1 ☐ Yes 2 ☐ No
Month 3 1 ☐ Yes 2 ☐ No
Month 4 1 ☐ Yes 2 ☐ No
Month 5 1 ☐ Yes 2 ☐ No
Month 6 1 ☐ Yes 2 ☐ No

118. Did you have abdominal (gynecological) pain?

1 ☐ Yes
2 ☐ No → Skip to question 120

119. State the months you had pains.
(answer for each month)

Month 1 1 ☐ Yes 2 ☐ No
Month 2 1 ☐ Yes 2 ☐ No
Month 3 1 ☐ Yes 2 ☐ No
Month 4 1 ☐ Yes 2 ☐ No
Month 5 1 ☐ Yes 2 ☐ No
Month 6 1 ☐ Yes 2 ☐ No

CONSUMPTION OF MEDICATIONS DURING MONTHS 1 - 2 - 3 IS OF ESPECIALLY LARGE IMPORTANCE FOR THIS INVESTIGATION

Try to remember whether you took other medicines (like for example antibiotics, steroids and common medications such as pain relievers (aspirin), remedies for heartburn, cough syrup, laxatives or any other medications).

Do not include vitamins or dietary supplements. They will be covered later.

120. Did you take medications during months 1 - 2 - 3 which you have not gotten the chance to state earlier in the questionnaire?
(answer for each month)

If "Yes", state the medication:

Month 1

1 ☐ Yes _____

_____

_____

2 ☐ No

Month 2

1 ☐ Yes _____

_____

_____

2 ☐ No

Month 3

1 ☐ Yes _____

_____

_____

2 ☐ No

121. Why did you take these medications?

Month 1

_____

_____

Month 2

_____

_____

Month 3

_____

_____

122. Did you receive any other medical treatments (for example, X-rays) during months 1 - 2 - 3 which you have not gotten the chance to state earlier in the questionnaire?
(answer for each month)

If "Yes", state the treatment:

Month 1

1 ☐ Yes _____

_____

_____

2 ☐ No

Month 2

1 ☐ Yes _____

_____

_____

2 ☐ No

Month 3

1 ☐ Yes _____

_____

_____

2 ☐ No

123. Why did you have these treatments?

Month 1

_____

_____

Month 2

_____

_____

Month 3

_____

_____

NB!
Remember to use the 3 months you have put down in question 77 when you answer the questions regarding months 1 - 2 - 3 in your pregnancy.

WORK AND LIVING CONDITIONS IN MONTHS 1 - 2 - 3

124. Did you have income-earning employment during any part of months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

125. Which one best describes your employment situation during months 1 - 2 - 3?

01 ☐ Full-time employee
02 ☐ Part-time employee
03 ☐ Self-employed
04 ☐ Student and employed full- or part-time
05 ☐ Full-time student → Skip to 129
06 ☐ Unemployed/ at home without pay → Skip to 129
07 ☐ Other (explain):

_____

126. What type of business/industry/trade did you work in during months 1 - 2 - 3?

_____

127. What job title did you have when you became pregnant?

_____

128. Briefly describe your daily work tasks in months 1 - 2 - 3.

_____

_____

129. Did your employment (situation, location or type of work) change during the course of months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 131

130. In which month did this change occur?

1 ☐ month 1
2 ☐ month 2
3 ☐ month 3

Describe the change(s):

_____

_____

New title: _____

New work tasks:_____

_____

131. Did the child's father have income-earning employment during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

132. What best describes his employment situation during months 1 - 2 - 3?

01 ☐ Full-time employee
02 ☐ Part-time employee
03 ☐ Self-employed
04 ☐ Student and employed full- or part-time
05 ☐ Full-time student → Skip to 136
06 ☐ Unemployed/ at home without pay → Skip to 136
07 ☐ Other (explain):

_____

133. What type of business/industry/trade did he work in during months 1 - 2 - 3?

_____

134. What job title did he have during months 1 - 2 - 3?

_____

135. Briefly describe his daily work tasks in months 1 - 2 - 3.

_____

_____

CHEMICALS AND SUCH DURING MONTHS 1 - 2 - 3

The next 4 pages focus on contact with chemical materials, metals, x-rays, and others during months 1 - 2 - 3.

136. **Have you been in contact with.....** (If "Yes", continue with the questions to the right, 137-142)		**137.** **Where?** →	**138.** **In total, how many days did you work with, or in close contact with this?** →
A. lead vapor, lead dust, lead particles, or lead alloys?	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
B. chromium, arsenic, cadmium, or composition compounds?	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
C. gasoline or exhaust? (does not include filling of gasoline for personal use)	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	⌊__⌋⌊__⌋
D. mercury steam, mercury, or work with (amalgam) fillings?	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
E. pesticides? **Which?** _____	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
F. herbicides? **Which?** _____	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
G. oil-based paint?	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
H. water-based or latex paint?	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
I. paint thinner, paint-, enamel- or glue remover or other remover agents? (for example, lynol, white spirits, toluene, carbon tetrachloride)	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
J. dyes or printing inks?	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
K. motor oil or lubrication?	1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋

139. **Did you use ventilation or protection hoods?**	140. **Did you usually use rubber or safety gloves?**	141. **Was a large amount of the material ever spilled (by accident) during months 1 - 2 - 3?** **What: ↓ ↓ ↓**	142. **Did you get anything on your skin or did you breathe in gases?**
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No Skip to question 141		1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

Continuation about chemical materials in months 1 - 2 - 3

136. **Have you been in contact with.....** (If "Yes", continue with the questions to the right, 137-142)	→ 137. **Where?**	→ 138. **In total, how many days did you work with, or in close contact with this?**
L. photographic chemicals? (fixing or developing solution) 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
M. welding? 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
N. soldering? 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
O. formalin or formaldehyde? 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
P. chemotherapy drugs? (do not include treatment as a patient) 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
Q. laughing gas or other narcotic gases? (do not include treatment as a patient) 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
R. sources of radiowaves or microwaves less than 2 meters away? (do not include use of your own microwave) 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋ Skip to S
S. laser printer, computer monitor, or copying machine less than 2 meters away? 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋ Skip to T
T. x-ray machine less than 2 meters away? 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋ Skip to U
U. other materials and situations? Explain: _____ 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋
V. other materials and situations? (if more) Explain: _____ 1 ☐ Yes→ 2 ☐ No	1 ☐ spare time 2 ☐ work	Number of days in months 1 - 2 - 3 ⌊__⌋⌊__⌋

139. **Did you use ventilation or protection hoods?**	**140.** **Did you usually use rubber or safety gloves?**	**141.** **Was a large amount of the material ever spilled (by accident) during months 1 - 2 - 3?** **What: ↓ ↓ ↓**	**142.** **Did you get anything on your skin or did you breathe in gases?**
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never		1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No Skip to R			
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No	1 ☐ always 2 ☐ sometimes 3 ☐ never	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

143. Did you ever clean your hands with white spirits or other removal agents during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

144. How often did you use an electric blanket or water bed during months 1 - 2 - 3? (If you used it every night, the answer is 90 days. Write 00 if none)

Number of nights: ⌊__⌋⌊__⌋

TOBACCO SMOKING

145. Have you smoked more than 100 cigarettes in your whole life?

1 ☐ Yes
2 ☐ No

146. Did you smoke cigarettes during the last 12 months before your last pregnancy?

1 ☐ Yes
2 ☐ No → Skip to question 148

147. If "Yes", how much did you smoke, on the average, during these 12 months? (state either per day or per month)

Average number of cigarettes per day: ⌊__⌋⌊__⌋

Average number of cigarettes per month: ⌊__⌋⌊__⌋⌊__⌋

148. After you became pregnant, did you smoke at all during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No → Skip to question 150

149. When you smoked in months 1 - 2 - 3, how much did you smoke? (state either per day or per month)

Number of cigarettes per day: ⌊__⌋⌊__⌋

Number of cigarettes per month: ⌊__⌋⌊__⌋⌊__⌋

150. Has the child's father ever smoked cigarettes regularly?

1 ☐ Yes
2 ☐ No

151. Did anyone live in the home who smoked cigarettes regularly during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

152. How many hours per day were you located less than two meters from somebody who was smoking cigarettes, either at home, at work, or at other places? (Write 00 if none)

Number of hours per day: ⌊__⌋⌊__⌋

WATER - DRINKS - ALCOHOL

153. What type of water supply did your home have during months 1 - 2 - 3?

1 ☐ Water works
2 ☐ Well water

154. How many glasses of water did you drink each day, on the average, from each of these water sources during months 1 - 2 - 3, and include juice mixed from concentrate? (write 00 if none)

Number per day

A. Number of glasses from water works at home: ⌊__⌋⌊__⌋

B. Number of glasses from water works at work: ⌊__⌋⌊__⌋

C. Number of glasses from pre-bottled water: ⌊__⌋⌊__⌋

D. Number of glasses of water from a well: ⌊__⌋⌊__⌋

155. Were there additives in the tap water you drank at home during months 1 - 2 - 3?

1 ☐ Did not drink tap water at home
2 ☐ Yes, added chemicals (for example chlorine)
3 ☐ No, no added chemicals
8 ☐ I do not know if the water had additives

156. Were there additives in the tap water you drank at work during months 1 - 2 - 3?

1 ☐ Did not drink tap water at work/did not work outside the home
2 ☐ Yes, added chemicals (for example chlorine)
3 ☐ No, no added chemicals
8 ☐ I do not know if the water had additives

157. How many times per week did you take a normal bath and/or shower during months 1 - 2 - 3?
Answer for both (write 00 if none)
Number of times per week

Bath ⌊__⌋⌊__⌋

Shower ⌊__⌋⌊__⌋

158. How many minutes did you normally shower each time during months 1 - 2 - 3?

Number of minutes: ⌊__⌋⌊__⌋

159. In total, how many times did you use a sauna during months 1 - 2 - 3? (every day would be 90, write 00 if none)

Number of times: ⌊__⌋⌊__⌋

160. In total, how many times did you take a hot tub bath during months 1 - 2 - 3? (every day would be 90, write 00 if none)

Number of times: ⌊__⌋⌊__⌋

COFFEE AND SUCH

161. How much of the following did you drink during the last 12 months before the pregnancy:	**Number of cups/glasses:** (state either per day, per week, per month, or per year)
A. Coffee with caffeine?	1 ☐ did not drink ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month ⌊__⌋⌊__⌋ per year
B. Coffee without caffeine?	1 ☐ did not drink ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month ⌊__⌋⌊__⌋ per year
C. Regular tea, warm or cold?	1 ☐ did not drink ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month ⌊__⌋⌊__⌋ per year
D. Herbal tea?	1 ☐ did not drink ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month ⌊__⌋⌊__⌋ per year
E. Other caffeinated beverages, such as Coke and Diet Coke?	1 ☐ did not drink ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month ⌊__⌋⌊__⌋ per year
F. Other beverages without caffeine, such as soda and juice? (not water and alcohol)	1 ☐ did not drink ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month ⌊__⌋⌊__⌋ per year

162. How much of the following did you drink during months 1 - 2 - 3:	**Number of cups/glasses:** (state either per day, per week, or per month)
A. Coffee with caffeine?	1 ☐ did not drink 1 ☐ less than once a month ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month
B. Coffee without caffeine?	1 ☐ did not drink 1 ☐ less than once a month ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month
C. Regular tea, warm or cold?	1 ☐ did not drink 1 ☐ less than once a month ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month
D. Herbal tea?	1 ☐ did not drink 1 ☐ less than once a month ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month
E. Other caffeinated beverages, such as Coke and Diet Coke?	1 ☐ did not drink 1 ☐ less than once a month ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month
F. Other beverages without caffeine, such as soda and juice? (not water and alcohol)	1 ☐ did not drink 1 ☐ less than once a month ⌊__⌋⌊__⌋ per day ⌊__⌋⌊__⌋ per week ⌊__⌋⌊__⌋ per month

163. Are you currently completely abstemious from alcohol?

1 ☐ Yes
2 ☐ No → Skip to question 166

164. If "Yes", what is the <u>main reason</u> that you do not drink? If there is more than one reason why you don't drink you may cross off up to 3.

1 ☐ a. I do not like the effects of alcohol
1 ☐ b. I do not like the taste of alcohol
1 ☐ c. It is too expensive, waste of money
1 ☐ d. I am breastfeeding (or was breastfeeding)
1 ☐ e. A family member or friend had problems with alcohol, I am afraid of excessive drinking
1 ☐ f. I am a recovered alcoholic
1 ☐ g. Religious, moral, or other beliefs
1 ☐ h. Medical reasons
Explain:

_____

1 ☐ i. Other reasons not mentioned
Explain:

_____

165. Have you always been completely abstemious?

1 ☐ Yes → Skip to question 170
2 ☐ No

166. How often did you drink alcohol in the last few years before you became pregnant with the newborn? (state either per week, per month, or per year)

1 ☐ did not drink → Skip to question 168
└┘└┘ days per week
└┘└┘ days per month
└┘└┘ days per year

167. How much did you drink each time during the last few years before you became pregnant? (as an alcohol unit is counted: a bottle of beer, a glass of wine, or a shot of liquor)

└┘└┘ number of units of alcohol per time

168. How often did you drink during months 1 - 2 - 3? (state per week or per month)

1 ☐ did not drink → Skip to question 170
1 ☐ less than one day per month in months 1 - 2 - 3
└┘└┘ days per week
└┘└┘ days per month

169. How many units of alcohol did you usually drink those times you drank during months 1 - 2 - 3?

└┘└┘ number of units of alcohol per time

SPECIAL INCIDENTS DURING MONTHS 1 - 2 - 3

170. Did you move to a new residence during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

171. Did you have any serious marriage or relationship problems during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

172. Did a close friend or a family member contract a serious or life-threatening illness during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

173. Did a close friend or a family member die during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

174. Did you contract any serious illness during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

If "Yes", describe:

_____

_____

_____

175. Did you experience any other difficult incidents during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

If "Yes" describe:

_____

_____

_____

176. Did you have any other experiences, good or bad, which led to large changes in your life during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

If "Yes", describe:

_____

_____

_____

177. **Did you take any of the following dietary supplements during the last 6 months <u>before</u> you became pregnant?**	**178.** **Cross off for every month you took the supplement.**	**179.** **How often?**	**180.** **Number?**
A. Multivitamins 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
B. Particularly Vitamin A - D supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
C. Particularly Vitamin B supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablet ⌊_⌋ number of tablespoons
D. Particularly Vitamin C supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
E. Particularly Vitamin E supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
F. Particularly "Folic acid" or "Folate" supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
G. Particularly Fish oil or cod liver oil supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
H. Q10 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
I. Kreatin 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
J. Iron 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
K. Other supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 6 before 1 ☐ mo 3 before 1 ☐ mo 5 before 1 ☐ mo 2 before 1 ☐ mo 4 before 1 ☐ mo 1 before	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons

THE FIRST 3 MONTHS OF PREGNANCY

181. Did you take any of the following dietary supplements during months 1 - 2 - 3?	182. Cross off for every month you took the supplement.	183. How often?	184. Number?
A. Multivitamins 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
B. Particularly Vitamin A - D supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
C. Particularly Vitamin B supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
D. Particularly Vitamin C supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
E. Particularly Vitamin E supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
F. Particularly"Folic acid" or "Folate" supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
G. Particularly Fish oil or cod liver oil supplement 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
H. Q10 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
I. Kreatin 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
J. Iron 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons
K. Other supplements 1 ☐ Yes 2 ☐ No Product name:	1 ☐ mo 1 1 ☐ mo 2 1 ☐ mo 3	1 ☐ per day 2 ☐ per week 3 ☐ per month 4 ☐ less than once a month	⌊_⌋ number of tablets ⌊_⌋ number of tablespoons

CHANGES IN DIET

185. Did you begin to avoid some types of foods either because you did not think that you should eat them or because you did not want to eat them during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

If "Yes", explain:

_____

_____

_____

186. Did your desire for certain types of food increase during months 1 - 2 - 3?

1 ☐ Yes
2 ☐ No

If "Yes", explain:

_____

_____

_____

CLEFT LIP OR PALATE IN THE FAMILY

187. Were you born with a cleft lip or palate?

1 ☐ No
2 ☐ cleft lip
3 ☐ cleft palate
4 ☐ cleft lip and palate

188. Did either of your parents have a cleft lip or cleft palate?

1 ☐ No
2 ☐ cleft lip
3 ☐ cleft palate
4 ☐ cleft lip and palate

189. Has the newborn child's father had a cleft lip or a cleft palate?

1 ☐ No
2 ☐ cleft lip
3 ☐ cleft palate
4 ☐ cleft lip and palate

190. Have either of the child's father's parents had a cleft lip or cleft palate?

1 ☐ No
2 ☐ cleft lip
3 ☐ cleft palate
4 ☐ cleft lip and palate

191. Does the child's father have children with someone other than you?

1 ☐ Yes
2 ☐ No → Skip to question 195

192. If "Yes", state number.

└┴┘ number of children with others

193. Were any of these other children born with a cleft lip or cleft palate?

1 ☐ Yes
2 ☐ No → Skip to question 195

194. If "Yes", state number:

└┴┘ number of children with cleft lip
└┴┘ number of children with cleft palate
└┴┘ number of children with cleft lip and palate

195. Have any of the child's other relatives, either on your side or on the child's father's side, had a cleft lip or cleft palate?

1 ☐ Yes
2 ☐ No → Skip to question 197

196. Explain how they are related to the newborn child.
(for example, the newborn's aunt)

Relationship:

_____

1 ☐ cleft lip
2 ☐ cleft palate
3 ☐ cleft lip and palate

Relationship:

_____

1 ☐ cleft lip
2 ☐ cleft palate
3 ☐ cleft lip and palate

197. Final question:

We would like to know if you think this questionnaire is lacking anything important in connection with this research of birth defects. If there is anything else which you think that we should know about yourself, your pregnancy, your family, or anything else, we ask that you write it here.

_____

_____

_____

_____

_____

_____

Today's Date: ⌊__⌋⌊__⌋ ⌊__⌋⌊__⌋ ⌊__⌋⌊__⌋⌊__⌋⌊__⌋
day mo yr

Thank you for taking the time to fill out the questionnaire. Please send it back to us in the included postmarked envelope.

Next and last mailing:
We are going to send you a questionnaire about nutrition and diet which we ask you to fill out. In addition, we are sending a package with a cotton swab so that we can acquire a specimen from the mouths of chosen members of the family. We are going to contact you regarding the sending of this.

If you have questions regarding the study, feel free to call our project office at telephone number 55 97 47 07/09

Your comments:
The rest of this page should be used for your comments or for elaborative explanations to any of our questions:

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C + C	1 ☐	Yes
	2 ☐	No
PJ	1 ☐	Yes
	2 ☐	No

EXTRA PAGE FOR MULTIPLE BIRTHS:

Only fill out this page if your last pregnancy was a multiple birth (twins or more).

Respond to each question separately for each of the children in the last pregnancy.

	first born child	second born child	third born child	fourth born child
198. Was the child alive at birth?	1 ☐ live-born 2 ☐ stillborn 3 ☐ other Explain:	1 ☐ live-born 2 ☐ stillborn 3 ☐ other Explain:	1 ☐ live-born 2 ☐ stillborn 3 ☐ other Explain:	1 ☐ live-born 2 ☐ stillborn 3 ☐ other Explain:
199. For the live-born children: Is this child still living?	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
200. Birth month/year? (now and then, twins are born at different times)	☐☐ mo ☐☐☐☐ yr	☐☐ mo ☐☐☐☐ yr	☐☐ mo ☐☐☐☐ yr	☐☐ mo ☐☐☐☐ yr
201. At how many weeks into the pregnancy was the child born?	☐☐ weeks	☐☐ weeks	☐☐ weeks	☐☐ weeks
202. What was the child's sex?	1 ☐ Boy 2 ☐ Girl	1 ☐ Boy 2 ☐ Girl	1 ☐ Boy 2 ☐ Girl	1 ☐ Boy 2 ☐ Girl
203. Was the child born with deformities?	1 ☐ Yes 2 ☐ No If "Yes", explain:	1 ☐ Yes 2 ☐ No If "Yes", explain:	1 ☐ Yes 2 ☐ No If "Yes", explain:	1 ☐ Yes 2 ☐ No If "Yes", explain:

twins

triplets

quadruplets

TURN BACK TO PAGE 6, QUESTION 40.

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Ind ☐

EXTRA PAGE FOR MORE THAN THREE LIVE-BORN CHILDREN:

Continue here with your fourth live-born child. Do not include your newborn child.

	Fourth child	Fifth child	Sixth child
44. When was the child born?	day mo yr	day mo yr	day mo yr
45. Was the child a single birth, twin, or triplet?	1 ☐ single birth 2 ☐ twins 3 ☐ triplets	1 ☐ single birth 2 ☐ twins 3 ☐ triplets	1 ☐ single birth 2 ☐ twins 3 ☐ triplets
46. Did you breastfeed this child?	1 ☐ Yes 2 ☐ No → Skip to Q48	1 ☐ Yes 2 ☐ No → Skip to Q48	1 ☐ Yes 2 ☐ No → Skip to Q48
47. When did you stop breast-feeding this child <u>at least once a day</u>?	mo yr	mo yr	mo yr
48. Was the father to the new child also father to this child?	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know	1 ☐ Yes 2 ☐ No 8 ☐ Don't know
49. Does this child live with you?	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
50. Was the child born with deformities?	1 ☐ Yes 2 ☐ No If "Yes" describe:	1 ☐ Yes 2 ☐ No If "Yes" describe:	1 ☐ Yes 2 ☐ No If "Yes" describe:
51. Is this child still living?	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

TURN BACK TO PAGE 7 QUESTION 52.