

PROBIT DATA FORM 1 - Maternity Hospital

I. Identifying information			
Hospital no. <input type="text"/>	Subject no. <input type="text"/>	Date form is completed <input type="text"/> <input type="text"/> 19 <input type="text"/> <input type="text"/> dd mm year	
1.1 Child's last name _____			
1.2 Mother's address 1.2.1 Region _____ 1.2.2 District _____			
1.2.3 City or Village _____ 1.2.4 Street _____			
1.2.5 Apt. # _____ 1.3 Home telephone no. _____			
1.4 Father's place of work _____ 1.5 Father's work telephone _____			
1.6 Other contacts and telephone numbers _____			

II. Background information			
2.1 Mother's birth date: <input type="text"/> <input type="text"/> 19 <input type="text"/> <input type="text"/> day month year	2.2 Baby's sex: 1 <input type="checkbox"/> F 2 <input type="checkbox"/> M		
2.3 Mother's education:	1 <input type="checkbox"/> completed university	2 <input type="checkbox"/> partial university	3 <input type="checkbox"/> secondary special
	4 <input type="checkbox"/> common secondary	5 <input type="checkbox"/> partial secondary	6 <input type="checkbox"/> initial
2.4 Mother's occupation:	1 <input type="checkbox"/> manual worker	2 <input type="checkbox"/> service worker	3 <input type="checkbox"/> farmer
	4 <input type="checkbox"/> pupil	5 <input type="checkbox"/> student	6 <input type="checkbox"/> housewife
	7 <input type="checkbox"/> unemployed		
2.5 Marital status:	1 <input type="checkbox"/> registered marriage	2 <input type="checkbox"/> unregistered marriage	3 <input type="checkbox"/> unmarried
2.6 Father's birth date:	<input type="text"/> <input type="text"/> 19 <input type="text"/> <input type="text"/>	<input type="checkbox"/> unknown	
	dd mm year		
2.7 Father's education:	1 <input type="checkbox"/> completed university	2 <input type="checkbox"/> partial university	3 <input type="checkbox"/> secondary special
	4 <input type="checkbox"/> common secondary	5 <input type="checkbox"/> partial secondary	6 <input type="checkbox"/> initial
	7 <input type="checkbox"/> unknown		
2.8 Father's occupation:	1 <input type="checkbox"/> manual worker	2 <input type="checkbox"/> service worker	3 <input type="checkbox"/> farmer
	4 <input type="checkbox"/> pupil	5 <input type="checkbox"/> student	6 <input type="checkbox"/> unemployed
	7 <input type="checkbox"/> unknown		
2.9 Number of other children living together in household: <input type="text"/>	2.10 Number < 3 years: <input type="text"/>		
No. of mother's previous infants breast-fed: 2.11: < 3 months <input type="text"/> 2.12: 3-5 months <input type="text"/> 2.13: ≥ 6 months <input type="text"/>			

III. Atopic history			
In mother:	3.1 <input type="checkbox"/> asthma	3.2 <input type="checkbox"/> hay fever	3.3 <input type="checkbox"/> eczema
	3.4 <input type="checkbox"/> none		
In father:	3.5 <input type="checkbox"/> asthma	3.6 <input type="checkbox"/> hay fever	3.7 <input type="checkbox"/> eczema
	3.8 <input type="checkbox"/> none	3.9 <input type="checkbox"/> unknown	
In <u>any</u> previous child from mother and same father:	3.10 <input type="checkbox"/> asthma	3.11 <input type="checkbox"/> hay fever	3.12 <input type="checkbox"/> eczema
	3.13 <input type="checkbox"/> none		

IV. Information on this pregnancy	
4.1 Delivery date:	<input type="text"/> <input type="text"/> <input type="text"/> 19 <input type="text"/> <input type="text"/> dd mm year
4.2 Gestational age (completed weeks):	<input type="text"/> <input type="text"/> weeks
4.3 Gestational age based on (check all that apply):	4.3.1 <input type="checkbox"/> ultrasound 4.3.2 <input type="checkbox"/> last normal menstrual period 4.3.3 <input type="checkbox"/> other obstetric criteria 4.3.4 <input type="checkbox"/> pediatric (neonatological) examination of newborn
4.4 Average number of cigarettes smoked per day during pregnancy:	1 <input type="checkbox"/> none 2 <input type="checkbox"/> 1-4 3 <input type="checkbox"/> 5-9 4 <input type="checkbox"/> 10-19 5 <input type="checkbox"/> ≥ 20
4.5 Average frequency of alcohol (vodka or wine) consumed during pregnancy?	1 <input type="checkbox"/> < 1 time/mo 2 <input type="checkbox"/> 1-3 times/mo 3 <input type="checkbox"/> 1 time/wk 4 <input type="checkbox"/> 2 times/wk 5 <input type="checkbox"/> ≥ 3 times/wk
4.5.1 On average, how much was consumed at these times?	1 <input type="checkbox"/> 0-50 ml vodka (0-100 ml wine) 2 <input type="checkbox"/> > 50-100 ml vodka (> 100-250 ml wine) 3 <input type="checkbox"/> > 150-250 ml vodka (> 250-500 ml wine) 4 <input type="checkbox"/> > 250-400 ml vodka (> 500-750 ml wine) 5 <input type="checkbox"/> > 400 ml vodka (> 750 ml wine)
4.6 Delivery method:	1 <input type="checkbox"/> spontaneous vaginal 2 <input type="checkbox"/> forceps 3 <input type="checkbox"/> vacuum extraction 4 <input type="checkbox"/> cesarean
4.7 Weight:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> grams 4.8 Length: <input type="text"/> <input type="text"/> <input type="text"/> cm 4.9 Head circumference <input type="text"/> <input type="text"/> <input type="text"/> cm
4.10 Apgar score at 1 minute:	<input type="text"/> <input type="text"/> 4.11 Apgar score at 5 minutes: <input type="text"/> <input type="text"/>

V. Delivery complications (check all that apply):	
5.1 <input type="checkbox"/> no delivery complications	5.2 <input type="checkbox"/> cephalhematoma 5.3 <input type="checkbox"/> clavicular fracture 5.4 <input type="checkbox"/> brachial plexus palsy
5.5 <input type="checkbox"/> need for respiratory support (bag and mask or endotracheal tube)	
5.6 <input type="checkbox"/> other complications	5.6.1 describe _____

VI. Postpartum maternal complications (check all that apply):	
6.1 <input type="checkbox"/> no maternal complications	6.2 <input type="checkbox"/> endometritis 6.3 <input type="checkbox"/> urinary tract infection 6.4 <input type="checkbox"/> hemorrhage
6.5 <input type="checkbox"/> other infection	6.5.1 describe _____
6.6 <input type="checkbox"/> other complications	6.6.1 describe _____

VII. Postpartum infant complications (check all that apply):	
7.1 <input type="checkbox"/> no infant complications	7.2 <input type="checkbox"/> need for oxygen 7.3 <input type="checkbox"/> hypoglycemia requiring intravenous glucose
7.4 <input type="checkbox"/> infection	7.4.1 describe _____
7.5 <input type="checkbox"/> jaundice requiring phototherapy or exchange transfusion	7.6 <input type="checkbox"/> need for transfusion
7.7 <input type="checkbox"/> transfer to intensive care unit	
7.8 <input type="checkbox"/> other complications	7.8.1 describe _____

VIII. Infant feeding in hospital (check all that apply):	
8.1 <input type="checkbox"/> breastfeeding	8.2 <input type="checkbox"/> mother's expressed breast milk 8.3 <input type="checkbox"/> donor milk
8.4 <input type="checkbox"/> water or glucose water	8.5 <input type="checkbox"/> formula 8.6 <input type="checkbox"/> other liquids

PROBIT DATA FORM 2 - Routine Polyclinic Visit

1

Identifying information		Last name _____	Child's first name _____
Hospital no.: [] []	Subject no.: [] []	Study visit no.: []	
Date form is completed: [] [] 19 [] []		Date of last study visit [] [] 19 [] []	
dd mm year		dd mm year	

1. General information

1.1 Weight [] [], [] [] kg	1.2 Length [] [], [] cm	1.3 Head circumference [] [], [] cm
1.4 Which vaccines were received since last study visit or at this visit?		
1.4.1 <input type="checkbox"/> none	1.4.2 <input type="checkbox"/> DPT	1.4.3 <input type="checkbox"/> DT
1.4.4 <input type="checkbox"/> oral polio	1.4.5 <input type="checkbox"/> measles	1.4.6 <input type="checkbox"/> mumps
1.4.7 <input type="checkbox"/> BCG	1.4.8 <input type="checkbox"/> other	1.4.8.1 describe _____
1.5 Average number of cigarettes smoked by mother per day since last study visit:		
1 <input type="checkbox"/> none	2 <input type="checkbox"/> 1-4	3 <input type="checkbox"/> 5-9
4 <input type="checkbox"/> 10-19	5 <input type="checkbox"/> ≥ 20	
1.6 Average frequency of alcohol (vodka or wine) consumed since last study visit?		
1 <input type="checkbox"/> < 1 time/mo	2 <input type="checkbox"/> 1-3 times/mo	3 <input type="checkbox"/> 1 time/wk
4 <input type="checkbox"/> 2 times/wk	5 <input type="checkbox"/> ≥ 3 times/wk	
1.6.1 On average, how much was consumed at these times?		
1 <input type="checkbox"/> 0-50 ml vodka (0-100 ml wine)	2 <input type="checkbox"/> > 50-100 ml vodka (> 100-250 ml wine)	
3 <input type="checkbox"/> > 150-250 ml vodka (> 250-500 ml wine)	4 <input type="checkbox"/> > 250-400 ml vodka (> 500-750 ml wine)	
5 <input type="checkbox"/> > 400 ml vodka (> 750 ml wine)		

2. Feeding information

2.1 Current feeding:		
2.1.1 Breastfeeding	[] [] times per day	
2.1.2.1 Mother's expressed breast milk	[] [] times per day;	2.1.2.2 [] [] [] [] ml per day
2.1.3.1 Donor breast milk	[] [] times per day;	2.1.3.2 [] [] [] [] ml per day
2.1.4.1 Formula	[] [] times per day;	2.1.4.2 [] [] [] [] ml per day
2.1.5.1 Cow milk	[] [] times per day;	2.1.5.2 [] [] [] [] ml per day
2.1.6.1 Other milk	[] [] times per day;	2.1.6.2 [] [] [] [] ml per day
2.1.7.1 Water	[] [] times per day;	2.1.7.2 [] [] [] [] ml per day
2.1.8.1 Juice or other liquids	[] [] times per day;	2.1.8.2 [] [] [] [] ml per day
2.1.9.1 Cereals	[] [] times per day	2.1.9.2 describe: _____
2.1.10.1 Other solid foods	[] [] times per day	2.1.10.2 describe: _____
2.2 Is the baby still breastfeeding?	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
2.2.1 If no, was the baby still breastfeeding at the last study visit?	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
2.2.2 If baby has stopped breastfeeding since last study visit, date last breastfed	[] [] [] [] 19 [] []	
	dd mm year	
2.2.3 Main reason for stopping (check one box only):		
1 <input type="checkbox"/> mother ill	2 <input type="checkbox"/> baby ill	3 <input type="checkbox"/> insufficient milk
4 <input type="checkbox"/> baby's age	5 <input type="checkbox"/> sore or infected nipples	6 <input type="checkbox"/> personal preference

3.	Rash with onset since last study visit?	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
3.1	If yes, date of onset:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 19 <input type="checkbox"/> <input type="checkbox"/> day month year
3.2	Itchy?	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
3.3	On face?	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
3.4	On extensor surfaces of arms?	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
3.5	On extensor surfaces of legs?	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
3.6	Duration \geq 2 weeks (must be verified if $<$ 2 weeks so far)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
3.7	Recurrent (after \geq 1 week clearing)?	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
3.8	Doctor visit because of this rash?	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.	Gastrointestinal illness with onset since last study visit?	
4.1	<u>Episode 1</u>	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.1.1	If yes, date of onset:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 19 <input type="checkbox"/> <input type="checkbox"/> day month year
4.1.2	Highest temperature recorded	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> C
4.1.3	Stool frequency greater than usual	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.1.4	Looser stools than usual	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.1.5	Vomiting (not just spitting up)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.1.6	Doctor visit because of this illness	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.1.7	Duration at least 2 days (<i>caution*</i>)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.2	<u>Episode 2</u> (minimum of one symptom-free week to qualify as new episode)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.2.1	If yes, date of onset:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 19 <input type="checkbox"/> <input type="checkbox"/> day month year
4.2.2	Highest temperature recorded	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> C
4.2.3	Stool frequency greater than usual	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.2.4	Looser stools than usual	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.2.5	Vomiting (not just spitting up)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.2.6	Doctor visit because of this illness	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.2.7	Duration at least 2 days (<i>caution*</i>)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.3	<u>Episode 3</u> (minimum of one symptom-free week to qualify as new episode)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.3.1	If yes, date of onset:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 19 <input type="checkbox"/> <input type="checkbox"/> day month year
4.3.2	Highest temperature recorded	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> C
4.3.3	Stool frequency greater than usual	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.3.4	Looser stools than usual	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.3.5	Vomiting (not just spitting up)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.3.6	Doctor visit because of this illness	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
4.3.7	Duration at least 2 days (<i>caution*</i>)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

If visit is not because of this illness (i.e., response to previous question is no) and illness episode began within the last 48 hours but has not yet resolved, you must recontact the family before answering this question.

5. Respiratory illness with onset since last study visit?

5.1	Episode 1	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.1	If yes, date of onset:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 19 <input type="checkbox"/> <input type="checkbox"/> day month year
5.1.2	Highest temperature recorded	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> C
5.1.3	Cough	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.4	Fast breathing	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.5	Runny nose	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.6	Wheeze	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.7	Otitis media	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.8	Croup	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.9	Chest X-ray (check one box):	1 <input type="checkbox"/> not obtained 2 <input type="checkbox"/> normal 3 <input type="checkbox"/> pneumonia 4 <input type="checkbox"/> other
5.1.10	Doctor visit because of this illness	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.1.11	Duration at least 2 days (<i>caution*</i>)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2	Episode 2 (minimum of one symptom-free week to qualify as new episode)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.1	If yes, date of onset:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 19 <input type="checkbox"/> <input type="checkbox"/> day month year
5.2.2	Highest temperature recorded	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> C
5.2.3	Cough	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.4	Fast breathing	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.5	Runny nose	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.6	Wheeze	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.7	Otitis media	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.8	Croup	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.9	Chest X-ray (check one box):	1 <input type="checkbox"/> not obtained 2 <input type="checkbox"/> normal 3 <input type="checkbox"/> pneumonia 4 <input type="checkbox"/> other
5.2.10	Doctor visit because of this illness	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.2.11	Duration at least 2 days (<i>caution*</i>)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3	Episode 3 (minimum of one symptom-free week to qualify as new episode)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.1	If yes, date of onset:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 19 <input type="checkbox"/> <input type="checkbox"/> day month year
5.3.2	Highest temperature recorded	<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> C
5.3.3	Cough	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.4	Fast breathing	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.5	Runny nose	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.6	Wheeze	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.7	Otitis media	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.8	Croup	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.9	Chest X-ray (check one box):	1 <input type="checkbox"/> not obtained 2 <input type="checkbox"/> normal 3 <input type="checkbox"/> pneumonia 4 <input type="checkbox"/> other
5.3.10	Doctor visit because of this illness	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
5.3.11	Duration at least 2 days (<i>caution*</i>)	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

If visit is not because of this illness (i.e., response to previous question is no) and illness episode began within the last 48 hours but has not yet resolved, you must recontact the family before answering this question.

6. Other illness with onset since last study visit? 1 yes 2 no

6.1 If yes, describe:

7. Hospitalized since last study visit? 1 yes 2 no

7.1 If yes, 19
day month year

7.2 Where: _____

7.3 Diagnosis: _____
