



The Danish National Birth Cohort

Parent: «**Parent name**»

Child: «**Christian name**» «**Surname**»

Children's health

– a follow-up survey of "The Danish National Birth Cohort"

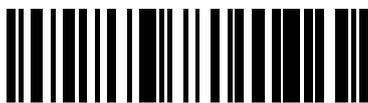
Questionnaire

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Version 1.3

Children's health

– a follow-up survey of "The Danish National Birth Cohort"

Dear «Parent name»,

Thank you for contributing to the follow-up survey of "The Danish National Birth Cohort" by filling in this questionnaire about your son/daughter. The questionnaire is about children's diseases, vaccinations, medicine, diet and exercise, height and weight – and there are a few questions for the parents.

Please answer the questions by ticking the box you think is correct. Use a black or blue ball pen. Please make sure to tick inside the box, and not outside. If you have ticked the wrong box, just shade it in and then tick the right one. Use a black or blue ball pen.

Most of the questions can be answered with a "yes", "no" or "don't know". Tick one box only. You can tick more boxes in some of the questions. These questions will be clearly marked.

In some of the questions, we ask you to write your own answer or comments. Please write as clearly as possible and only on the lines provided. Your comments will not be registered if you write outside the lines.

Please use the allocated boxes for numbers. If there is room for two digits and you only need to write one – use the box to the right.

Example: How old was your daughter when she started school? | 7 | years

Some of the questions will most probably make you guess, but please do your best to remember.

Some of the questions will require that you have specific information at hand. It is therefore a good idea to have the following ready:

- the vitamin pills and any dietary supplements your daughter takes
- the type of medicine your daughter has been taking over a longer period (for example asthma or epilepsy)
- any vaccinations apart from the normal course of children's vaccinations
- your daughter's height, weight, waist measurements and dates for when she was measured and weighed
- yours and the other biological parent's height, weight and waist measurement
- yours and the other biological parent's birth weight

Please return the completed questionnaire in the stamped addressed envelope provided.

Thank you very much!

This questionnaire is about: «**Child's Christian name**»

Date of completion:

| | | | **20** | | |

(dd/mm/yyyy)

1. Are you the child's biological mother?

Yes

No

If no:

This questionnaire has not been completed by the child's biological mother, but by:

The child's biological father

Another person, whom? _____

About your daughter's home and family

The first part of the questionnaire deals with your daughter's home and family. If she has more than one home, answer the following questions about her home and family in relation to where she has lived most of her life.

2. Has your daughter lived with her mother and father since birth?

Yes

No

If no:

Where has she lived most of her life?

(Tick one box only)

With her mother

With her father

With her mother and mother's new partner

With her father and father's new partner

Equally with both parents

With appointed guardian/foster parents

Other, whom?: _____

3. Does your daughter live with you at present?

- Yes
 No

If no:

Where does she live now? _____

**4. Was/Is your child cared for in any of the following institutions of child care?
 (Tick appropriate boxes)**

- Crèche
 Child minder in child minder's home
 Child minder at home
 Mixed institution
 Kindergarten
 Leisure centre
 School leisure centre
 Other : _____
 Has never been cared for by others **(skip to question 6)**

**5. How old was your daughter when she was cared for by others?
 (Tick one year and one month)**

	0	1	2	3	4	5	6	7	8	9	10	11	Don't know
Year	<input type="checkbox"/>			<input type="checkbox"/>									
Months	<input type="checkbox"/>												

Example.: If your daughter was cared for outside her home at 9 months, then tick 0 years and tick 9 months

	0	1	2	3	4	5	6	7	8	9	10	11	Don't know
Year	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>								
Months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About your daughter's dietary habits

Which of the following statements best describe your daughter's dietary habits during the past year?

9. How often does she consume the foods below?
(Tick one box on each line)

	6 or more times a week	4-5 times a week	2-3 times a week	About once a week	Rarely or never
She drinks sugary soft drinks (fruit juice, orange juice, lemonade)	<input type="checkbox"/>				
She eats "fast-food" (burgers, pizza, hamburgers, etc.)	<input type="checkbox"/>				
She drinks milk	<input type="checkbox"/>				
She eats sweets/chocolate/ice cream	<input type="checkbox"/>				
She eats breakfast	<input type="checkbox"/>				
She eats snacks between meals	<input type="checkbox"/>				
She eats lunch	<input type="checkbox"/>				
She eats dinner	<input type="checkbox"/>				
She eats fruit	<input type="checkbox"/>				
She eats vegetables	<input type="checkbox"/>				

10. Has a doctor said that your daughter is allergic to certain types of food?

- Yes
 No

If yes:

Which types of food? (Tick appropriate boxes)

<input type="checkbox"/>	Milk	<input type="checkbox"/>	Tomato
<input type="checkbox"/>	Egg	<input type="checkbox"/>	Shellfish
<input type="checkbox"/>	Fish	<input type="checkbox"/>	Rye
<input type="checkbox"/>	Citrus fruits	<input type="checkbox"/>	Wheat
<input type="checkbox"/>	Nuts	<input type="checkbox"/>	Soya
<input type="checkbox"/>	Other: _____		

11. Has she taken vitamin pills during the past year?

(Tick one box only)

- Yes, always/nearly always
 Yes, but only in winter
 Yes, occasionally
 No, not at all or very rarely

If yes:

Which pill does she take? (Tick the appropriate box)

- Childrens BiOrtomin
 Livol MultiTotal for children
 Matas vitamins for children
 Matas vitamins for children with calcium and magnesium
 Multi-tabs
 Nycoplus Extra-Multi for children
 Nycoplus Multi for children
 Omnimini
 Other : _____

12. Has she taken any dietary supplements during the past year?

Yes

No

If yes:

Which dietary supplement does she take?

(Tick the appropriate box)

Other: _____

13. Does the family eat dinner together at least 4 times a week?

Yes

No

Don't know

Physical activity

The following questions deal with your daughter's activity or inactivity. We ask you now to assess how active your daughter is in kindergarten, school or at the leisure centre on a normal weekday after school or school leisure centre and during a normal day at the weekend.

14. How many hours is your daughter physically active in kindergarten, school or at the leisure centre/school leisure centre, e.g. running, hopping, climbing, cycling, training sport or other activities, which require a lot of movement (Tick one box only)

- Never or very rarely
- Less than once a week
- Once or twice a week
- 2-4 hours a week
- 4-6 hours a week
- 6 hours or more

15. How many hours is your daughter physically active with e.g. running, hopping, climbing, cycling, training sport or other activities, which require a lot of movement? Please assess how physically active she is on a normal weekday after kindergarten, school or the leisure centre/school leisure centre compared to a normal day during the weekend. (Tick one box in each column)

Activity time	Normal weekday	Day at the weekend
Never or very rarely	<input type="checkbox"/>	<input type="checkbox"/>
Less than ½ hour daily	<input type="checkbox"/>	<input type="checkbox"/>
½ - 1 hour a day	<input type="checkbox"/>	<input type="checkbox"/>
1 - 2 hours a day	<input type="checkbox"/>	<input type="checkbox"/>
2 - 3 hours a day	<input type="checkbox"/>	<input type="checkbox"/>
3 - 4 hours a day	<input type="checkbox"/>	<input type="checkbox"/>
4 hours or more	<input type="checkbox"/>	<input type="checkbox"/>

16. How many hours is your daughter physically inactive on a normal weekday/day during the weekend, i.e. rests, sleeps during the day, reads, watches TV, plays computer games, is tutored, etc. after school or school leisure centre/leisure centre? (Tick one box in each column)

Activity time	Normal weekday	Day at the weekend
Never or very rarely	<input type="checkbox"/>	<input type="checkbox"/>
Less than ½ hour daily	<input type="checkbox"/>	<input type="checkbox"/>
½ - 1 hour a day	<input type="checkbox"/>	<input type="checkbox"/>
1 - 2 hours a day	<input type="checkbox"/>	<input type="checkbox"/>
2 - 3 hours a day	<input type="checkbox"/>	<input type="checkbox"/>
3 - 4 hours a day	<input type="checkbox"/>	<input type="checkbox"/>

4 hours or more	<input type="checkbox"/>	<input type="checkbox"/>
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About your daughter's health

The following questions deal with your daughter's health. Any comments or other information you may have may be added at the end of the questionnaire.

17. How is your daughter's health compared with other girls her age?

(Tick one box only)

- Better
- Same as other girls her age
- Worse

If worse:

What is the reason for her bad health?

- Frequent colds and fever
- Recurring bouts of pneumonia
- Stomach and headaches
- Other: _____

18. Is she getting her regular jabs under the children's vaccination programme?

- Yes
- No
- Don't know

19. Has she had other vaccinations apart from the usual ones (e.g. in order to travel or due to outbreak of disease)?

- Yes
- No
- Don't know

If yes:

Which vaccinations?

- Infectious hepatitis, Hepatitis A - Havrix date: | | | | | | | | | |
- Infectious hepatitis, Hepatitis A - Gammaglobulin date: | | | | | | | | | |
- Infectious hepatitis, Hepatitis B - Engerix date: | | | | | | | | | |
- Infectious hepatitis, Hepatitis A+B - Twinrix date: | | | | | | | | | |
- Meningitis date: | | | | | | | | | |
- Yellow fever date: | | | | | | | | | |
- Other, _____ date: | | | | | | | | | |
(type of vaccination)

20. Has your daughter had the following childrens' diseases?
(Tick each childrens' disease)

	Yes	No	Don't know
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Three day fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Has your daughter had inflammation of the inner ear since birth?
(Tick one box only)

- Yes, 1-3 times
- Yes, more than 3 times
- No
- Don't know

22. Has your daughter ever had her ears drained?

- Yes
- No
- Don't know

23. Has your daughter ever had fever cramps in infancy?

- Yes (go to the next question)
- No (skip to question 27)
- Don't know (skip to question 27)

24. How many times has she had fever cramps altogether?
(Tick one box only)

- 1
- 2-5
- 6 or more

30. Does your daughter take (or has she ever taken) medicine for epilepsy?

- Yes
 No
 Don't know

If yes:

Which medicine?
(Tick appropriate boxes)

	Medicine's registered trade name	Chemical
<input type="checkbox"/>	Carbamazepine "Dak", Tegretol®, Trimonil® Retard	Carbamazepine
<input type="checkbox"/>	Frisium®	Clobazam
<input type="checkbox"/>	Rivotril®	Clonazepam
<input type="checkbox"/>	Zarondan®	Ethosuximide
<input type="checkbox"/>	Gabapentine	Gabapentine
<input type="checkbox"/>	Labileno "Orifarm", Lamictal®	Lamotrigine
<input type="checkbox"/>	Keppra®	Levetiracetam
<input type="checkbox"/>	Apodorm®, Mogadon®, Nitrazepam, Pacisyn®	Nitrazepam
<input type="checkbox"/>	Apydan®, Trileptal®	Oxcarbazepine
<input type="checkbox"/>	Fenemal "Dak"	Phenobarbital
<input type="checkbox"/>	Phenytoin "Dak"	Phenytoin
<input type="checkbox"/>	Primidone "Era"	Primidone
<input type="checkbox"/>	Gabitril®	Tiagabin
<input type="checkbox"/>	Epitomax, Topamac, Topimax®, Topiramate	Topiramate
<input type="checkbox"/>	Delepsine®, Deprakine®, Orfiril®	Valproate
<input type="checkbox"/>	Sabrillex®	Vigabatrin
<input type="checkbox"/>	Other medicine: _____	

31. Has your daughter taken any other medicine (apart from epilepsy medicine) for 3 or more months at a time?

- Yes
- No
- Don't know

If yes:

Which type of medicine and for which disease?

1	_____	_____
	(medicine)	(disease)
2	_____	_____
	(medicine)	(disease)
3	_____	_____
	(medicine)	(disease)
4	_____	_____
	(medicine)	(disease)

32. Has your daughter ever been concussed?
(Tick one box only)

- Never
- Once
- 2 or more times
- Don't know

33. Has your daughter ever fractured a bone (e.g. broken arm, leg or finger)?
(Tick one box only)

- Never
- Once
- 2 or more times
- Don't know

34. Has a doctor ever said that your daughter had eczema, also known as allergic rash?

- Yes
 - No
-

35. Has your child ever had an itchy rash which was coming and going for at least 6 months?

Yes (go to next question)

No (skip to question 41)

36. Has your daughter had this itchy rash at any time in the last 12 months?

Yes (go to next question)

No (skip to question 41)

37. Has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck, ears or eyes?

Yes

No

38. At what age did this itchy rash first occur?

Under 2 years

Age 2-4

Age 5 or more

39. Has this rash cleared completely at any time during the last 12 months?

Yes

No

40. In the last 12 months, how often, on average, has your child been kept awake at night by this itchy rash?

Never in the last 12 months

Less than 1 night per week

1 or more nights per week

41. Has your daughter ever had eczema, also known as allergic rash?

Yes

No

42. Does your daughter have dry skin?

- Yes
- No

43. Has your child ever had wheezing or whistling in the chest at any time in the past?

- Yes (go to next question)
- No (skip to question 48)

44. Has your child had wheezing or whistling in the chest **in the last 12 months?**

- Yes (go to next question)
- No (skip to question 48)

45. How many attacks of wheezing has your child had **in the last 12 months?**

- None
- 1 to 3 times
- 4 to 12 times
- 13 or more times

46. **In the last 12 months** how often, on average, has your child's sleep been disturbed due to wheezing?

- Never woken with wheezing
- Less than 1 night per week
- 1 or more nights per week

47. **In the last 12 months** has wheezing ever been severe enough to limit your child's speech to only one or two words at a time between breaths?

- Yes
- No

48. Has your child ever had asthma?

- Yes
 - No
-

49. **In the past 12 months**, has your child had a dry cough at night, apart from a cough associated with a cold or a chest infection?

- Yes
 No

50. Apart from coughing because of a cold or other chest infection, has your daughter had a dry cough during the night **during the past 12 months**?

- Yes
 No

51. Has a doctor ever said that your daughter had asthma?

- Yes (go to next question)
 No (skip to question 53)

52. Has your daughter taken asthma medicine during the past 12 months?

- Yes
 No

If yes:

Which type of medicine?

(Tick appropriate boxes)

- Bricanyl
 Salbuvent
 Spirocort
 Ventoline
 Pulmicort
 Flixotide
 Terbasmin
 Other asthma medicine: _____

53. Has a doctor ever said that your daughter has hay fever?

- Yes
 No
-

54. Does your daughter have normal vision in both eyes?

- Yes (skip to question 58)
- No

If no:

Which eye has abnormal vision?
(Tick one box only)

- Left
- Right
- Both

55. Do you know why her vision is abnormal?

- Yes
- No

If yes:

What is the reason for her abnormal vision?
(Tick one box only)

- Premature birth
- Birth trauma (lack of oxygen, brain haemorrhage)
- Squint
- Hereditary cataract
-
- Shortsightedness
- Longsightedness
- Other, please describe: _____

56. Does she wear glasses/contact lenses?

- Yes
- No (skip to question 58)

If yes:

Does she have normal vision when she wears glasses/contact lenses?

- Yes
- No
-

57. How old was your daughter when she started wearing glasses/contact lenses?
(Tick one year and one month)

	0	1	2	3	4	5	6	7	8	9	10	11	Don't know
Year	<input type="checkbox"/>			<input type="checkbox"/>									
Months	<input type="checkbox"/>												

58. Has your daughter ever had a squint?

- Yes (go to next question)
- No (skip to question 61)
- Don't know (skip to question 61)

59. Has she been treated for the squint?

- Yes
- No
- Don't know

60. What age was she when the squint was discovered?
(Tick one year and one month)

	0	1	2	3	4	5	6	7	8	9	10	11	Don't know
Year	<input type="checkbox"/>			<input type="checkbox"/>									
Months	<input type="checkbox"/>												

61. Does your daughter have a permanent hearing loss?

- Yes (go to next question)
- No (skip to question 63)
- Don't know (skip to question 63)

62. Has her hearing loss been treated?

- Yes, with a hearing aid
- Yes, with : _____
- No

63. Is your daughter right or left handed? (Tick one box only)

- Righthanded
- Lefthanded
- Uses both
- Don't know

64. Has your daughter been constipated and treated with a laxative?

- Yes
- No
- Don't know

65. Do you think that your daughter has had more infections than other girls her age?

- Yes
- No
- Don't know

66. Does your daughter get migraines?

- Yes
- No
- Don't know

67. Does your daughter have a handicap or chronic illness?

- Yes
- No
- Don't know

If yes:

(Tick appropriate boxes)

- Cleft lip and palate
 - Hypospadias
 - Heart disease
 - Asthma
-

Allergy

Other: _____

68. Insert your daughter's present height and weight?

Height: cm Date for measurement:
(dd/mm/yyyy)

Weight: kg Date for measurement:
(dd/mm/yyyy)

69. Insert your daughter's waist measurement (where she is most slender)?

Waist: cm Date for measurement:
(dd/mm/yyyy)

Questions about your daughter's strengths and weaknesses

70. Please consider whether the below statements are Not true, Partly true or Very true of your daughter. Please answer all the questions, even if you are in doubt or feel that they are not meaningful in relation to your daughter's age. Your answers should relate to your daughter's behaviour within the past 6 months.
(Tick one box on each line)

	Not true	Partly true	Very true
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies and cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

continues...

	Not true	Partly true	Very true
Picked on and bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, day-care centre, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

71. Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people??
(Tick one box only)

- No (skip to question 76)
- Yes, minor difficulties (go to next question)
- Yes, definite difficulties (go to next question)
- Yes, severe difficulties (go to next question)

72. How long have these difficulties been present?
(Tick one box only)

- Less than a month
- 1-5 months
- 6-12 months
- Over a year

73. Do the difficulties upset or distress your child?
(Tick one box only)

- Not at all
- Only a little
- Quite a lot
- A great deal

74. Do the difficulties interfere with your child's everyday life in the following areas??
(Tick one box on each line)

	Not at all	Only a little	Quite a lot	A great deal
Home life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Classroom learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

75. Do the difficulties put a burden on you or the family as a whole??
(Tick one box)

- Not at all
- Only a little
- Quite a lot
- A great deal

About your own childhood

76. Which of the following statements best suits your own childhood?
(Tick one box on each line)

	Not true	Partly true	Very true
Was restless, "hyperactive", had problems keeping quiet long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches, tummy aches or nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lost temper easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a loner, played alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was often worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had good friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About your own and the other biological parent's habits

77. Do you or other biological parent smoke?
(Tick one box on each line)

	You	The other biological parent
1-9 cigarettes/day	<input type="checkbox"/>	<input type="checkbox"/>
10-19 cigarettes/day	<input type="checkbox"/>	<input type="checkbox"/>
20 or more cigarettes/day	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>
Non-smoker	<input type="checkbox"/>	<input type="checkbox"/>

78. Have you or the other biological parent smoked since the birth of your daughter?
(Tick one box on each line)

	You	The other biological parent
Yes	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>

79. Is your daughter exposed to tobacco smoke in the home?
(Tick one box only)

- Never
 Rarely
 Often
 Daily
 Don't know

80. How many units do you/the other biological parent drink during a normal week?
(Tick one box on each line)

	You	The other biological parent
None	<input type="checkbox"/>	<input type="checkbox"/>
1-14 units/week	<input type="checkbox"/>	<input type="checkbox"/>
15-21 units/week	<input type="checkbox"/>	<input type="checkbox"/>
22-29 units/week	<input type="checkbox"/>	<input type="checkbox"/>
30 or more units/week	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>

81. Insert your/the other biological parent's height and weight and waist measurement?

	You	The other biological parent
Height	<input type="text"/> cm	<input type="text"/> cm
Weight	<input type="text"/> kg	<input type="text"/> kg
Waist measurement	<input type="text"/> cm	<input type="text"/> cm
Don't know	<input type="checkbox"/>	<input type="checkbox"/>

82. Insert your/the other biological parent's birth weight

	You	The other biological parent
Birth weight	<input type="text"/> g	<input type="text"/> g
Don't know	<input type="checkbox"/>	<input type="checkbox"/>

83. If you are/the other biological parent is aware of your birth weight, where did you get this information from?
(Tick one box on each line)

	You	The other biological parent
From birth certificate	<input type="checkbox"/>	<input type="checkbox"/>
From mother	<input type="checkbox"/>	<input type="checkbox"/>
From other source	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>

84. Were you/the other biological parent born prematurely?
(Tick one box on each line)

	Du	The other biological parent
Yes	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>

About the parents' situation

85. Are you/the other biological parent employed?
(Tick one box on each line)

	You	The other biological parent
37 hours/week or more	<input type="checkbox"/>	<input type="checkbox"/>
30-36 hours/week	<input type="checkbox"/>	<input type="checkbox"/>
15-29 hours/week	<input type="checkbox"/>	<input type="checkbox"/>
Less than 15 hours/week	<input type="checkbox"/>	<input type="checkbox"/>
Unemployed	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>

86. Do you know the Christian names of your closest neighbours?
(Tick one box only)

- Yes, 1-4 of them
- Yes, 5-9 of them
- Yes, 10 or more of them
- No

87. Do you take part in local social activities?
(Tick one box only)

- Yes, often
- Yes, sometimes
- Rarely or never

88. Do you take part in organisational work?
(Tick one box only)

- Yes, a lot
- Yes, a little
- Rarely or never

89. Have you had a psychiatric illness or bad nerves since birth?

- Yes (go to next question)
- No (skip to page 30)
- Don't know (skip to page 30)
- Prefer not to answer (skip to page 30)

90. Have you been in contact with a doctor or psychologist because of this?

- Yes
- No
- Don't know
- Prefer not to answer

91. Have you ever been hospitalised because of this illness ?

- Yes
- No
- Don't know
- Prefer not to answer

92. Which type of illness had you suffered from?
(Tick appropriate boxes)

- Alcohol misuse
 - Anxiety
 - Depression
 - Family problems
 - Postnatal depression
 - Crisis after death/stillbirth
 - Life crisis
 - Manic depression
 - Neurosis
 - Childhood/Child Psychiatric Disorder
 - Psychosis (schizophrenia, delusions)
 - Suicide
 - Eating disorder (anorexia, bulimia)
 - Substance misuse
 - Other: _____

 - Don't know
 - Prefer not to answer
-

About mobile phones

93. Do you have a mobile phone?
(Tick one box only)

- Yes
 No

94. Is it your own mobile phone?
(Tick one box only)

- Yes
 No

95. When did you start using a mobile phone?
(Tick one box only)

- Less than 5 years ago
 5-9 years ago
 More than 10 years ago

96. Did you use a mobile phone when you were pregnant with your daughter?
(Tick one box only)

- Yes
 No
 Don't know

97. When did you use the mobile phone?
(Tick one box only)

- 1st – 3rd month
 4th – 6th month
 7th month - delivery

98. How many times a day on average did you speak on the phone while pregnant?
(Messages do not count)
(Tick one box only)

- 1-2 times
 3-6 times
 7 or more times a day
 Don't know

99. Where did you carry your mobile while pregnant?

(Tick one box only)

- In trouser pocket
- In pocket of dress
- In my bag
- Other: _____

100. Was the mobile on while you had it on you?

(Tick one box only)

- Yes, all the time
- Yes, 50 - 99% of the time
- Yes, but less than 50% of the time
- No, never or almost never

101. Did you have an earpiece for your mobile?

(Tick one box only)

- Yes, but I rarely used it
- Yes, I used it often
- No

102. Does your daughter use a mobile phone? (Messages do not count)

(Tick one box only)

- No, never
- Yes, but less than 1 hour/week
- Yes, more than 1 hour/week

103. Is your home telephone...

(Tick appropriate boxes)

- a mobile telephone
- an ordinary telephone with a cable
- a wireless telephone

104. Does your daughter use the wireless telephone more than 1 hour/day?

(Sæt kun ét kryds)

- Yes
 - No
 - Don't know
-

You have now finished this questionnaire.

We hope that we may contact you again when your daughter is older. This contact may be by email. If you consent to this, please state your email address below (your mail address is of course strictly confidential).

I can be contacted at the following address (write clearly):

_____ @ _____

Comments and supplementary information

Thank you very much!

Remember to return the questionnaire in the stamped addressed envelope provided.

Yours sincerely



Joern Olsen, Project manager

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