NorFlu

The Norwegian Cohort study

Questionnaire about yourself and your child 6 months after birth

The form will be read by a machine. Please use blue or black ballpoint pen and write clearly.
• In the small check boxes, indicate the answer that you think is best, as follows: x
• If you feel that you have set the cross in the wrong box, you can correct it by filling the box completely, as follows:
•Number boxes have two or more squares. When you write a one-digit numbers, use the right pane. Example: 5 is written as 5

Enter day, month and year of completion of the form (write the year with 4 digits, e.g. 2010)
day month year

The child's growth and nutrition

1. Referring to the child's health card, please enter below the child's weight, length and head circumference at the age of 6 weeks, 3 months and 6 months. Enter the date of measurement:

Date of measurement
Day | month |year | Length | Head circumference | Weight
Approx. 6 weeks
Approx. 3 months
5 - 6 months

2. Did you breastfeed your child?
No
Yes, still breastfeeding
Yes, but have now stopped
Child's age when you stopped:
months and / or weeks

3. Does your child consume cod lever oil or other dietary supplements?
No
Yes
If yes, which? Cod liver oil
Vitamin D mixture? (drops)
Other, what?

Illness and health problems

The following questions concern any illnesses or health problems the child has had. First, we ask about more long-term problems. On the next page you will find questions about illnesses and problems of more acute nature.

4. Does your child have or has she/he had any of the following health problems? If yes, was the child referred to a specialist investigation?
(Mark each ithem)

	Has the child had problems?		Has the child been referred to a specialist for this?	
	No	Yes	No	Yes
1. Impaired hearing				
2. Impaired vision				
3. Delayed motor development (movement development)				
4. Heart defects				
5. Testicles not descended into scrotum				
6. Atopic (childhood) eczema				
7. Hives/ urticaria				
8. Allergy, what kind – describe				
9. Congenital malformation - describe				

10. Other – describe

5. Has your child had the following diseases / health problem? If yes, did you seek medical attention? (Mark for each line.)
Has the child had a health problem |Number of times |Did you seek medical attention for this? | was the child admitted to hospital for this?
No Yes

1. Common cold
2. Ear infection
3. False croup
4. Influenza
5. Bronchitis / RS-virus / pneumonia
6. Gastric flu / diarrhoea
7. Urinary tract infection
8. Febrile convulsions
9. Other convulsions (without any fever)
10. Colic
11. Injury / Accident - describe
12. Other - please describe

More about influenza (If the child has not had influenza, go to question 10)

6. If your child has had influenza, how old was he / she?
If the child has not had influenza, go to question 10
Months| Weeks

7. No Yes Do not know
Was a nasal sample taken from the child?
Was a blood sample taken from the child?
Did the test confirmed influenza?

8. How ill was the child when he / she had influenza?
Hardly ill
Quite ill for a few days
Very sick
Hospitalised

9. If your child has had influenza, mark which symptoms the child had and how many days they lasted?
(Mark for each symptom)
Number of days with symptoms
No |Yes |1-2| 3-5| More than 5

1. Restless and irritable
2. Stuffy nose / runny nose
3. Sore throat
4. Cough
5. Shortness of breathing
6. Fever below 39.0 C
7. Fever of 39.0 C or higher
8. Fever (not measured)
9. Febrile convulsions
10. Other convulsions
11. Vomiting, diarrhoea
12. Ear infection
13. Pneumonia
14. Other
Describe:

At the specialist or at hospital

10. If the child was examined by a specialist at the hospital or hospitalized after you came home from the maternity ward, please name the hospital(s) and the diagnosis (es)
Hospital / Specialist:
Diagnosis:

11. Has the child had an operation or does he/she have a condition that will require surgery?
No
Yes, which:

Medicines and vaccines

12. Has your child ever used medication? No Yes

13. If yes, mark the type of medicine, and when / how long it was used. If you do not remember the name, state the type of medicine, such as influenza medicine, anti-pyretic, etc. Include all types of medicine, including nutrition supplements and non-prescripted medicine.
How old was your child when medicine was used
<1 month| 1- 2 months | 3-4 months | 5-6 months | > 6 months | Number days used in total
Name of medicine
(Eg. Apocillin, Paracetamol)

14. Do you want your child to follow the Childhood Immunisation Programme recommended at the health clinic?
Yes
No, do`nt want vaccines
No, just want a few vaccines
Do`nt know

More about the child's development and behaviour

15. Mark whether you agree or disagree with these statements about the child's mood and temperament. Think of a typical life situation. (Mark on each line.)

Completely disagree| Disagree| Slightly disagree| Neither agree nor disagree | slightly agree| Agree| Completely agree

1. The child whimpes and cries a lot
2. The child is usually easy to pacify when he / she is criying
3. It doesn't take much before your child to become upset and starts crying
4. When the child is crying, he/she usually screams angrily and loudly
5. He/she is easy to deal with
6. The child demands an awful lot of attention
7. When the child is left alone, he / she is usually play contently
8. The child is so demanding that he/she would pose a major problem for most parents
9. The child smiles and laughs often
10. The child seems passive
11. The child is easy to put down and goes to sleep quickly

16. Currently how often does your child wake up during the night?
(Mark only one box.)

3 or more times every night
Once or twice every night
A few times a week
Seldom or never

17. How many hours does your child usually sleep per day?
Less than 8 hours
8 - 10 hours
11 - 12 hours
13 - 14 hours
15 - 18 hours
More than 18 hours

18. Are you concerned about your child's sleep pattern?
No
Yes, the child is sleeping more than usual
Yes, the child is sleeping less than usual
Yes, the child is unusually restless in his/her sleep
Yes, other description:

19. Do you have other concerns about your child's development or health?
No
Yes, please describe:

20. Here are some questions about the child's development. If you have not noticed it, take some time to observe what the child actually does.
(Please mark each question.)
Yes often | Yes rarely| No, not yet | Do not know

1. When the child is lying on his/her back, does he/she play by grabbing hold of his/her feet?
2. When the child is lying on his/her tummy, does he/she lift his/her upper body off the ground with straight arms?
3. Does the child roll over from his/her back onto his/her tummy?
4. When you "chat" to your child, does he/she "chat" back to you?
5. Does the child babble and make sounds when he/she is lying on his/her own?
6. Can you tell how the child is just by listening to the sounds he/she is making (e.g. contented, hungry, angry, in pain)?
7. Do you get a smile from the child when you just smile at him/her? (without touching or tickling the child or without holding up a toy)?
8. When you call the child, does he/she turns towards you one of the first times you say his/her name?
9. Does the child grab hold of a toy you give him/her and then put it in his/her mouth or hold it?
10. When the child is sitting on your lap, does he /she stretch for a toy or anything else on the table in front of you?
11. Does your child hold onto a toy with both hands when he/she examining it?

21. Many of these questions are quite similar, but most differ in small details to highlight various elements in development. We hope that you take the time to answer all the questions even though they may not all apply for your child.
Yes Sometimes Not yet

1. Does your child whine in a high pitched voice?
2. If there is a loud noise, does the child turn to see where it comes from?
3. Does the child make sounds like "da", "ga", "ka" and "ba"?
4. When the child is lying on his back, does he/she lift his legs high enough to see his feet?
5. When you sit your child on the floor, does he/she lean on her hands and support herself while sitting? (If he/she can already sit straight up without leaning on his/her hands, mark "yes.")
6. If you hold both the child's hands so that he/she keeps his balance, does he/she stand?
7. Does the child come into a crawling position on hands and knees?
8. When the child is lying on his/her back, does he/she place her foot in his/her mouth?
9. If you give your child a toy, will he/she keep it, look at it, wave it, or try chewing on it for about a minute?
10. Does the child stretch after or grab a toy with both hands at once?
11. Does the child stretch after a crumb or raisin and pick it with his/her fingers? (If he/she is already picking up small objects the size of a pea, mark "Yes.")
12. Does your baby pick up a small toy, holding it in the palm with fingers wrapped around it?

13. Does your child try to pick up a crumb or raisin by using all the fingers in a rake movement, even if he/she fails to take hold of it? (If the child is already able to pick up a raisin, mark "Yes.")
14. Does the child pick up a small toy with only one hand?
15. Does the child try to grab a toy that is out of reach?
(He/she can roll, move on his/her stomach or crawl to get it.)
16. When your child has a toy in front of him/her, does he/she stretch after it with both hands?
17. If the child is lying on his/her back and loses a toy, does he/she then turn his/her head to look for it?
(If the child is already picking up toys, mark "Yes.")
18. When the child is lying on his/her back, does he/she try to pick up a toy he/her has dropped if he/she can see it?
19. Does your child often pick up toys and put them in his/her mouth?
20. Does your child transfer a toy from one hand to the other?
21. Does your child play by hitting the toy repeatedly against the floor or table?
22. When your child is sitting in front of a mirror, does he/she smile and make noises to his/her mirror image?
23. When the child is sitting in front of a large mirror, does he/she stretch out and pat the mirror?
24. Does your child react differently to strangers than to you and other familiar people? (Reactions may be staring, frowning, withdrawal or crying)

About You

Pregnancy

22. How much did you weigh at the end of pregnancy, and how much do you weigh now (in kg)?
At the end of pregnancy: kg Now: kg

23. Did you have high blood pressure in this pregnancy?
Don't know
No
Yes, highest blood pressure was:

24. Did you have vaginal bleeding during this pregnancy? If yes, please mark when you had bleeding and if you contact a doctor/midwife because of it? (You can mark multiple boxes).

Week of pregnancy	Had bleeding		Contacted doctor / midwife	
	No	Yes	No	Yes
Before week 27				
27-28				
29-34				
35 or later				

25. In the last trimester of pregnancy, did you experience periods with altered foetal activity / kicking?
No
Yes
Do`nt know

26. If yes, please mark when you experienced the altered foetal activity / kicking and if you consulted a doctor or midwife
(You can mark several boxes.)

Week of pregnancy	Less activity/kicking than normal	More activity/kicking than normal	Consulted doctor/midwife	
			No	Yes
Before week 27				
27-28				
29-34				
35 +				

27. In the last three months before birth or after birth have you ever had periods which was marked by some of the following problems:

No | Yes If yes | In last 3 months of pregnancy| 0-3 months after birth| 4-6 months after birth
1. Mental and/or physical fatigue
2. Sleeping problems
3. Depressed mood
4. Concentration problems
5. Difficulty performing daily activities, work, school, etc.

28. Were there any complications during birth?
No
Yes
If yes, please describe

Health and Disease

29. Do you have a chronical / long-term diseases that occurred in the latter part of pregnancy or after birth?
No
Yes, which:

30. Were you on full or partial sick leave after 30th week of pregnancy? If yes, please state the reason.
(Don`t include maternity leave)
No
Yes, partial sick leave, number of weeks. Cause:
Yes, full sick leave, number of weeks. Cause:

31. Excepting birth, have you ever been hospitalised in the latter part of pregnancy or after birth?
No
Yes, in the latter part of pregnancy
Yes, after the birth
What was the diagnosis?
Which hospital?

32. Have you had any of the following diseases / health problems during pregnancy? If yes, please mark in which week of pregnancy.
(You can mark several for several periods.)
In pregnancy week After birth
No Yes 0-8 9-12 13-20 21-28 29-34 35+ 0-3 months 4 months +

1. Long-term nausea with vomiting
2. Cystitis / pyelitis
3. Common cold
4. Sore throat
5. Sinus / ear infection
6. Influenza
7. Pneumonia
8. Fever 38.0 or higher
9. Sugar in urine
10. Pre-eclampsia
11. Chronic fatigue syndrome /ME
12. Other
Describe:

33. Have you had influenza since April 1st 2009?
Dont know
No, go to question 40
Yes, when?
Month Year

34. Did you visit the doctor?
No Yes

If yes, No Yes Don't know

Was a nasal sample taken from you?
Was a blood sample taken from you?
Did the test confirm you had influenza?

35. How ill did you feel?
Not very ill
Quite ill, in bed for several days
Very ill
Hospitalised

36. If you had influenza, mark which symptoms you had and how many days they lasted. (You can select multiple symptoms.)

	If yes, number of days with symptoms			
	No	yes	1-2	3-5	More than 5 days
1. Headache				
2. Stuffy nose / runny nose				
3. Sore throat				
4. Cough				
5. Shortness of breath				
6. Chest pain				
7. Fever `below 39.0				
8. Fever of 39.0 or higher				
9. Fever (not measured)				
10. Convulsions				
11. Joint pain				
12. Muscle pain				
13. Vomiting, diarrhoea				
14. Ear infection				
15. Pneumonia				
16. Other				

Describe

37. Did you experience fatigue after swine influenza / influenza?
No
Yes, number of weeks duration
Yes, I am still experience fatigue
Describe

Vaccines, medicines and nutrition supplements

38. Has anyone in your household had influenza since April 1st 2009?
No
Yes If yes, who?
Spouse / Partner
Children
Other

39. On a scale of 0 to 10, how worried are you that swine influenza /influenza vaccine may be dangerous for you or your child?
Very little worried Very worried
0 1 2 3 4 5 6 7 8 9 10

40. Have you received a vaccine against influenza after April 1st 2010?
No Yes If yes, when |Year | Month

41. Have you received other vaccines since April 1st 2010
No Yes
If yes, which?

42. After the vaccination you received after t April 1s 2010, did you experience adverse events?
No Yes
If yes, which vaccine and which adverse events?

43. On a scale of 0 to 10, how worried are you that the influenza vaccine may be dangerous for you?
Very little worried Very worried
0 1 2 3 4 5 6 7 8 9 10

44. Have you used medicine for influenza or other medicines during the last 6 months?
No Yes

45. If yes, which medicine did you use and for how long time?
Number of days used
1-5 6-10 more than 10
Influenza medicine:
Tamiflu
Relenza
Antipyretic drugs (to reduce fever):
Name of medicine
Antibiotics:
Name of medicine
Other prescribed medicine:
Name of medicine
Other non- prescription medicine:
Name of medicine

46. Please mark whether you have used vitamins or nutritional supplements in late pregnancy or after birth. Enter the name of the product and when you have used it. Include all kinds of supplements, including herbal remedies and alternative medicines.
Name of product | The last part of pregnancy |after childbirth

Cod liver oil
(Other) Omega-3
Folate (separate tablets 0.4 mg)
Multivitamin / mineral
Other vitamins / supplements
Other vitamins / supplements

47. How often are you so physically active at present (during your spare time or at work) that you get out of breath or sweat?
Before last pregnancy | First half of pregnancy| last half of pregnancy| currently

Never
Less than once per week
Once a week
Twice a week

3-4 times a week
5 times or more a week

48. What were you and your partner/husband smoking habits during the last 3 months of pregnancy and after birth?
(Mark for each period.)

Yourself Your partner / spouse
Last 3 months in pregnancy | 0-3 months after birth| 4-6 months after birth Last 3 months in pregnancy | 0-3 months after birth| 4-6 months after birth

Didn't smoke
Smoked occasionally
Smoked daily
If daily, number of cigarettes per day
If occasionally, number of cigarettes per week

49. Is the child ever present in the room where someone smokes?
No | Yes, sometimes | Yes, several times a week | Yes, daily

Units of alcohol
In order to compare different types of alcohol, we ask for the number of alcohol units (= 1.5 cl of pure alcohol). In practice this means the following:
1 glass (1/3 litre) of beer = 1 alcohol unit
1 wine glass of red or white wine = 1 alcohol unit
1 sherryglass of sherry or other fortified wine = 1 alcohol unit
1 brandy glass of spirits or liqueur = 1 alcohol unit
1 bottle of alcopop/ cider = 1 alcoholunit

50. How often and how many units of alcoholic do you usually consume? (See earlier explanation of units of alcohol) (Mark for each line)

Daily | 3-5 times per week | 1-2 times per week | 1-3 times per month| Less than once a month| Never

10 or more
7-9
5-6
3-4
1-2
Fewer than 1

51. Do you have a husband/partner/cohabitant?
No
Yes

52. If you have a husband/partner/cohabitant, do you agree with these descriptions? (Please mark each line.)
Completely agree |agree |Slightly agree |Slightly disagree |disagree |Completely disagree

1. My partner and I have problems in our relationship
2. I am very happy in my relationship
3. My partner is usually understanding
4. I am satisfied with the relationship with my partner
5. We agree on how children should be raised

53. During the past 2 weeks have you been bothered with any of the following? (please mark each line)
Not bothered|A little bothered| Quite bothered|Very much bothered

1. Feeling fearful
2. Nervousness or shakiness inside
3. Feeling hopeless about the future

4. Feeling blue, melancholy
5. Worrying too much about things
6. Feeling everything is an effort
7. Feeling tense or keyed up
8. Suddenly scared for no reason

55. In the last 12 months have you experiences any of the following situations? If yes, how painful or difficult was it for you?
(Please enter a cross for each ithem)

		If yes		
	No	Yes	Not so bad	Difficult	Very difficult
1. Have you had financial problems?					
2. have you been divorced, separated or ended your relationship with your parter?					
3. Have you had problems or conflicts with family, friends or at work?					
4. Have you been seriously ill or injured?					
5. Have you lost someone closed to you?					
6. Other					

56. Do you agree or disagree with the following statements? (Put a mark on each ithem)

	Completely disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Completely agree
1. My life is largely what I want it to be							
2. My life is very good							
3. I am satisfied with my life							
4. So far I have achieved what is important for me in my life							
5. If I could start all over, there is very little I would do differently							
6. I really enjoy my work							

Comments or additional information

Have you remembered to fill in the date for completing the form on page 1?
Thank you for your help!