PREGNANCY, HEREDITY, AND ENVIRONMENT
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  Skip to question 95

94. Which months did you receive this anesthetization? (answer for each month)
   Month 1  1  Yes
   2  No
   Month 2  1  Yes
   2  No
   Month 3  1  Yes
   2  No

- 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.
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?
   1  Married
   2  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?
   1  Yes $\rightarrow$ Skip to question 9
   2  No

7. What country were you born in?
   ______________________________________

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?
    1  Yes $\rightarrow$ Skip to question 16
    2  No

14. What country was he born in?
    ______________________________________
15. When did he move to Norway?

   Yr: __________ __________ __________

16. Are you and the child’s father related?

   1  Yes  2  No  → Skip to question 18

17. If so, how are you related?

   __________________________________________________________

18. How long have you lived in your current residence? If it is less than one year, give the number of months.

   # of years __________ # of months: __________

19. About what year was your residence built?

   Year: __________ __________ __________ __________

20. Do you go on vacation to a cottage or summer place?

   1  Yes  2  No

21. Have you or the child’s father stayed in a foreign country in the past year?

   1  Yes  2  No

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

23. What is your husband’s/live in’s 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

24. How many people are fully supported by these incomes?

   Number: ________

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 were using 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: ________

   Describe if the irregularities are too large to estimate the number of days:

   ______________________________________________________

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?
   1  Yes  
   2  No

30. Have you ever visited the doctor because you had difficulties getting pregnant?
   1  Yes  Skip to question 36 
   2  No

31. During what year was the first time you visited the doctor for this?
   Year: ____________________________

32. Did you receive any medical treatment or medication to help you get pregnant with your newborn child?
   1  Yes  Skip to question 34 
   2  No

33. If treatment:
   What type of treatment did you receive to help you get pregnant?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   If medication(s):
   What medication(s) did you use to help you get pregnant?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

34. When was your child born?
   Date: _______ _______ _______
day  mo  yr

35. Was your baby born on time?
   1  Yes → Skip to question 36 
   2  No

If early:
   How many days early? ________ days

If late:
   How many days late? ________ days

36. Were you pregnant with one child or several children during this pregnancy?
   1  one child
   2  twins
   3  triplets
   4  quadruplets

More than one child: 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

37. What sex is the new child?
   1  Boy
   2  Girl

38. Was the child born with deformities?
   1  Yes
   2  No

39. If yes, describe the child’s deformities.
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

40. When was your child born?
   Date: _______ _______ _______
day  mo  yr
40. Are you pregnant again now?

1  Yes  
2  No  

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?

1  Yes  
2  No  

43. How many liveborn children have you given birth to before you became pregnant with your newborn child?

Number: 

44. When was the child born?

<table>
<thead>
<tr>
<th>First child</th>
<th>Second child</th>
<th>Third child</th>
</tr>
</thead>
<tbody>
<tr>
<td>day mo yr</td>
<td>day mo yr</td>
<td>day mo yr</td>
</tr>
</tbody>
</table>

45. Was the child a single birth, twin, or triplet?

1  single birth  
2  twins  
3  triplets 

46. Did you breastfeed this child?

1  Yes  
2  No  

47. When did you stop breastfeeding this child at least once a day?

mo yr 

48. Was the father to the new child also father to this child?

1  Yes  
2  No  
3  Don't know 

49. Does this child live with you?

1  Yes  
2  No  

50. Was the child born with deformities?

1  Yes  
2  No  

If “Yes” describe: 

51. Is this child still living?

1  Yes  
2  No  

---

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.
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.*

<table>
<thead>
<tr>
<th>First</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>54. What month/year did the miscarriage/stillbirth occur?</strong></td>
<td><strong>mo</strong></td>
<td><strong>yr</strong></td>
</tr>
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<tr>
<td><strong>55. How many weeks did this pregnancy last?</strong></td>
<td>Number of weeks:</td>
<td>Number of weeks:</td>
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<tr>
<td><strong>56. Did the child you lost have any deformities?</strong></td>
<td>1 Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td>2 No</td>
<td>2 No</td>
<td>2 No</td>
</tr>
<tr>
<td>8 Don’t know</td>
<td>8 Don’t know</td>
<td>8 Don’t know</td>
</tr>
<tr>
<td>If “Yes”, describe:</td>
<td>If “Yes”, describe:</td>
<td>If “Yes”, describe:</td>
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<tr>
<td><strong>57. Was the father of the new child also the father of the child in this case?</strong></td>
<td>1 Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td>2 No</td>
<td>2 No</td>
<td>2 No</td>
</tr>
<tr>
<td>8 Don’t know</td>
<td>8 Don’t know</td>
<td>8 Don’t know</td>
</tr>
</tbody>
</table>
58. Have you ever had an induced (provoked) abortion?
   (Do not include tubal pregnancies)
   1 [ ] Yes
   2 [ ] No

   If “Yes”:
   How many induced (provoked) abortions?
   Number:  [________]

59. Have you ever had a tubal pregnancy?
   1 [ ] Yes
   2 [ ] No

   If “Yes”:
   How many tubal pregnancies?
   Number:  [________]

---

**Fill out for each induced (provoked) abortion and tubal pregnancy. Only include the first three.**

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<thead>
<tr>
<th></th>
<th>First</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.</td>
<td>mo</td>
<td>yr</td>
<td>mo</td>
</tr>
<tr>
<td>61.</td>
<td></td>
<td></td>
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<tr>
<td>62.</td>
<td></td>
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<tr>
<td>63.</td>
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</tbody>
</table>
64. Have you ever used any of the following methods to prevent pregnancy?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
| 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”
| 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: __________________________________________________________

65. Which of the above method(s) you have already marked did you use at the very end before you became pregnant with your newborn child?

1   2

66. Did you stop using this method before you became pregnant with your new baby?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

We are interested in finding out when you stopped using this method, even if you were still using it when you became pregnant.

67. When did you stop using this method? (Try to estimate month and year the best you can)

   [ ] [ ] [ ] [ ] [ ] [ ] mo  yr

68. Were you planning to get pregnant?

   | Yes | No  
---|-----|-----
   1 |     | 

69. For how many months were you trying to get pregnant?

   | Less than 2 months | 2 months | 3 months | more than 3 months |
---|-------------------|----------|----------|--------------------|
   1 |                   |          |          |                    |
   2 |                   |          |          |                    |

Number, if more than 3 months. ______

70. Did you use birth control pills (regardless of the reason) during the course of the last three months before you became pregnant with your newborn child?

   | Never used any method | Skip to question 68 |
---|-----------------------|---------------------|
   1 |                      |

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 |
---|------------------------|-------------------------------------|--------------------------------------|
   1 |                       |                                     |                                      |
   2 |                       |                                     |                                      |
   3 |                       |                                     |                                      |

Number of days after ______

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?

<p>| | | | |</p>
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<tbody>
<tr>
<td>01</td>
<td>january</td>
<td>05</td>
<td>may</td>
</tr>
<tr>
<td>02</td>
<td>february</td>
<td>06</td>
<td>june</td>
</tr>
<tr>
<td>03</td>
<td>march</td>
<td>07</td>
<td>july</td>
</tr>
<tr>
<td>04</td>
<td>april</td>
<td>08</td>
<td>august</td>
</tr>
<tr>
<td>09</td>
<td>september</td>
<td>10</td>
<td>october</td>
</tr>
<tr>
<td>11</td>
<td>november</td>
<td>12</td>
<td>december</td>
</tr>
</tbody>
</table>

Year: ____________

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.

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

1. Yes
2. No  Skip to question 82

79. Which of these months did you have nausea?

(answer for each month)

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1. Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>Month 2</td>
<td>1. Yes</td>
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<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
</tbody>
</table>

80. Which of these months did you have nausea with vomiting?

(answer for each month)

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1. Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>Month 2</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
</tbody>
</table>

81. Did you take prescribed or over-the-counter medicines for this nausea during months 1 - 2 - 3?

(=answer for each month)

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1. Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>Month 2</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
</tbody>
</table>
82. Did you ever have a fever during the course of months 1 - 2 - 3?
   1  Yes
   2  No  → Skip to question 87

83. What was the cause of the fever?
   (state if possible what kind of infection)
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

84. All together, how many days did you have a fever during months 1 - 2 - 3?
   Number of days: [ ] [ ] [ ]

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

86. Did you take any medications to lower the fever during months 1 - 2 - 3? (with or without prescription)
   If “Yes”, state the medication:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

87. Did you have any other infections which did not give you a fever during months 1 - 2 - 3? (for example, colds, sinus infection, urinary tract infection, or others)
   1  Yes
   2  No  → Skip to question 89

   State the illness or infection:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

88. Did you take any medications for these problems during months 1 - 2 - 3? (both prescription and over-the-counter)
   (answer for each month)
   If “Yes”, state the medication
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

89. Did you get any new amalgam fillings in your teeth during months 1 - 2 - 3?
   1  Yes
   2  No  → Skip to question 91

90. Which month did you get the new fillings?
   (answer for each)
   Month 1
   1  Yes
   2  No

   Month 2
   1  Yes
   2  No

   Month 3
   1  Yes
   2  No
91. Did you get laughing gas or full narcotics in connection with dental treatment during months 1 - 2 - 3?

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td></td>
<td></td>
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<tr>
<td>Month 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

92. Which months did you receive laughing gas or full narcotics during dental work? (answer for each month)

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td></td>
<td></td>
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<tr>
<td>Month 2</td>
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<tr>
<td>Month 3</td>
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</tbody>
</table>

93. Did you undergo other operations or medical treatment wherein you received anesthetics during months 1 - 2 - 3? (not including dental work)

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td></td>
<td></td>
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<tr>
<td>Month 2</td>
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<td></td>
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<tr>
<td>Month 3</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
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<tbody>
<tr>
<td>Month 1</td>
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<tr>
<td>Month 2</td>
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<tr>
<td>Month 3</td>
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</tbody>
</table>

95. Did you take sleeping pills during months 1 - 2 - 3?

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
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<tbody>
<tr>
<td>Month 1</td>
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<td>Month 2</td>
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<tr>
<td>Month 3</td>
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</tbody>
</table>

96. Which months did you take sleeping pills? (answer for each month) If “Yes”, state the medication:

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
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<tr>
<td>Month 2</td>
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<td></td>
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<tr>
<td>Month 3</td>
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</tr>
</tbody>
</table>

97. Did you take sedatives during months 1 - 2 - 3?

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
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<td>Month 2</td>
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<tr>
<td>Month 3</td>
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</table>

98. Which months did you take sedatives? (answer for each month) If “Yes”, state the medication:

<table>
<thead>
<tr>
<th>Month</th>
<th>1 Yes</th>
<th>2 No</th>
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<tbody>
<tr>
<td>Month 1</td>
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<td>Month 2</td>
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</tr>
<tr>
<td>Month 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
99. Did you have pain during months 1 - 2 - 3?  
(for example, headaches or toothaches) 
(answer for each month) 

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
</tbody>
</table>

100. Did you take pain relieving medication during months 1 - 2 - 3?  
(for example, Paracet, Paralgin Forte)  (answer for each month) 

If “Yes”, state the medication:

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
</tbody>
</table>

102. Did you use medications against pimples or blemishes during months 1 - 2 - 3?  
(pills or creams, prescription or over-the-counter)  (answer for each month)  

If “Yes”, state the medication:

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
</tbody>
</table>

103. Do you have sugar sickness, diabetes?  (do not include gestational diabetes) 

| 1 Yes | 2 No | Skip to question 106 |

104. Which type of diabetes do you have? 

| 1 Insulin dependent | 2 Not insulin dependent |

105. Did you take any medications for diabetes during months 1 - 2 - 3?  
(answer for each month)  

If “Yes”, state the medication:

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1 Yes</td>
<td>2 No</td>
</tr>
</tbody>
</table>
106. Do you have epilepsy or do you get other types of fits?

1  Yes
2  No  → Skip to question 109

107. Describe the type of epilepsy or fits:


108. Did you take medications for epilepsy or other types of fits during months 1 - 2 - 3? (prescription or over-the-counter) (answer for each month)

If “Yes”, state the medication:

Month 1
1  Yes______________________________
2  No

Month 2
1  Yes______________________________
2  No

Month 3
1  Yes______________________________
2  No

109. Do you have chronic medical conditions or handicaps which are not included in the previous questions?

1  Yes
2  No  → Skip to question 112

110. Describe these chronic medical conditions or handicaps:


111. Did you take medications for these problems during months 1 - 2 - 3? (prescription or over-the-counter) (answer for each month)

If “Yes”, state the medication:

Month 1
1  Yes______________________________
2  No

Month 2
1  Yes______________________________
2  No

Month 3
1  Yes______________________________
2  No

112. Did you get any type of seizure or convulsion with or without spasms during months 1 - 2 - 3 - 4 - 5 - 6?

1  Yes
2  No  → Skip to question 115

113. Which months did you have seizures like these? (answer for each month)

Month 1
1  Yes
2  No

Month 2
1  Yes
2  No

Month 3
1  Yes
2  No

Month 4
1  Yes
2  No

Month 5
1  Yes
2  No

Month 6
1  Yes
2  No
114. Did you take medications because of these seizures or to prevent these seizures? (answer for each month)

If “Yes”, state the medication:

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1</th>
<th>Yes</th>
<th>2</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 4</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 5</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 6</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1</th>
<th>Yes</th>
<th>2</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 4</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 5</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 6</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

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

1 | Yes
2 | No → Skip to question 118

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

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1</th>
<th>Yes</th>
<th>2</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 4</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 5</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 6</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

118. Did you have abdominal (gynecological) pain?

1 | Yes
2 | No → Skip to question 120

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

<table>
<thead>
<tr>
<th>Month 1</th>
<th>1</th>
<th>Yes</th>
<th>2</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 3</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 4</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 5</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Month 6</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>
CONSUMPTION OF MEDICATIONS DURING MONTHS 1 - 2 - 3 IS OF ESPECIALLY LARGE IMPORTANCE FOR THIS INVESTIGATION

Try to remember whether you took other medicines (like for example antibiotics, steroids and common medications such as pain relievers (aspirin), remedies for heartburn, cough syrup, laxatives or any other medications).

Do not include vitamins or dietary supplements. They will be covered later.

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:

Month 1
1 □ Yes _____________________________
   ________________________________
   ________________________________
2 □ No

Month 2
1 □ Yes _____________________________
   ________________________________
   ________________________________
2 □ No

Month 3
1 □ Yes _____________________________
   ________________________________
   ________________________________
2 □ No

121. Why did you take these medications?

Month 1
   ___________________________________________
   ___________________________________________
   ___________________________________________

Month 2
   ___________________________________________
   ___________________________________________
   ___________________________________________

Month 3
   ___________________________________________
   ___________________________________________
   ___________________________________________

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? (answer for each month)

If “Yes”, state the treatment:

Month 1
1 □ Yes _____________________________
   ________________________________
   ________________________________
2 □ No

Month 2
1 □ Yes _____________________________
   ________________________________
   ________________________________
2 □ No

Month 3
1 □ Yes _____________________________
   ________________________________
   ________________________________
2 □ No

123. Why did you have these treatments?

Month 1
   ___________________________________________
   ___________________________________________
   ___________________________________________

Month 2
   ___________________________________________
   ___________________________________________
   ___________________________________________

Month 3
   ___________________________________________
   ___________________________________________
   ___________________________________________

NB!

Remember to use the 3 months you have put down in question 77 when you answer the questions regarding months 1 - 2 - 3 in your pregnancy.
124. Did you have income-earning employment during any part of months 1 - 2 - 3?

1  Yes
2  No

125. Which one best describes your 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 129
06 Unemployed/ at home without pay  →  Skip to 129
07 Other (explain):

126. What type of business/industry/trade did you work in during months 1 - 2 - 3?

_________________________________________

127. What job title did you have when you became pregnant?

_________________________________________

128. Briefly describe your daily work tasks in months 1 - 2 - 3.

_________________________________________

_________________________________________

129. Did your employment (situation, location or type of work) change during the course of months 1 - 2 - 3?

1  Yes
2  No  →  Skip to question 131

130. In which month did this change occur?

1  month 1
2  month 2
3  month 3

Describe the change(s):

_________________________________________

131. Did the child’s father have income-earning employment during months 1 - 2 - 3?

1  Yes
2  No

132. 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):

133. What type of business/industry/trade did he work in during months 1 - 2 - 3?

_________________________________________

134. What job title did he have during months 1 - 2 - 3?

_________________________________________

135. Briefly describe his daily work tasks in months 1 - 2 - 3.

_________________________________________

_________________________________________
The next 4 pages focus on contact with chemical materials, metals, x-rays, and others during months 1 - 2 - 3.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>136.</strong> Have you been in contact with...... (If &quot;Yes&quot;, continue with the questions to the right, 137-142)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A.</strong> lead vapor, lead dust, lead particles, or lead alloys?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>B.</strong> chromium, arsenic, cadmium, or composition compounds?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>C.</strong> gasoline or exhaust? (does not include filling of gasoline for personal use)</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>D.</strong> mercury steam, mercury, or work with (amalgam) fillings?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>E.</strong> pesticides? Which?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>F.</strong> herbicides? Which?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>G.</strong> oil-based paint?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>H.</strong> water-based or latex paint?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>I.</strong> paint thinner, paint-, enamel- or glue remover or other remover agents? (for example, lynol, white spirits, toluene, carbon tetrachloride)</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>J.</strong> dyes or printing inks?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td><strong>K.</strong> motor oil or lubrication?</td>
<td>1 Yes</td>
<td>1 spare time</td>
<td>Number of days in months 1 - 2 - 3</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 work</td>
<td></td>
</tr>
<tr>
<td>139. Did you use ventilation or protection hoods?</td>
<td>140. Did you usually use rubber or safety gloves?</td>
<td>141. Was a large amount of the material ever spilled (by accident) during months 1 - 2 - 3?</td>
<td>142. Did you get anything on your skin or did you breathe in gases?</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td>always</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>sometimes</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>never</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Skip to question 141

| 1 | Yes | always | Yes |
| 2 | No | sometimes | No |
| 3 | never | No | No |

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No

1 always 1 Yes 1 Yes 1 Yes
2 sometimes 2 No 2 No 2 No
3 never 3 No 3 No 3 No
Continuation about chemical materials in months 1 - 2 - 3

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td></td>
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</tbody>
</table>

136. Have you been in contact with......
(If “Yes”, continue with the questions to the right, 137-142)

<p>| | | |</p>
<table>
<thead>
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<th></th>
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137. Where?

<p>| | | |</p>
<table>
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<tbody>
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</table>

138. In total, how many days did you work with, or in close contact with this?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>L. photographic chemicals? (fixing or developing solution)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>M. welding?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>N. soldering?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>O. formalin or formaldehyde?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P. chemotherapy drugs? (do not include treatment as a patient)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Q. laughing gas or other narcotic gases? (do not include treatment as a patient)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>R. sources of radiowaves or microwaves less than 2 meters away? (do not include use of your own microwave)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>S. laser printer, computer monitor, or copying machine less than 2 meters away?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T. x-ray machine less than 2 meters away?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>U. other materials and situations? Explain:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>V. other materials and situations? (if more) Explain:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>139. Did you use ventilation or protection hoods?</td>
<td>140. Did you usually use rubber or safety gloves?</td>
<td>141. Was a large amount of the material ever spilled (by accident) during months 1 - 2 - 3?</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>1 Yes</td>
<td>1 always</td>
<td>1 Yes</td>
</tr>
<tr>
<td>2 No</td>
<td>2 sometimes</td>
<td>2 No</td>
</tr>
<tr>
<td>3 never</td>
<td>3 never</td>
<td>3 never</td>
</tr>
</tbody>
</table>

What: ↓ ↓ ↓ ↓
143. Did you ever clean your hands with white spirits or other removal agents during months 1 - 2 - 3?
   1   Yes
   2   No

144. How often did you use an electric blanket or water bed during months 1 - 2 - 3? (If you used it every night, the answer is 90 days. Write 00 if none)
   Number of nights:   

145. Have you smoked more than 100 cigarettes in your whole life?
   1   Yes
   2   No

146. Did you smoke cigarettes during the last 12 months before your last pregnancy?
   1   Yes
   2   No  

147. If “Yes”, how much did you smoke, on the average, during these 12 months? (state either per day or per month)
   Average number of cigarettes per day:   
   Average number of cigarettes per month:   

148. After you became pregnant, did you smoke at all during months 1 - 2 - 3?
   1   Yes
   2   No  

149. When you smoked in months 1 - 2 - 3, how much did you smoke? (state either per day or per month)
   Number of cigarettes per day:   
   Number of cigarettes per month:   

150. Has the child’s father ever smoked cigarettes regularly?
   1   Yes
   2   No

151. Did anyone live in the home who smoked cigarettes regularly during months 1 - 2 - 3?
   1   Yes
   2   No

152. 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:   

153. What type of water supply did your home have during months 1 - 2 - 3?
   1   Water works
   2   Well water

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)
   Number per day
   A. Number of glasses from water works at home:   
   B. Number of glasses from water works at work:   
   C. Number of glasses from pre-bottled water:   
   D. Number of glasses of water from a well:   

155. Were there additives in the tap water you drank at home during months 1 - 2 - 3?
   1   Did not drink tap water at home
   2   Yes, added chemicals (for example chlorine)
   3   No, no added chemicals
   8   I do not know if the water had additives

156. Were there additives in the tap water you drank at work during months 1 - 2 - 3?
   1   Did not drink tap water at work/did not work outside the home
   2   Yes, added chemicals (for example chlorine)
   3   No, no added chemicals
   8   I do not know if the water had additives

157. How many times per week did you take a normal bath and/or shower during months 1 - 2 - 3?
   Answer for both (write 00 if none)
   Number of times per week
   Bath   
   Shower   

158. How many minutes did you normally shower each time during months 1 - 2 - 3?
   Number of minutes:   

22
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: ______

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: ______

### COFFEE AND SUCH

<table>
<thead>
<tr>
<th>Question</th>
<th>Number of cups/glasses: (state either per day, per week, per month, or per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Coffee with caffeine?</strong></td>
<td>1 did not drink per day per week per month per year</td>
</tr>
<tr>
<td><strong>B. Coffee without caffeine?</strong></td>
<td>1 did not drink per day per week per month per year</td>
</tr>
<tr>
<td><strong>C. Regular tea, warm or cold?</strong></td>
<td>1 did not drink per day per week per month per year</td>
</tr>
<tr>
<td><strong>D. Herbal tea?</strong></td>
<td>1 did not drink per day per week per month per year</td>
</tr>
<tr>
<td><strong>E. Other caffeinated beverages, such as Coke and Diet Coke?</strong></td>
<td>1 did not drink per day per week per month per year</td>
</tr>
<tr>
<td><strong>F. Other beverages without caffeine, such as soda and juice?</strong> (not water and alcohol)</td>
<td>1 did not drink per day per week per month per year</td>
</tr>
</tbody>
</table>

**A. Coffee with caffeine?**

1 did not drink less than once a month per day per week per month per year

**B. Coffee without caffeine?**

1 did not drink less than once a month per day per week per month per year

**C. Regular tea, warm or cold?**

1 did not drink less than once a month per day per week per month per year

**D. Herbal tea?**

1 did not drink less than once a month per day per week per month per year

**E. Other caffeinated beverages, such as Coke and Diet Coke?**

1 did not drink less than once a month per day per week per month per year

**F. Other beverages without caffeine, such as soda and juice?** (not water and alcohol)

1 did not drink less than once a month per day per week per month per year
163. Are you currently completely abstemious from alcohol?

1. Yes
2. No  ➔ Skip to question 166

164. If “Yes”, what is the main reason that you do not drink? If there is more than one reason why you don’t drink you may cross off up to 3.

1. a. I do not like the effects of alcohol
2. b. I do not like the taste of alcohol
3. c. It is too expensive, waste of money
4. d. I am breastfeeding (or was breastfeeding)
5. e. A family member or friend had problems with alcohol, I am afraid of excessive drinking
6. f. I am a recovered alcoholic
7. g. Religious, moral, or other beliefs
8. h. Medical reasons
   Explain:
   ________________________________
   ________________________________

165. Have you always been completely abstemious?

1. Yes  ➔ Skip to question 170
2. No

166. How often did you drink alcohol in the last few years before you became pregnant with the newborn? (state either per week, per month, or per year)

1. did not drink  ➔ Skip to question 168
2. ____________ days per week
3. ____________ days per month
4. ____________ days per year

167. How much did you drink each time during the last few years before you became pregnant? (as an alcohol unit is counted: a bottle of beer, a glass of wine, or a shot of liquor)

   ____________ number of units of alcohol per time

168. How often did you drink during months 1 - 2 - 3? (state per week or per month)

1. did not drink  ➔ Skip to question 170
2. less than one day per month in months 1 - 2 - 3
   ____________ days per week
   ____________ days per month

169. How many units of alcohol did you usually drink those times you drank during months 1 - 2 - 3?

   ____________ number of units of alcohol per time

170. Did you move to a new residence during months 1 - 2 - 3?

1. Yes
2. No

171. Did you have any serious marriage or relationship problems during months 1 - 2 - 3?

1. Yes
2. No
172. Did a close friend or a family member contract a serious or life-threatening illness during months 1 - 2 - 3?

1 Yes
2 No

173. Did a close friend or a family member die during months 1 - 2 - 3?

1 Yes
2 No

If “Yes”, describe:

__________________________________________

__________________________________________

__________________________________________

174. Did you contract any serious illness during months 1 - 2 - 3?

1 Yes
2 No

If “Yes”, describe:

__________________________________________

__________________________________________

__________________________________________

175. Did you experience any other difficult incidents during months 1 - 2 - 3?

1 Yes
2 No

If “Yes” describe:

__________________________________________

__________________________________________

__________________________________________

176. Did you have any other experiences, good or bad, which led to large changes in your life during months 1 - 2 - 3?

1 Yes
2 No

If “Yes”, describe:

__________________________________________

__________________________________________

__________________________________________
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>177.</td>
<td>Did you take any of the following dietary supplements during the last 6 months before you became pregnant?</td>
<td></td>
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<td>178.</td>
<td>Cross off for every month you took the supplement.</td>
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<td>179.</td>
<td>How often?</td>
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<td>180.</td>
<td>Number?</td>
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</tbody>
</table>

### A. Multivitamins
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### B. Particularly Vitamin A - D supplement
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### C. Particularly Vitamin B supplement
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### D. Particularly Vitamin C supplement
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### E. Particularly Vitamin E supplement
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### F. Particularly “Folic acid” or “Folate” supplement
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### G. Particularly Fish oil or cod liver oil supplement
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### H. Q10
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### I. Kreatin
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### J. Iron
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons

### K. Other supplement
- **Product name:**
- **Before:**
  - mo 6 before
  - mo 5 before
  - mo 4 before
  - mo 3 before
  - mo 2 before
  - mo 1 before
- **Frequency:**
  - per day
  - per week
  - per month
  - less than once a month
- **Number:**
  - number of tablets
  - number of tablespoons
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<th>Supplement Category</th>
<th>Yes/No</th>
<th>1 mo 1</th>
<th>1 mo 2</th>
<th>1 mo 3</th>
<th>How Often?</th>
<th>Number?</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Multivitamins</strong></td>
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<td><strong>D. Particularly Vitamin C supplement</strong></td>
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<td><strong>F. Particularly “Folic acid” or “Folate” supplement</strong></td>
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<td><strong>K. Other supplements</strong></td>
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<td>less than once a month</td>
<td>number of tablespoons</td>
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</tbody>
</table>
CHANGES IN DIET

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   Yes
2   No

If “Yes”, explain:

_________________________________________

_________________________________________

186. Did your desire for certain types of food increase during months 1 - 2 - 3?

1   Yes
2   No

If “Yes”, explain:

_________________________________________

_________________________________________

CLEFT LIP OR PALATE IN THE FAMILY

187. Were you born with a cleft lip or palate?

1   No
2   cleft lip
3   cleft palate
4   cleft lip and palate

188. Did either of your parents have a cleft lip or cleft palate?

1   No
2   cleft lip
3   cleft palate
4   cleft lip and palate

189. Has the newborn child’s father had a cleft lip or a cleft palate?

1   No
2   cleft lip
3   cleft palate
4   cleft lip and palate

190. Have either of the child’s father’s parents had a cleft lip or cleft palate?

1   No
2   cleft lip
3   cleft palate
4   cleft lip and palate

191. Does the child’s father have children with someone other than you?

1   Yes
2   No   →   Skip to question 195

192. If “Yes”, state number.

________ number of children with others

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

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   Yes
2   No   →   Skip to question 197

196. Explain how they are related to the newborn child. (for example, the newborn’s aunt)

Relationship:

_________________________________________

_________________________________________

_________________________________________

_________________________________________
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:  __________  __________  __________

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:
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.

<table>
<thead>
<tr>
<th>Question</th>
<th>first born child</th>
<th>second born child</th>
<th>third born child</th>
<th>fourth born child</th>
</tr>
</thead>
<tbody>
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<td>Explain:</td>
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<tr>
<td>199.</td>
<td>For the live-born children: Is this child still living?</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>200.</td>
<td>Birth month/year? (now and then, twins are born at different times)</td>
<td>mo</td>
<td>mo</td>
<td>mo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>yr</td>
<td>yr</td>
<td>yr</td>
</tr>
<tr>
<td>201.</td>
<td>At how many weeks into the pregnancy was the child born?</td>
<td>weeks</td>
<td>weeks</td>
<td>weeks</td>
</tr>
<tr>
<td>202.</td>
<td>What was the child’s sex?</td>
<td>☐ Boy</td>
<td>☐ Boy</td>
<td>☐ Boy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Girl</td>
<td>☐ Girl</td>
<td>☐ Girl</td>
</tr>
<tr>
<td>203.</td>
<td>Was the child born with deformities?</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>If “Yes”, explain:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Twins</th>
<th>Triplets</th>
<th>Quadruplets</th>
</tr>
</thead>
</table>

TURN BACK TO PAGE 6, QUESTION 40.
Continue here with your fourth live-born child. Do not include your newborn child.

<table>
<thead>
<tr>
<th>Question</th>
<th>Fourth child</th>
<th>Fifth child</th>
<th>Sixth child</th>
</tr>
</thead>
<tbody>
<tr>
<td>44. When was the child born?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. Was the child a single birth, twin, or triplet?</td>
<td>1 single birth</td>
<td>1 single birth</td>
<td>1 single birth</td>
</tr>
<tr>
<td></td>
<td>2 twins</td>
<td>2 twins</td>
<td>2 twins</td>
</tr>
<tr>
<td></td>
<td>3 triplets</td>
<td>3 triplets</td>
<td>3 triplets</td>
</tr>
<tr>
<td>46. Did you breastfeed this child?</td>
<td>1 Yes</td>
<td>1 Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 No</td>
<td>2 No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skip to Q48</td>
<td>Skip to Q48</td>
</tr>
<tr>
<td>47. When did you stop breastfeeding this child at least once a day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. Was the father to the new child also father to this child?</td>
<td>1 Yes</td>
<td>1 Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 No</td>
<td>2 No</td>
</tr>
<tr>
<td></td>
<td>8 Don’t know</td>
<td>8 Don’t know</td>
<td>8 Don’t know</td>
</tr>
<tr>
<td>49. Does this child live with you?</td>
<td>1 Yes</td>
<td>1 Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 No</td>
<td>2 No</td>
</tr>
<tr>
<td>50. Was the child born with deformities?</td>
<td>1 Yes</td>
<td>1 Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 No</td>
<td>2 No</td>
</tr>
<tr>
<td>If “Yes” describe:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51. Is this child still living?</td>
<td>1 Yes</td>
<td>1 Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td></td>
<td>2 No</td>
<td>2 No</td>
<td>2 No</td>
</tr>
</tbody>
</table>