PREGNANCY, HEREDITY, AND ENVIRONMENT

SAM-prosjektet Medisinsk fødselsregister Armauer Hansens Hus Haukeland sykehus 5021 BERGEN

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2 55 97 4707/09

February 16, 1999

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

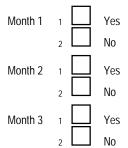
You answer the questions by putting a cross in a box. For some of the questions you will continue with the next one or jump to another one. You will get help from arrows and messages concerning "skip to". By other questions there is open space to write the answer.

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 $ ightarrow$ Skip to question 95

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



- 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.

7. What country were you born in?

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?
 - Married
 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?
 - $\begin{array}{c|c} 1 & & \\ 2 & & \\ \end{array} \begin{array}{c} Yes \longrightarrow Skip \text{ to question 9} \\ No \end{array}$

- 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

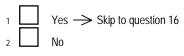
 3
 Technical College (Vocational School)

 4
 2 4 College (Technical School, Nursing School, District [community] College)

 5
 University (including: Technical College of Norway, Norwegian Business School)

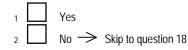
 6
 Other: Describe:

13. Was he born in Norway?



14. What country was he born in?

- 15. When did he move to Norway?
 - Yr:
- 16. Are you and the child's father related?



How long have you lived in your current

residence? If it is less than one year, give the

of years _____ # of months: _____

About what year was your residence built?

Do you go on vacation to a cottage or summer

21. Have you or the child's father stayed in a foreign

17. If so, how are you related?

number of months.

18.

19.

20.

Year:

place?

1

2

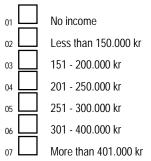
Yes No

country in the past year?

Yes

No

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



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:

- 22. What is your 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

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

Number of times:

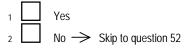
29.	Have you, in any twelve-month period, had regular intercourse without protection and not gotten pregnant?	 35. Was your baby born on time? 1
30.	Have you ever visited the doctor because you had difficulties getting pregnant? 1	If late: How many days late? Let days 36. Were you pregnant with one child or several
31.	During what year was the first time you visited the doctor for this? Year:	children during this pregnancy? 1 one child 2 twins 3 triplets 4 quadruplets
32.	Did you receive any medical treatment or medication to help you get pregnant with your newborn child? 1	More than one child: <i>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</i>
33.	If treatment: What type of treatment did you receive to help you get pregnant?	 What sex is the new child? Boy Girl
	If medication(s): What medication(s) did you use to help you get pregnant?	 38. Was the child born with deformities? 1 Yes 2 No
		39. If yes, describe the child's deformities.
34.	When was your child born? Date: Land Land Land Land day mo yr	

40. Are you pregnant again now?



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?



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	I hird 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	 single birth twins triplets
46.	Did you breastfeed this child?	$\begin{array}{c c} 1 & \square & Yes \\ 2 & \square & No \Rightarrow Skip to Q48 \end{array}$	$\begin{array}{c c} 1 & \square & Yes \\ 2 & \square & No \Rightarrow Skip \text{ to } Q48 \end{array}$	$\begin{array}{c c} 1 & \square & Yes \\ 2 & \square & No \Rightarrow Skip to Q48 \end{array}$
47.	When did you stop breast- feeding this child <u>at least</u> <u>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	1 Yes

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)	59. Have you ever had a tubal pregnancy?
abortion? (Do not include tubal pregnancies) 1 Yes	1 Yes 2 No
2 No	If "Yes": How many tubal pregnancies?
If "Yes": How many induced (provoked) abortions?	Number:
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?	We are interested in finding out when you stopped using this method, even if you were still using it when you became pregnant.
	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"	 67. When did you stop using this method? (Try to estimate month and year the best you can) ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓
	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: Describe:	 69. For how many months were you trying to get pregnant? 1 Less than 2 months 2 months 3 3 months 4 more than 3 months Number, if more than 3 months.
	$_{1}$ Never used any method \rightarrow Skip to question 68	 70. Did you use birth control pills (regardless of the reason) <u>during the course of the last three</u> months before you became pregnant with your newborn child? 1 Yes 2 No
65.	Which of the above method(s) you have already marked did you use at the <u>very end</u> before you became pregnant with your newborn child? Last method(s) to prevent pregnancy:	 71. When did you realize that you were pregnant? Before the next period When the next period should have come After the next period should have come Number of days after
66.	Did you stop using this method before you became pregnant with your new baby? 1 Yes 2 No	 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:

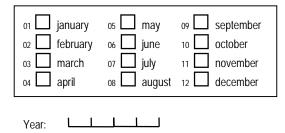
74. How tall are you?

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?



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.

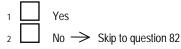
- 1. Month with most bleeding:
- 2. Month after:
- 3. Month after:

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)

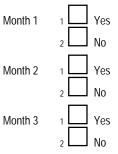
 Did you experience nausea, either with or without vomiting, during the course of months 1 - 2 - 3?



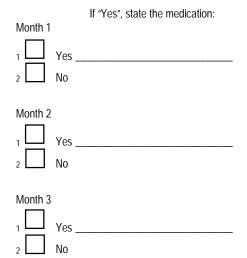
79. Which of these months did you have nausea? (answer for each month)



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



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



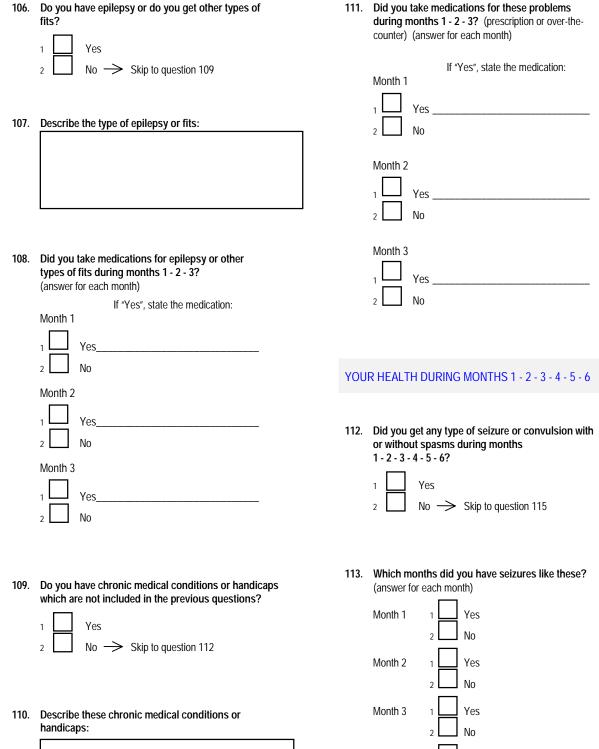
82.	Did you ever have a fever during the course of months 1 - 2 - 3? 1 Yes 2 No → Skip to question 87	87.	Did you have any other infections which did <u>not</u> give you a fever during months $1 - 2 - 3$? (for example, colds, sinus infection, urinary tract infection, or others) 1 Yes 2 No \rightarrow Skip to question 89
83.	What was the cause of the fever? (state if possible what kind of infection)		2 No → Skip to question 89 State the illness or infection:
84.	All together, how many days did you have a fever during months 1 - 2 - 3? Number of days:	88.	Did you take any medications for these problems during months 1 - 2 - 3? (both prescription and over- the-counter) (answer for each month)
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 Month 3 1 Yes 2 No		Month 1 1 Yes 2 No Month 2 1 Yes 2 No Month 3 1 Yes 1 Yes 1 Yes 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	89.	2 No Did you get any new amalgam fillings in your teeth during months 1 - 2 - 3? 1 Yes 2 No → Skip to question 91
	1 Yes 2 No Month 3 1 Yes 2 No	90.	Which month did you get the new fillings?(answer for each month)Month 112NoMonth 212NoMonth 31Yes 2NoMonth 31Yes 2No

- 96. Which months did you take sleeping pills? 91. Did you get laughing gas or full narcotics in (answer for each month) connection with dental treatment during months If "Yes", state the medication: 1-2-3? Month 1 Yes _____ Yes_ No \rightarrow Skip to question 93 No Month 2 _____ Which months did you receive laughing gas or full 92. Yes narcotics during dental work? (answer for each month) No Month 1 Yes Month 3 No 2 _____ Yes ____ Month 2 Yes 1 No No Month 3 Yes No 97. Did you take sedatives during months 1 - 2 - 3? Yes 1 No \rightarrow Skip to question 99 2 Did you undergo other operations or medical 93. treatment wherein you received anesthetics during months 1 - 2 - 3? (not including dental work) 98. Which months did you take sedatives? Yes 1 (answer for each month) No \rightarrow Skip to question 95 2 If "Yes", state the medication: Month 1 Yes _____ Which months did you receive this 94. No 2 anesthetization? (answer for each month) Month 1 Yes Month 2 1 Yes ______ No 2 Month 2 Yes No 2 No Month 3 Month 3 Yes Yes _____ No No
- 95. Did you take sleeping pills during months 1 2 3?
 - 1
 Yes

 2
 No → Skip to question 97

99. Did you have pain during months 1 - 2 - 3? 102. Did you use medications against pimples or (for example, headaches or toothaches) blemishes during months 1 - 2 - 3? (pills or creams, (answer for each month) prescription or over-the-counter) (answer for each month) Month 1 Yes If "Yes", state the medication: Month 1 No 2 Yes Month 2 Yes No No 2 2 Month 3 Yes 1 Month 2 No 2 _____ Yes No 100. Did you take pain relieving medication during Month 3 months 1 - 2 - 3? (for example, Paracet, Paralgin Forte) (answer for each month) Yes If "Yes", state the medication: No Month 1 1 Yes No 103. Do you have sugar sickness, diabetes? (do not include gestational diabetes) Month 2 Yes 1 Yes No \rightarrow Skip to question 106 2 No Month 3 104. Which type of diabetes do you have? Yes Insulin dependent 1 Not insulin dependent No 2 105. Did you take any medications for diabetes during 101. Did you have problems with pimples or other skin months 1 - 2 - 3? problems during months 1 - 2 - 3? (answer for each month) If "Yes", state the medication: 1 Yes Month 1 No \rightarrow Skip to question 103 2 _____ Yes_ 2 No Month 2 Yes 2 No





Month 4

Month 5

Month 6

Yes

No

Yes

No

Yes No

1

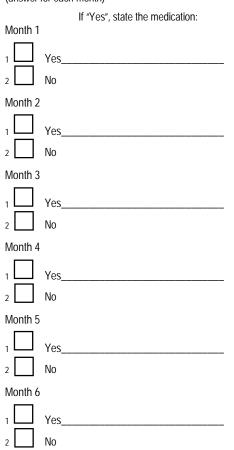
2

1

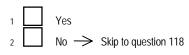
2

2

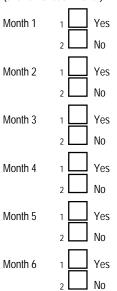
114. Did you take medications because of these seizures or to prevent these seizures? (answer for each month)



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



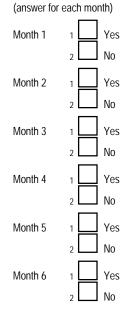
117. State which months you bled or had spotting. (answer for each month)



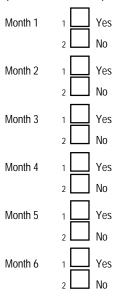
118. Did you have abdominal (gynecological) pain?



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



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



1 - 2	SUMPTION OF MEDICATIONS DURING MONTHS - 3 IS OF ESPECIALLY LARGE IMPORTANCE FOR INVESTIGATION	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?
exam as pa	remember whether you took other medicines (like for ole antibiotics, steroids and common medications such in relievers (aspirin), remedies for heartburn, cough laxatives or any other medications).		(answer for each month) If "Yes", state the treatment: Month 1
	t include vitamins or dietary supplements. They will be ed later.		1 Yes
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:		2 No Month 2 1 Yes
	Month 1 1 Yes		
			2 No
	2 No Month 2		Month 3 1 Yes
	1 Yes		2 No
	2 No		
	Month 3	123.	Why did you have these treatments? Month 1
	1 Yes		
	2 No		Month 2
121.	Why did you take these medications?		
	Month 1		Month 3
	Month 2		
	Month 3	ques	Tember to use the 3 months you have put down in stion 77 when you answer the questions regarding ths 1 - 2 - 3 in your pregnancy.

WOF	RK AND LIVING CONDITIONS IN MONTHS 1 - 2 - 3	130.	In which month did this change occur?
124.	Did you have income-earning employment during any part of months 1 - 2 - 3?		1 month 1 2 month 2 3 month 3 Describe the change(s):
125.	Which one best describes your employment situation during months 1 - 2 - 3?01Full-time employee02Part-time employee03Self-employed04Student and employed full- or part-time05Full-time student \rightarrow Skip to 12906Unemployed/ at home without pay \rightarrow Skip to 12907Other (explain):	131.	New title:
126. 127.	in during months 1 - 2 - 3? What job title did you have when you became pregnant?	132.	2 No 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):
128.	Briefly describe your daily work tasks in months 1 - 2 - 3.		What type of business/industry/trade did he work in during months 1 - 2 - 3? What job title did he have during months 1 - 2 - 3?
	2 No \rightarrow Skip to question 131	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.

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

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: $\psi \psi \psi$	142. Did you get anything on your skin or did you breathe in gases?
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes 2 No Skip to question 141		1 Yes 2 No	1 Yes 2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No

Continuation about chemical materials in months 1 - 2 - 3

			\rightarrow	\rightarrow
	5. ve you been in contact with 'Yes", continue with the questions		137. Where?	138. In total, how many days did you work with, or in close contact with this?
	he right, 137-142)			un s :
L.	photographic chemicals? (fixing or developing solution)	1	1 spare time 2 work	Number of days in months 1 - 2 - 3
М.	welding?	1	1 spare time 2 work	Number of days in months 1 - 2 - 3
N.	soldering?	1	1 spare time 2 work	Number of days in months 1 - 2 - 3
0.	formalin or formaldehyde?	1 Yes→ 2 No	1 spare time 2 work	Number of days in months 1 - 2 - 3
Ρ.	chemotherapy drugs? (do not include treatment as a patient)	1	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
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
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
U.	other materials and situations? Explain:	1	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: $\psi \psi \psi$	142. Did you get anything on your skin or did you breathe in gases?
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes 2 No	1 always 2 sometimes 3 never		1 Yes 2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes 2 No Skip to R			
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No
1 Yes	1 always 2 sometimes 3 never	1 Yes	1 Yes
2 No		2 No	2 No

143.	Did you ever clean your hands with white spirits or other removal agents during months 1 - 2 - 3?	 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:
144.	How often did you use an electric blanket or water bed during months 1 - 2 - 3? (If you used it every night, the	WATER - DRINKS - ALCOHOL 153. What type of water supply did your home have during
	answer is 90 days. Write 00 if none)	months 1 - 2 - 3?
	Number of nights:	1 Water works 2 Well water
TOBA	ACCO SMOKING	
145.	Have you smoked more than 100 cigarettes in your whole life?	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)
	2 No	Number per day
146.	Did you smoke cigarettes during the last 12 months before your last pregnancy?	A. Number of glasses from water works at home:
		B. Number of glasses from water works at work:
	$\begin{array}{c c} 1 & & Yes \\ 2 & & No \rightarrow Skip to question 148 \end{array}$	C. Number of glasses from pre-bottled water:
		D. Number of glasses of water from a well:
147.	If "Yes", how much did you smoke, on the average, during these 12 months? (state <u>either</u> per day <u>or</u> per month)	155. Were there additives in the tap water you drank <u>at home</u> during months 1 - 2 - 3?
	Average number of cigarettes per day:	1 Did not drink tap water at home
	Average number of cigarettes per month:	2 Yes, added chemicals (for example chlorine)
		3 No, no added chemicals
148.	After you became pregnant, did you smoke at all during months 1 - 2 - 3?	8 I do not know if the water had additives
	1 Yes	156. Were there additives in the tap water you drank <u>at work</u> during months 1 - 2 - 3?
	$_{2}$ No \rightarrow Skip to question 150	Did not drink tap water at work/did not work outside the home
149.	When you smoked in months 1 - 2 - 3, how much did you smoke? (state <u>either</u> per day <u>or</u> per month)	2 Yes, added chemicals (for example chlorine)
	Number of cigarettes per day:	3 No, no added chemicals
	Number of cigarettes per way.	8 I do not know if the water had additives
		157. How many times per week did you take a normal bath
150.	Has the child's father ever smoked cigarettes regularly?	and/or shower during months 1 - 2 - 3? Answer for both (write 00 if none)
	1 Yes	Number of times per week
	2 No	Bath
151.	Did anyone live in the home who smoked cigarettes regularly during months 1 - 2 - 3?	Shower
	1 Yes	158. How many minutes did you normally shower each time during months 1 - 2 - 3?
	2 . No	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:

COFFEE AND SUCH

161. How much of the following did you drink during the last <u>12 months</u> before the pregnancy:	Number of c (state either week, per mo 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
		•
D. Herbal tea?		per year
D. Herbartea?	1	did not drink
		per day
		per week
		per month
E. Other caffeinated		per year
beverages, such as Coke and Diet Coke?	1	did not drink
		per day
		per week
		•
C. Other houseness		per year
F. Other beverages without caffeine, such as soda and juice?	1	did not drink
(not water and alcohol)		per day
		per week
		per year

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:

162. How much of the following did you drink during <u>months</u> <u>1 - 2 - 3</u> :	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 Image: did not drink 1 Image: less than once a month
	per day
	per week
5 01 1	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 167. How much did you drink each time during the last few alcohol? years before you became pregnant? (as an alcohol unit is counted: a bottle of beer, a glass of wine, or a shot of Yes liquor) \rightarrow Skip to question 166 No -_____ number of units of alcohol per time L 164. If "Yes", what is the main reason that you do not drink? If there is more than one reason why you don't 168. How often did you drink during months 1 - 2 - 3? (state drink you may cross off up to 3. per week or per month) 1 a. I do not like the effects of alcohol Skip to question 170 did not drink \rightarrow b. I do not like the taste of alcohol 1 less than one day per month in 1 It is too expensive, waste of money 1 C. months 1 - 2 - 3 d. I am breastfeeding (or was 1 days per week breastfeeding) A family member or friend had e. 1 days per month problems with alcohol, I am afraid of excessive drinking f. I am a recovered alcoholic 1 169. How many units of alcohol did you usually drink those Religious, moral, or other beliefs times you drank during months 1 - 2 - 3? 1 g. h. Medical reasons 1 number of units of alcohol per time Explain: SPECIAL INCIDENTS DURING MONTHS 1 - 2 - 3 Other reasons not mentioned 1 Explain: 170. Did you move to a new residence during months 1 - 2 - 3? Yes 165. Have you always been completely abstemious? 2 No Yes \rightarrow Skip to question 170 1 No 2 171. Did you have any serious marriage or relationship problems during months 1 - 2 - 3? 166. How often did you drink alcohol in the last few years before you became pregnant with the newborn? (state Yes either per week, per month, or per year) No 2 did not drink \rightarrow Skip to question 168 days per week days per month
 - _____ days per year

172. Did a close friend or a family member contract a serious or life-threatening illness during months 175. Did you experience any other difficult incidents during months 1 - 2 - 3? 1 - 2 - 3? Yes 1 Yes 1 No 2 No 2 If "Yes" describe: 173. Did a close friend or a family member die during months 1 - 2 - 3? Yes 1 No 2 174. Did you contract any serious illness during months 1 -2 - 3? 176. Did you have any other experiences, good or bad, which led to large changes in your life during months Yes 1 1 - 2 - 3? No 2 Yes If "Yes", describe: 1 No 2 If "Yes", describe:

VITAMINS - MINERALS - DIETARY SUPPLEMENTS - BEFORE PREGNANCY

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 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 1 Yes supplement 2 No	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 1 Yes supplement 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 1 Yes supplement 2 No Product name: 1 Yes	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 1 Yes supplement 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" 1 Yes supplement 2 No Product name: 1 Yes	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 Product name: Yes 2 No	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
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
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 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	1 🔲 mo 1 1 🗍 mo 2	1 per day 2 per week	number of tablets
Product name:	2 No	1 mo 3	 3 per month 4 less than once a month 	number of tablespoons
B. Particularly Vitamin A - D supplement	1 Yes 2 No	1 mo 1 1 mo 2	 per day per week per month 	tablets
Product name:		1 mo 3	4 less than once a month	tablespoons
C. Particularly Vitamin B Supplement	1 Yes	1 🔲 mo 1 1 🛄 mo 2	1 per day 2 per week	tablets
Product name:	2 110	1 🔲 mo 3	3 per month 4 less than once a month	number of tablespoons
D. Particularly Vitamin C supplement	1 Yes	1 🔲 mo 1 1 🔲 mo 2	 per day per week 	tablets
Product name:	2 No	1 🛄 mo 3	 3 per month 4 less than once a month 	number of tablespoons
E. Particularly Vitamin E supplement	1 Yes	1 mo 1	1 per day 2 per week	number of tablets
Product name:	2 No	1 🛄 mo 2 1 🥅 mo 3	 a per month 4 less than once a month 	number of tablespoons
F. Particularly"Folic acid" or "Folate"	1 Yes	1 🔲 mo 1	1 per day 2 per week	number of tablets
supplement Product name:	2 No	1 🛄 mo 2 1 🥅 mo 3	 3 per month 4 less than once a month 	number of tablespoons
G. Particularly Fish oil or cod liver	1 Yes	1 🔲 mo 1	1 per day 2 per week	number of tablets
oil supplement Product name:	2 No	1 🛄 mo 2 1 🥅 mo 3	 a per month 4 less than once a month 	number of tablespoons
H. Q10	1 Yes	1 🔲 mo 1	1 per day 2 per week	number of tablets
Product name:	2 No	1 🛄 mo 2 1 🛄 mo 3	 a per month 4 less than once a month 	number of tablespoons
I. Kreatin	1 Yes	1 🔲 mo 1	1 per day 2 per week	number of tablets
Product name:	2 No	1 🛄 mo 2 1 🛄 mo 3	 a per month 4 less than once a month 	number of tablespoons
J. Iron	1 Yes	1 🔲 mo 1	1 per day 2 per week	number of tablets
Product name:	2 No	1 🛄 mo 2 1 🥅 mo 3	 a per month 4 less than once a month 	number of tablespoons
K. Other supplements	1 Yes	1 🔲 mo 1	1 per day	number of tablets
Product name:	2 No	1 🛄 mo 2 1 🛄 mo 3	 2 per week 3 per month 4 less than once a month 	number of tablespoons

CHA	NGES IN DIET	190.	Have either of the child's father's parents had a cleft lip or cleft palate?
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 No 2 cleft lip 3 cleft palate 4 cleft lip and palate
	If "Yes", explain:	191.	Does the child's father have children with someone other than you?
186.	Did your desire for certain types of food increase during months 1 - 2 - 3?	192.	If "Yes", state number.
	1 Yes 2 No If "Yes", explain:	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
CLEF 187.	T LIP OR PALATE IN THE FAMILY Were you born with a cleft lip or 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 No 2 cleft lip 3 cleft palate 4 cleft lip and palate	196.	$\begin{array}{c c} 1 & & \\ 2 & & \\ \end{array} Yes \\ 2 & & \\ No \longrightarrow Skip to question 197 \end{array}$
188.	Did either of your parents have a cleft lip or cleft palate?		Relationship:
	1 No 2 cleft lip 3 cleft palate 4 cleft lip and palate		1 Image: cleft lip 2 Image: cleft palate 3 Image: cleft lip and palate
189.	Has the newborn child's father had a cleft lip or a cleft palate?		Relationship:
	1 No 2 Cleft lip 3 Cleft palate 4 Cleft lip and palate		1 Image: cleft lip 2 Image: cleft palate 3 Image: 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:	لــــاـــا day	L 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:

Office U	se Only
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?	 live-born stillborn other Explain: 	 live-born stillborn 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		
200.	Birth month/year? (now and then, twins are born at different times)	mo L_L	mo L J J J J J J J J J J J J J J J J J J J				
201.	At how many weeks into the pregnancy was the child born?	L weeks	L weeks	L weeks	L 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:		
L	L twins triplets quadruplets						

TURN BACK TO PAGE 6, QUESTION 40.

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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?	$\begin{array}{c c} 1 & \square & Yes \\ 2 & \square & No \twoheadrightarrow Skip to Q48 \end{array}$	$\begin{array}{c c} 1 & \square & Yes \\ 2 & \square & No \rightarrow Skip \text{ to } Q48 \end{array}$	$\begin{array}{c c} 1 & \square & Yes \\ 2 & \square & No \rightarrow Skip \text{ to } Q48 \end{array}$
47.	When did you stop breast- feeding this child <u>at least</u> <u>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	1 Yes	1 Yes

TURN BACK TO PAGE 7 QUESTION 52.