GLOFAL
Questionnaire for Allergic Diseases
Multi-Centre Study

Date : __ __/ __ __/ __ __ __ __ **Country:** *GHANA*

Name of Interviewer : __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Name of Recorder : __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

A. Child's details

1. Name / ID number :__ __ __ __ __ __ __ __ __ __ __ __ __ __ __/ __ __ __ __ __
2. Date of birth / Age : __ __/ __ __/ __ __ __ __ [ ] year(s)
3. Place of Birth (including Region): __ __ __ __ __ __ __ __ __ __ __ __ __ _____

   [Country IF NOT Ghana]: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ___
4. Ethnicity: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ _

   [Country of Origin IF NOT Ghana]: __ __ __ __ __ __ __ __ __ __ __ __ _
5. Sex : [ ] Male [ ] Female
6. What is the position of this child in sib-ship? : __ __ __ __ of __ __ __ children
7. School information
   Class : __ __ __ __ __ __ __ __
   Name of school : __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
   __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
8. House information
   House Number : __ __ __ __ __ __ __ __
   Suburb/ Area : __ __ __ __ __ __ __ __
   Telephone : __ __ __ __ __ __ __ __

   GPS Readings
   a. Latitude : __ __ __ __ __ __ __ __
   b. Longitude : __ __ __ __ __ __ __ __
   c. Altitude : __ __ __ __ __ __ __ __
9. How far is the school from home (GPS reading)? : __ __ __ __ __ __ __ Km

10. How does the child get to school most of the time?

[ ] Walk
[ ] Bicycle
[ ] Taxi
[ ] Bus / Trotro
[ ] Private Car
[ ] Other, please specify __ __ __ __ __ __ __ __ __ __

B. Socio-economic Status and Environmental Factors.

1. Has the child lived in this town/village since he/she was born? **[ ] Yes [ ] No**

2. If you answered "no" where has the child lived before and for how long?

   Area A In. __ __ __ __ __ __ __ __ __ for__ __ __ month(s) __ __ __ Year(s)
   Area B In. __ __ __ __ __ __ __ __ __ for__ __ __ month(s) __ __ __ Year(s)
   Area C In. __ __ __ __ __ __ __ __ __ for__ __ __ month(s) __ __ __ Year(s)
   Area D In. __ __ __ __ __ __ __ __ __ for__ __ __ month(s) __ __ __ Year(s)

3. Who provides financially for this child?
   [ ] Father and Mother
   [ ] Father
   [ ] Mother
   [ ] Other, please specify: __ __ __ __ __ __ __ __ __ __ __ __ __

4. Occupation of person in question number 3: __ __ __ __ __ __ __ __ __ __ __

   Occupation of the spouse of this person: __ __ __ __ __ __ __ __ __ __ __ __ __

5. The highest level of formal education completed by:
   Person (question number 3)
   [ ] Primary/Elementary [ ] Middle school [ ] JSS [ ] SSS [ ] O'level
   [ ] A' level [ ] Vocational/ Commercial [ ] Training College
   [ ] Polytechnic/University
   [ ] Other, please specify __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

   Spouse of this person
   [ ] Primary/Elementary [ ] Middle school [ ] JSS [ ] SSS [ ] O' level
   [ ] A' level [ ] Vocational/ Commercial [ ] Training College
   [ ] Polytechnic/University
   [ ] Other, please specify __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

6. Who does this child live with (if different from response in question "3" above)?
   [ ] Father and Mother
   [ ] Father
   [ ] Mother
   [ ] Other, please specify: __ __ __ __ __ __ __ __ __ __ __ __ __

7. Occupation of person in question number 6: __ __ __ __ __ __ __ __ __ __ __

   Occupation of the spouse of this person: __ __ __ __ __ __ __ __ __ __ __ __ __

8. The highest level of formal education completed by:
   Person (question number 6)
   [ ] Primary/Elementary [ ] Middle school [ ] JSS [ ] SSS [ ] O'level
   [ ] A' level [ ] Vocational/ Commercial [ ] Training College
   [ ] Polytechnic/University
   [ ] Other, please specify __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

   Spouse of this person
   [ ] Primary/Elementary [ ] Middle school [ ] JSS [ ] SSS [ ] O'level
   [ ] A' level [ ] Vocational/ Commercial [ ] Training College
   [ ] Polytechnic/University
   [ ] Other, please specify __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

9. The house in which the child lives is made primarily of :
   [ ] Cement [ ] Wood [ ] Mud [ ] Other, please specify __ __ __ __ __

10. What is the main source of water supply to the home?
    [ ] Pipe-borne [ ] Tanker (treated) [ ] Tanker (untreated)
    [ ] River/ Stream [ ] Well/ Borehole
    [ ] Other, please specify __ __ __ __ __ __ __ __ __ __ __ __ __

11. What is the type of toilet in the home?
    [ ] Indoor WC [ ] Compound latrine [ ] Public latrine
    [ ] Other, please specify __ __ __ __ __ __ __

12. The fuel **mostly** used at home for cooking is*(tick one):*
    [ ] LPG [ ] Electricity [ ] Charcoal [ ] Firewood
    [ ] Kerosene [ ] Other__ __ __ __ __ __ __

13. What kind of accommodation does the child live in?
    [ ] Detached house [ ] Semi-detached [ ] Flat
    [ ] Compound house [ ] Other, please specify__ __ __ __ __ __ __ __

14. How much money did your family spend on electricity in the past month?

    ¢ __ __ __ __ __ __ __ __ __
    [ ] Respondent unable to estimate

15. How much money did your family spend on food in the past month?

    ¢ __ __ __ __ __ __ __ __ __
    [ ] Respondent unable to estimate

C. ISAAC Core Questionnaires

C1 Core Questionnaire for Wheezing and Asthma

All questions are about problems which occur when this child <u>DOES NOT</u> have a cold or the flu

1. Has this child ever had wheezing or whistling in the chest? **[ ] Yes** **[ ] No**

IF YOU HAVE ANSWERED "NO" PLEASE SKIP TO QUESTION 6

2. Has this child had wheezing or whistling in the chest in the past 12 months?
[ ] Yes **[ ] No**

IF YOU HAVE ANSWERED "NO" PLEASE SKIP TO QUESTION 6

3. How many attacks of wheezing has this child had in the past 12 months?
[ ] None
[ ] 1-3
[ ] 4-12
[ ] > 12

4. In the past 12 months how often, on average, has this child's sleep been disturbed due to wheezing?
[ ] Never woken with wheezing
[ ] Less than one night per week
[ ] One or more nights per week

5. In the past 12 months, has wheezing ever been severe enough to limit this child's speech to only one or two words at a time between breaths? **[ ] Yes** **[ ] No**

6. In the past 12 months, has this child's chest sounded wheezy during or after exercise? **[ ] Yes** **[ ] No**

7. In the past 12 months, has this child had a dry cough ***at night***, apart from a cough associated with a cold or chest infection? **[ ] Yes** **[ ] No**

8. Has a doctor ever diagnosed your child as having asthma? **[ ] Yes** **[ ] No**

9. If yes to question number 8, what is the name of the medicine(s) the doctor gave to your child?
Medicine(s) __
[ ] Cannot recall name of medicine

10. Has any member of this child's family ever had asthma?
[ ] Yes **[ ]No** **[ ] No idea**

11. If you answered "yes" to question 10, indicate relationship to child (*tick all that apply*)
[ ] Father
[ ] Mother
[ ] Brother or Sister
[ ] Father's __ __ __ __ __ __ __ __ __ (family member eg. sister, father)
[ ] Mother's __ __ __ __ __ __ __ __ __ (family member eg. sister, father)

C2 Core Questionnaire for Rhinitis/Hayfever
***All questions are about problems which occur when this child <u>DOES NOT</u> have a cold or the flu*.**

1. Has this child ever had a problem with sneezing or a runny or blocked nose (nose problem) without cold or the flu? **[ ] Yes [ ] No**

IF YOU HAVE ANSWERED "NO" PLEASE SKIP TO QUESTION 6

2. Has this child had this nose problem in the past 12 months? **[ ] Yes [ ] No**

IF YOU HAVE ANSWERED "NO" PLEASE SKIP TO QUESTION 6

3. In the past 12 months, has this child's nose problem been associated with itchy-watery eyes? **[ ] Yes [ ] No**
4. In which of the past 12 months did this nose problem occur? (please tick any which apply)

[ ] January	**[ ] June**	**[ ] November**
[ ] February	**[ ] July**	**[ ] December**
[ ] March	**[ ] August**	**[ ] Rainy season**
[ ] April	**[ ] September**	**[ ] Dry season**
[ ] May	**[ ] October**	**[ ] Anytime**
		[ ] No idea

5. In the past 12 months, how much did this nose problem interfere with this child's daily activities such as school or play?
   [ ] Not at all
   [ ] A little
   [ ] A Moderate
   [ ] A lot

6. Has a doctor ever diagnosed your child as having allergic rhinitis / hay fever?
   [ ] Yes [ ] No

7. If "Yes" to question number 6, what is the name of medicine the doctor gave your child?
   Medicine(s) __
   [ ] Cannot recall name of medicine

8. Has any member of this child's family ever had allergic rhinitis / hay fever?
   [ ] Yes [ ] No [ ] No idea

9. If you answered "yes" to question 8, indicate relationship to child (*tick all that apply*)
   [ ] Father
   [ ] Mother
   [ ] Brother or Sister
   [ ] Father's __ __ __ __ __ __ __ __ __ (family member eg. sister, father)
   [ ] Mother's __ __ __ __ __ __ __ __ __ (family member eg. sister, father)

C3 Core Questionnaire for Atopic Dermatitis/Eczema
Show pictures from the* "Observer's protocol for recording signs of visible flexural dermatitis"** ***to the respondent

1. Has this child ever had one or more skin problem(s) like in the pictures accompanied by an itchy rash which was coming and going for at least 6 months?
   [ ] Yes, Picture number__ __ __ __[ ]No

IF YOU HAVE ANSWERED "NO" PLEASE SKIP TO QUESTION 6

2. Has this child ever had this skin problem (itchy rash) in the last 12 months?
   [ ] Yes [ ] No

IF YOU HAVE ANSWERED "NO" PLEASE SKIP TO QUESTION 6

3. Has this skin problem (itchy rash) at any time affected any of the following places: The folds of this child's elbows, behind the knees, in front of ankles, under the buttocks or around the neck, ears or eyes?
   [ ] Yes [ ] No

4. How often, on average, has this child been kept awake at night by this itchy rash?
   [ ] Never in the past 12 months
   [ ] Less than one night per week
   [ ] One or more nights per week

5. Did this rash clear completely at any time during the past 12 months?
   [ ] Yes [ ] No

6. Has a doctor ever diagnosed your child as having allergic eczema/ atopic dermatitis? **[ ] Yes [ ] No**

7. If yes to question number 5, what is the name of the medicine(s) the doctor gave to your child?
   Medicine(s) __
   [ ] Cannot recall name of medicine

8. Has any member of this child's family ever had allergic eczema/ atopic dermatitis? **[ ]Yes [ ]No [ ]No idea**

9. If you answered "yes" to question 8, indicate relationship to child (*tick all that apply*)
   [ ] Father
   [ ] Mother
   [ ] Brother or Sister
   [ ] Father's __ __ __ __ __ __ __ __ __ (family member eg. sister, father)
   [ ] Mother's __ __ __ __ __ __ __ __ __ (family member eg. sister, father)

D. Health concerns

1. When was the last time this child had any medical treatment?
   [ ] < 1 month ago **[ ] 1 to 3 months ago**
   [ ] 3 to 6 months ago **[ ]> 6 months**

2. What was the name of the medicine in '1' and for which condition was it given?
   Medicine1__ __ __ __ __ __ __ __ __ __ Condition1 __ __ __ __ __ __ __ __ __

   Medicine2__ __ __ __ __ __ __ __ __ __ Condition2 __ __ __ __ __ __ __ __ __

   Medicine3__ __ __ __ __ __ __ __ __ __ Condition3 __ __ __ __ __ __ __ __ __

3. When did this child last have treatment for worm infection?
   [ ] < 1 month ago **[ ] 1 to 3 months ago**
   [ ] 3 to 6 months ago **[ ]> 6 months**
   [ ] No idea

4. What was the name of the medicine used when this child was last treated for worm infection? __ __ __ __ __ __ __ __ __ __ __ __ __
   [ ] Cannot recall name of medicine

5. Is there any smoker in your house **[ ]Yes** **[ ]No**

6. If you answered "yes" to question 5, does this person smoke when the child is present? **[ ]Yes** **[ ]No**

7. Is this child exposed to tobacco smoke outside your home?
   [ ] Yes **[ ] No** **[ ] No idea**

8. Do you use groundnut oil for any other purpose (example as skin ointment)?
   [ ]Yes **[ ]No**

E. Diet

For this section, please ask the respondent how frequently **the child** consumes each food item and the cooking method used to prepare the food item.

FOOD ITEM	FREQUENCY OF CONSUMPTION					COOKING METHOD			
Staples	***Daily***	***1x weekly (at least)***	***1x monthly (at least)***	***Every half year (at least)***	***Never***	***Boiling/ Steaming***	***Frying***	***Smoking/ Grilling/ Roasting***	***Other***
Rice	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Cassava	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Plantain	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Yam	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Maize/ Corn	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Other	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Meat/Protein Source									
Cattle (Beef)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Sheep (Mutton)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Goat (Chevron)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Pig (Pork)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Chicken	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Fish	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Other__ __ __ __ __ __ __	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Shellfish (Crab, shrimp etc)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Snail	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Mushroom	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Beans	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Eggs	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Other__ __ __ __ __ __ __	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _

FOOD ITEM	FREQUENCY OF CONSUMPTION					COOKING METHOD			
	Daily	***1x weekly (at least)***	***1x monthly (at least)***	***Every half year (at least)***	***Never***	***Boiling/ Steaming***	***Frying***	***Smoking/ Grilling/ Roasting***	***Other***
Industrially processed oils									
Cooking oil (e.g. Frytol, Palmin)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Other__ __ __ __ __ __ __	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Home-made oils									
Palm oil	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Palm Kernel oil	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Coconut Oil	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Groundnut oil	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Shea Butter	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Other__ __ __ __ __ __ __	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Evaporated Milk (eg. Ideal)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Powdered Milk (eg Nido)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Margarine (e.g. Blue Band)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Cheese/Butter (e.g. Even, Laughing Cow)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Ice-cream/ Yoghurt (e.g. Fanice or FanYogo)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Groundnuts/ Peanuts	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Pastries (e.g. Cakes, pies,)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Fresh fruits (e.g., orange)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _
Fresh vegetables (e.g. salads, fresh ground pepper sauce)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	__ __ __ __ _

F. Food Allergy

The following questions are about the child's reactions to food OTHER than reactions caused by food poisoning, illness or a bacterial infection such as cholera etc.

1. Has your child ever had adverse events (reactions) after food intake?
[ ] Yes **[ ] No**

If yes which food? __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

(Show list in **Table F2** if needed)

2. Has the child had any problems eating any other food or foods that not listed in **Table F2**? If yes please list:

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

IF YOU HAVE ANSWERED "NO" TO QUESTION 1 & 2 PLEASE SKIP TO QUESTION 13

3. How old was the child when s/he had the first problem eating this food?
__ __ __ __ **year(s)**

4. How old was the child when s/he had the most recent problem eating this food?
__ __ __ __ **year(s)**

5. Has the child had this illness or trouble after eating this food?
[ ] Only once
[ ] 2-4 times
[ ] More than 4 times

6. Has the child avoided eating that food since the illness or trouble?
[ ] Yes **[ ] No**

7. Did this illness or trouble include any of the following? (please mark if yes)

Table F1

	Yes	**No**
Itching, tingling or swelling in the mouth, lips or throat		
A rash, nettle sting-like rash or itchy skin		
Diarrhoea or vomiting (other than food poisoning)		
Runny or stuffy nose		
Red, sore or running eyes		
Difficulty swallowing		
Breathlessness		
Stiffness in your joints		
Fainting or dizziness		
Headaches		

8. Has the child had any other symptoms? **[ ]Yes** **[ ]No**
If yes, please describe __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

9. How long after eating the food did the child start having the first symptom?
[ ] Minutes **[ ] Hours** **[ ] Days**

10. .How long did it last? [ ] Minutes [ ] Hours [ ] Days

11. Did the child receive any treatment? **[ ]Yes** **[ ]No**

12. If yes for question number 11, what was the name of medicine given?

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

13. Have you ever been told by a doctor that the child has a food allergy? **[ ]Yes** **[ ]No**

14. Say approximately how often the child eats the following foods, and whether or not s/he avoids them because they make him/her ill:

Table F2

Food	**Any Reaction**		**How often does the child eat this food (in season)** ***Tick one column only***					**Does the child avoid this food because it makes him/her ill?**	
	Yes	**No**	**Most Days**	**Most weeks**	**Most months**	**Rarely**	**Never**	**Yes**	**No**
Cow's milk	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Hen's eggs	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Fish	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Shrimp	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Groundnuts	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Pineapple	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Banana	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Apple	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cassava	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Soybean	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Mango	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Pawpaw	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Plantain	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Coconut	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Wheat	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Sweet potato	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Potato	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Sorghum	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Millet	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Carrot	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Avocado	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Beans	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Tomato	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Orange	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Palm Nut	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Food	**Any Reaction**		**How often does the child eat this food (in season)** ***Tick one column only***					**Does the child avoid this food because it makes him/her ill?**	
	Yes	**No**	**Most Days**	**Most weeks**	**Most months**	**Rarely**	**Never**	**Yes**	**No**
Corn	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Melon	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Rice	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Water Yam	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cocoyam	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Kontomire	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Okro	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Flour	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Nutmeg	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

G. Early Life factors

*For the following questions please ask to see the **child's weighing card**.*

Is the child's weighing card available? [ ] Yes [ ] No

1. Was your child born prematurely? [ ] Yes [ ] No

2. If Yes, how many months premature?_____ (in months)

3. What was your child's weight at birth?_____ kg Date Recorded ___/___/___

4. After birth, when did your child START breastfeeding:

   [ ] After Hours [ ] After Days [ ] After Weeks

5. For how long was your child breast-fed? Duration_____ (in months)

6. For how long was your child fed with ONLY breast-milk? Duration____(in months)

7. What was the first food OTHER than breast-milk given to your child?

   Food_____ at what age? _____ (in months)

8. Was your child breast-fed by anyone OTHER than his or her mother at any point?

   [ ] Yes [ ] No

9. What were the reasons that your child was stopped breastfeeding?

   Please state these reasons:

_____

_____

_____

10. Did your child receive the following immunizations: **(Please Verify with Child' Immunization Record)**

	No	Yes	Not Sure
Oral Polio Vaccine (OPV)			
Bacillus Calmette Guérin (BCG)			
Diphtheria Pertussis Tetanus (DPT)			
Yellow Fever			
Measles			

Other Immunizations, please state:

_____

11. In your child's first 2 years of life, were you told by a health worker such as a doctor or nurse that your child suffered from any of the following? :

	No	Yes	Cannot Recall
Respiratory infection such as Pneumonia or Bronchiolitis			
Bacterial Meningitis			
Worm infection			
Measles			
German Measles (Rubella)			
Hepatitis A			

Other Diseases/Infections, please state:

_____

_____

_____

12. In your child's first 2 years of life, did he or she attend a crèche or nursery?

[ ] Yes **[ ] No**