

## Parent's Questionnaire

Section	Page
- Personal Details	2
- GP Details	3
I General Background	4-6
II Residential history	7-8
III Employment history	10-11
IV General health	12-13
V X-ray history	14-15
VI Social habits	16
VII Obstetric history ( <i>mother only</i> )	17-18
VIII Index pregnancy ( <i>mother only</i> )	19-26
IX Index child ( <i>mother only</i> )	27-40
X Family illness	41-42
XI Employment in specific industries	43
- Consent Form	44
XII Further information	45
- Interview details	46

## Appendices

- I Residential and occupational pre-interview questionnaire



Identifying Number 

--	--	--	--	--	--	--

**EPIDEMIOLOGICAL SURVEY  
Consent Form**

Parents Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I consent to be interviewed about my child's and my residential, occupational and medical and similar aspects of my family history.

In accordance with the Data Protection Act (Section 29) 1984, I understand that

- (i) the data custodian for the above study is responsible for the data collected herein
- (ii) the data are not communicated to third parties

Signature \_\_\_\_\_ Date \_\_\_\_\_

Interviewer's signature \_\_\_\_\_ Date \_\_\_\_\_

I agree to this interview being tape recorded

Parents signature \_\_\_\_\_ Date \_\_\_\_\_



Identifying Number		Region		Case No.	

**GP Details**

Parent ID  1=Mother  
 2=Father

May I have (or confirm) the name and address of the GP you are currently registered with.

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is .....registered with the same GP?

1=yes   
 2=no

*If No:*

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I would also like to check which GP ..... was registered with 6 months ago.

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Identifying Number

Region

Case No.

Section I General background Mother/Father

Parent ID

1=Mother

2=Father

1a) So that I can make this interview as short as possible and collect the right information, may I ask if you are the natural mother/father of .....? 1=yes   
2=no   
9=NK

b) *If no: then ask* When did .....first live with you? date      
or      
age of child

*If mother/father is not the biological parent limited questions to be asked: see separate instructions*

2a) Has .....ever lived away from you for longer than six months? 1=yes/ 2=no/ 9=NK

*If yes:*

b) Why was this .....

Please could you tell me when this was: from     or      
Mch Yr Yr Mch

to     or      
Mch Yr Yr Mch

Why was this .....

Please could you tell me when this was: from     or      
Mch Yr Yr Mch

to     or      
Mch Yr Yr Mch

Total number of times away

Identifying Number Region Case no.

--	--	--	--	--	--

<b>Section I</b>	<b>General background</b>	<b>Mother/Father</b>	<b>Parent ID</b>	<b>1=Mother</b> <b>2=Father</b>
------------------	---------------------------	----------------------	------------------	------------------------------------

May I ask you some general questions about yourself?

Day	Mth	Yr

3. What is your date of birth?

4. Would you currently describe yourself as

circle 1=married/ 2=cohabiting/ 3=widowed  
4=separated/ 5=divorced/ 6=single?

5. How would you describe yourself

circle 1=White/ 2=Black-Caribbean/ 3=Black-African/ 4=Black-Other/ 5=Indian/ 6=Pakistani/  
7=Bangladeshi/ 8=Chinese/ 9=any 'other' ethnic group

*If other:*

How would you describe yourself? \_\_\_\_\_

6. How old were you when you left school?

yrs

7. Do you have any educational qualifications such as:

CSEs / 'O' levels / 'O' Grades / GCSEs / or their equivalents?

Highers / 'A' levels or their equivalents?

Any higher or professional qualifications?

1=yes  
2=no  
9=NK




*yes:*

What are these qualifications? \_\_\_\_\_

8. Do you own or rent your current home?

1=owner/ 2=tenant/ 3=other/ 9=NK

*If other: Specify* \_\_\_\_\_

*If tenant:*

Who do you rent it from?

1=council/ 2=housing association/ 3=private/ 4=other/ 9=NK

*If other: Specify* \_\_\_\_\_

Identifying Number 

--	--	--	--	--	--	--

 Page No. 

--	--	--	--	--	--

 Case No. 

--	--	--	--	--	--

**Section I      General background      Mother/Father      Parent ID**

1=Mother	
2=Father	

9. Do you have a paid job at present? 1=yes / 2=no / 9=NK

*If no:* go to Page 7

*If yes:* What is your job? \_\_\_\_\_

--	--	--

10. Are you.....1=employed / 2=self-employed / 9=NK

11. What does the organisation you work for make or do? \_\_\_\_\_

--	--	--	--	--

**employed:**

12. Do you manage or supervise other people? 1=yes / 2=no / 9=NK

*If yes:* How many (fill in actual number)

--	--

**If self employed:**

13. Do you have any employees? 1=yes / 2=no / 9=NK

*If yes:* How many (fill in actual number)

--	--

CODING Socio-economic Group (SEG)

--	--

Social class (SC)

--	--



Identifying Number 

--	--	--	--	--	--	--	--

 Region 

--	--

 Case No. 

--	--	--	--	--	--

**Section II Residential history: 1 Mother/Father Parent ID**

1=Mother	
2=Father	

Please go through the addresses section of the pre-interview questionnaire and confirm dates and correct where necessary. Then ask the following Residential history 1, 2 & 3 about each place of residence in turn, starting with the year before.....was BORN. DO NOT REPEAT FOR BOTH MOTHER AND FATHER IF INFORMATION THE SAME

Day Mch Yr 

--	--	--	--	--	--

 Fill in after interview Total number of residences about which details taken 

--	--

Moved in 

Mch		Yr	

 Moved out 

Mch		Yr	

 Postcode 

--	--	--	--	--	--	--	--	--	--

 Residence No 

--	--

1. Was ..... living with you at this address 1=yes/ 2=no/ 9=NK
2. What type of accommodation did you have? Was it a...?   
 circle 1=House or bungalow/ 2=Maisonette/ 3=Flat/ 4=Caravan/ 5=Boat/ 6=bedsit/ 7=Other   
 If other: Specify \_\_\_\_\_
3. On which floor was the main living area? 0=basement/ 1=ground/ 2=1st floor/ 3=above first floor/ 4=other   
 If other: Specify \_\_\_\_\_
4. On which floor was your bedroom? 0=basement/ 1=ground/ 2=1st floor/ 3=above first floor/ 4=other   
 If other: Specify \_\_\_\_\_
5. Did you have double glazing in the living area? 1=yes/ 2=no/ 9=NK   
 If yes: was it there when you moved in? 1=yes/ 2=no/ 9=NK   
 If no: can you remember when it was installed? Mch & Yr 

--	--	--	--
6. Did you have double glazing in any of the bedrooms? 1=yes/ 2=no/ 9=NK   
 If yes: was it there when you moved in? 1=yes/ 2=no/ 9=NK   
 If no: can you remember when it was installed? Mch & Yr 

--	--	--	--
7. Did you have central heating in the living area? 1=yes/ 2=no/ 9=NK   
 If yes: was it there when you moved in? 1=yes/ 2=no/ 9=NK   
 If no: can you remember when it was installed? Mch & Yr 

--	--	--	--
8. Did you have central heating in any of the bedrooms? 1=yes/ 2=no/ 9=NK   
 If yes: was it there when you moved in? 1=yes/ 2=no/ 9=NK   
 If no: can you remember when it was installed? Mch & Yr 

--	--	--	--
9. Was the water supply to this house 1=mains/ 2=spring water/ 3=well water/ 7=other/ 9=NK   
 If other: Specify \_\_\_\_\_
10. Has the house at this address been demolished? 1=yes/ 2=no/ 9=NK

CONTINUE TO ASK RESIDENTIAL HISTORY: 2 FOR EACH ADDRESS IN WHICH THE CHILD HAS EVER LIVED

Identifying Number

Region

Case No.

**Section II Residential history: 2 Mother/Father Parent ID**

1=Mother 2=Father

Residence No.

11. How many rooms were there?
12. How many adults lived there?
13. How many children lived there?
14. Did ..... always sleep on the same floor of the house?
- 1=yes/ 2=no/ 9=NK*
- If yes: which floor*
- 0=basement/ 1=ground/ 2=1st floor/ 3=above first floor/ 4=other*
- If no: floor where most time was spent*

Did ..... share a bedroom with anyone for more than one month including yourself?

*1=yes/ 2=no/ 9=NK*

*If yes:*

with whom?

(specify name and relationship)

and when was this? *from (age of index) Yr & Mth*     *to (age of index) Yr & Mth*

*<or> from (date) Mth & Yr*     *to (date) Mth & Yr*

with whom?

(specify name and relationship)

and when was this? *from (age of index) Yr & Mth*     *to (age of index) Yr & Mth*

*<or> from (date) Mth & Yr*     *to (date) Mth & Yr*

with whom?

(specify name and relationship)

and when was this? *from (age of index) Yr & Mth*     *to (age of index) Yr & Mth*

*<or> from (date) Mth & Yr*     *to (date) Mth & Yr*

with whom?

(specify name and relationship)

and when was this? *from (age of index) Yr & Mth*     *to (age of index) Yr & Mth*

*<or> from (date) Mth & Yr*     *to (date) Mth & Yr*

with whom?

(specify name and relationship)

and when was this? *from (age of index) Yr & Mth*     *to (age of index) Yr & Mth*

*<or> from (date) Mth & Yr*     *to (date) Mth & Yr*

Identifying Number		Region		Case No.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Section II Residential history: 3 Mother/Father**

Parent ID  1=Mother  
 2=Father

16. Was this house ever chemically treated for woodworm, wet or dry rot or any other conditions while you were living there?

Residence No.

1=Yes 2=No 9=NK

If No: go to Q23

17. Please can you tell me when it was treated?

date

Month		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

or age

Years		Month	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

18. Can you remember why the house was treated?

19. Did you treat the house yourself?

1=Yes 2=No 9=NK

If No: ask Q20

20. What was the name of the firm who carried out the treatment?

21. Can you remember the name of the product?

22. Did you evacuate the house after treatment?

1=Yes 2=No 9=NK

If Yes:

For how many days

If a past address (ie NOT present/current address)

23. Do you know anyone who **now** lives at this address?

1=Yes 2=No 9=NK

If Yes record detail including nature and relationship (eg friend, relative etc)

Response to queries (if appropriate)

\*We are planning to make measurements in houses where you have lived before and the current occupants will be asked if they are prepared to take part.

Identifying Number

--	--	--	--	--	--

Section III **Employment history** Mother/Father

Parent ID

1=Mother  
2=Father

*Please go through the employment section of the pre-interview questionnaire (Appendix I), confirm jobs and dates recorded, and correct where necessary. Show card listing exposures as below.*

*Then ask the following about each job in turn.*

I would like to ask you some more details about each of your jobs:

Did your job as ..... ever involve you in handling or being exposed to:

*show prompt card and code answers on the pre-interview questionnaire*

None 0

Solvents, degreasers or cleaning agents such as benzene, toluene or carbon tetrachloride? 1

Paints, lacquers, paint removers, turpentine products or thinners? 2

Dyes or pigments? 3

Petrol, petroleum products or paraffin? 4

Lead or compounds containing lead? 5

Fertilizers, pesticides, fungicides or herbicides? 6

Radioactive materials, X-rays or any other form of ionizing radiation? 7

Wood dust/Sawdust? 8

Not known 9

*Fill in after interview*

Section III **Employment history**

Mother/Father

Detail

Number of sheets

--	--

Identifying Number 

--	--	--	--	--	--

 Regional Case No. 

--	--	--	--	--	--

**Section III Employment history Mother/Father Exposure record Page:** Parent ID 

1=Mother	
2=Father	

To be completed for any job where an exposure is reported.  
Complete record for each exposure.

Fill in after interview  
Total Number of Job Exposures 

--	--

1. Do you remember the names of the materials involved? (specify) \_\_\_\_\_ Job No. 

--	--

  

--	--	--	--

 Exp. No. 

--	--
2. Did you yourself work with ... (as above) 1=Yes 2=No 9=NK 

--
3. Please can you describe in detail your contact with ... ? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Over what period was this? date from 

--	--	--	--

 Mch Yr to 

--	--	--	--

 Mch Yr  
 or age 

--	--	--	--

 Mch Yr to 

--	--	--	--

 Mch Yr

**If exposure is to ionizing radiation:**

5. During this time were you monitored for exposure to radiation? 1=Yes 2=No 9=NK 

--
- If yes: How? circle 1=film badge/ 2=blood tests/ 3=film badge and blood test/4=other/ 9=NK 

--
- If other: Specify \_\_\_\_\_ 

--

1. Do you remember the names of the materials involved? (specify) \_\_\_\_\_ Job No. 

--	--

  

--	--	--	--

 Exp. No. 

--	--
2. Did you yourself work with ... (as above) 1=Yes 2=No 9=NK 

--
- Please can you describe in detail your contact with ... ? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Over what period was this? date from 

--	--	--	--

 Mch Yr to 

--	--	--	--

 Mch Yr  
 or age 

--	--	--	--

 Mch Yr to 

--	--	--	--

 Mch Yr

**If exposure is to ionizing radiation:**

5. During this time were you monitored for exposure to radiation? 1=Yes 2=No 9=NK 

--
- If yes: How? circle 1=film badge/ 2=blood tests/ 3=film badge and blood test/4=other/ 9=NK 

--
- If other: Specify \_\_\_\_\_ 

--

Do you suffer from, or have you ever suffered from, any of the following illnesses:

- |  |    | 1=Yes<br>2=No<br>9=NK    |   |
|--|----|--------------------------|---|
| Diabetes                               | 1  | <input type="checkbox"/> |   |
| Thyroid disease                        | 2  | <input type="checkbox"/> |   |
| Rheumatoid arthritis                   | 3  | <input type="checkbox"/> |   |
| Pernicious anaemia                     | 4  | <input type="checkbox"/> |   |
| Asthma                                 | 5  | <input type="checkbox"/> |   |
| Multiple sclerosis                     | 6  | <input type="checkbox"/> |   |
| Epilepsy                               | 7  | <input type="checkbox"/> |   |
| Glandular fever                        | 8  | <input type="checkbox"/> | <div style="text-align: right; margin-bottom: 5px;">1=Yes<br/>2=No<br/>9=NK</div> <div style="margin-bottom: 5px;"><i>If Yes:</i> Did you have a blood test? <input type="checkbox"/></div> <div><i>If Yes:</i> Was the glandular fever confirmed? <input type="checkbox"/></div> |
| Leukaemia or lymphoma                  | 9  | <input type="checkbox"/> |   |
| Other cancer or tumour                 | 10 | <input type="checkbox"/> |   |
| Have you ever had a blood transfusion? | 11 | <input type="checkbox"/> |   |

*If yes to any of these please complete a record for each condition and enter the total number of illnesses below*

Total number of illness records following 

--	--



Identifying Number 

--	--	--	--	--	--

Region

--	--	--	--	--

Case No.

**Section V X-ray history Mother/Father Page 1**

Parent ID 

--	--

1=Mother  
2=Father

I have already asked you about illnesses you may have had. I would like to ask you more specifically about any x-rays and investigations you may have had at any time in your life

(mothers) BEFORE you became pregnant with .....  
 (fathers) BEFORE ..... was born

1=Yes  
 2=No  
 9=NK

Have you had any of the following...?

- Fluoroscope - eg, pictures taken of your lungs while you are breathing swallowing or moving 1
- IVP or intravenous pyelogram - ie, x-rays of your kidneys 2
- Barium meal - ie, x-rays of your stomach taken after swallowing a glass of chalky liquid 3
- Cholecystogram - ie, x-rays of your gall bladder taken after swallowing a glass of thick liquid 4
- Barium enema - ie, x-rays taken after a tube has been passed up your back passage and fluid poured in 5
- A venogram - ie, x-rays of a vein after dye has been injected 6
- A lymphangiogram - ie, x-rays taken of different parts of the body after dye has been injected 7
- An angiogram or arteriogram - ie, x-rays of your heart or blood vessels taken after a tube has been passed into your arm or groin 8
- Radioactive or isotope injections with pictures or x-rays taken afterwards 9
- Radiotherapy - ie, treatment with x-rays 10
- A CAT scan - ie, x-rays of your head or body taken inside a machine where the equipment rotates around you 11
- An NMR or MRI (magnetic resonance imaging) scan - ie, where you are put inside a large magnet 12
- (Mothers only) Salpingiogram or insufflation - ie, where x-rays are taken of your fallopian tubes after dye has been injected 13
- (Mothers only) A mammogram - ie, an x-ray of your breast 14
- (Mothers only) Pelvimetry in relation to previous pregnancies 15
- Chest x-rays 16
- X-rays to show possible broken bones 17
- Skull x-rays 18
- Any other x-rays or x-ray investigations - (specify) (Excluding dental x-rays) 19

If yes to 1-15 and 19 please complete an x-ray record for each examination/investigation  
 Do not complete further records for 16 to 18.

Total number of x-ray records following 

--	--





Identifying Number	Region		Case No.			
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Section VI	<b>Social habits</b>	Mother/Father	Parent ID	1=Mother 2=Father	<input type="text"/>
------------	----------------------	---------------	-----------	----------------------	----------------------

I now have some questions about smoking.

1. Have you ever regularly smoked at least one.....a day for at least a year?

1=Yes  
2=No  
9=NK

cigarettes

cigars

a pipe

*Cigarettes= manufactured or hand rolled*

**If yes ask questions below; if no - go to next section**

	Cigarettes yrs	Cigars yrs	Pipe yrs
1. How old were you when you started smoking?	age <input type="text"/>	<input type="text"/>	<input type="text"/>

2. Do you still smoke?	1=yes/ 2=no/ 9=NK <input type="text"/>	<input type="text"/>	<input type="text"/>
------------------------	--	----------------------	----------------------

2a. **If yes:**

i) On average how many did you smoke per day one year <b>before</b> .....was born?	no. <input type="text"/>	no. <input type="text"/>	oz/wk <input type="text"/>
--	--------------------------	--------------------------	----------------------------

ii) How many one year <b>after</b> .....was born?	no. <input type="text"/>	no. <input type="text"/>	oz/wk <input type="text"/>
---	--------------------------	--------------------------	----------------------------

iii) How many one year ago?	no. <input type="text"/>	no. <input type="text"/>	oz/wk <input type="text"/>
-----------------------------	--------------------------	--------------------------	----------------------------

2b. **If no:**

When did you stop smoking?	age yrs <input type="text"/>	yrs <input type="text"/>	yrs <input type="text"/>
----------------------------	------------------------------	--------------------------	--------------------------

ii) Was that <b>before</b> .....was born?	1=yes/ 2=no/ 9=NK <input type="text"/>	<input type="text"/>	<input type="text"/>
---	--	----------------------	----------------------

**If yes:**

2ba.i) On average how many did you smoke per day one year <b>before</b> .....was born?	no. <input type="text"/>	no. <input type="text"/>	oz/wk <input type="text"/>
--	--------------------------	--------------------------	----------------------------

**If no:**

2bb.i) On average how many did you smoke per day one year <b>before</b> .....was born?	no. <input type="text"/>	no. <input type="text"/>	oz/wk <input type="text"/>
--	--------------------------	--------------------------	----------------------------

ii) How many one year <b>after</b> .....was born?	no. <input type="text"/>	no. <input type="text"/>	oz/wk <input type="text"/>
---	--------------------------	--------------------------	----------------------------

**Section X Family illness Page 1**

Parent ID 1=Mother 2=Father

**MOTHER ONLY** We are interested in certain illnesses that.....'s brothers and sisters may have had, including half brothers and sisters. (Refer back to obstetric history Page 17 and go through pregnancies)

**FATHER ONLY** Do you have any children who are not members of this household? 1=yes 2=no 9=NK

If no: go to Page 43

If yes: How many   May I have their names?

Has <sib> ever been diagnosed with .....

Name							
Pregnancy number: / (F1)	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
	1=yes 2=no 9=NK	1=yes 2=no 9=NK	1=yes 2=no 9=NK	1=yes 2=no 9=NK	1=yes 2=no 9=NK	1=yes 2=no 9=NK	1=yes 2=no 9=NK
1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Pernicious anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Glandular fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Leukaemia or Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Other cancer or tumour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total illness records following

Identifying Number 

--	--	--	--	--	--

 Region 

--	--	--	--

 Case No. 

--	--	--	--	--	--

Section X Family illness page 2

Parent ID 

--	--

 1=Mother  
2=Father

Please complete for each illness recorded above.  
May I have more details of these illnesses (only record details not already obtained).

Full name \_\_\_\_\_ Preg. No./id 

--	--	--

Condition \_\_\_\_\_ illness no. 

--	--	--	--	--	--

Date of birth 

--	--	--	--	--	--

 Date of death 

--	--	--	--	--	--

Place of death \_\_\_\_\_

How old was ..... when it was first diagnosed? Yrs 

--	--

 Mths 

--	--

Address when diagnosed \_\_\_\_\_ 

--	--

Was ..... treated as a hospital inpatient, an outpatient or by the GP?  
(Please record as appropriate) 

--

 1=inpatient  
2=outpatient  
3=GP  
4=other  
9=NK

GP \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consultant \_\_\_\_\_ Hospital \_\_\_\_\_  
\_\_\_\_\_

Hospital code 

--	--	--	--	--	--

Full name \_\_\_\_\_ Preg. No./id 

--	--	--

Condition \_\_\_\_\_ illness no. 

--	--	--	--	--	--

Date of birth 

--	--	--	--	--	--

 Date of death 

--	--	--	--	--	--

Place of death \_\_\_\_\_

How old was ..... when it was first diagnosed? Yrs 

--	--

 Mths 

--	--

Address when diagnosed \_\_\_\_\_ 

--	--

Was ..... treated as a hospital inpatient, an outpatient or by the GP?  
(Please record as appropriate) 

--

 1=inpatient  
2=outpatient  
3=GP  
4=other  
9=NK

GP \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consultant \_\_\_\_\_ Hospital \_\_\_\_\_  
\_\_\_\_\_

Hospital code 

--	--	--	--	--	--

--	--	--	--	--	--	--	--

Section XI Employment in specific industries

Mother/Father

Parent ID 1=Mother 2=Father

--

You have already told me about the jobs that you have had.

More specifically can I just check if you have ever done any work at: **SHOW CHECK LIST**

Yes=1   
 No=2   
 NK=9

If yes:

1. Name \_\_\_\_\_

If yes: When?

Mth	Yr		

to

Mth	Yr		

2. What was your job? \_\_\_\_\_

3. Were you monitored for radiation exposure? \_\_\_\_\_

4. If yes: Did you wear a film badge? \_\_\_\_\_

5. Were any other checks carried out on you? \_\_\_\_\_

If yes: specify \_\_\_\_\_

1=yes   
 2=no   
 9=NK

1=yes   
 2=no   
 9=NK

1=yes   
 2=no   
 9=NK

1. Name \_\_\_\_\_

If yes: When?

Mth	Yr		

to

Mth	Yr		

2. What was your job? \_\_\_\_\_

3. Were you monitored for radiation exposure? \_\_\_\_\_

4. If yes: Did you wear a film badge? \_\_\_\_\_

5. Were any other checks carried out on you? \_\_\_\_\_

If yes: specify \_\_\_\_\_

1=yes   
 2=no   
 9=NK

1=yes   
 2=no   
 9=NK

1=yes   
 2=no   
 9=NK

1. Name \_\_\_\_\_

If yes: When?

Mth	Yr		

to

Mth	Yr		

2. What was your job? \_\_\_\_\_

3. Were you monitored for radiation exposure? \_\_\_\_\_

4. If yes: Did you wear a film badge? \_\_\_\_\_

5. Were any other checks carried out on you? \_\_\_\_\_

If yes: specify \_\_\_\_\_

1=yes   
 2=no   
 9=NK

1=yes   
 2=no   
 9=NK

1=yes   
 2=no   
 9=NK

Identifying Number	Region	Case No.
<input type="text"/>	<input type="text"/>	<input type="text"/>

**REQUEST FOR PERMISSION**

Parent ID  1=Mother  
 2=Father

I give permission for my medical and related records to be examined for confidential use in the UK Child Health study. YES  NO  (initials) \_\_\_\_\_

I give permission for my children's medical and related records to be examined for confidential use in the UK Child Health study. YES  NO  (initials) \_\_\_\_\_

I give permission for my present and previous employers to be contacted and asked for information about my work and my working environment. YES  NO  (initials) \_\_\_\_\_

I give permission for my hairdressing records to be examined YES  NO  (initials) \_\_\_\_\_

I agree to give a blood sample for research purposes. YES  NO  (initials) \_\_\_\_\_

I agree for my children named below to give a blood sample for research purposes. YES  NO  (initials) \_\_\_\_\_

Name \_\_\_\_\_ Name \_\_\_\_\_  
 Name \_\_\_\_\_ Name \_\_\_\_\_

PLEASE READ CAREFULLY AND TICK AND INITIAL THE APPROPRIATE BOXES

Signature \_\_\_\_\_ Date \_\_\_\_\_

Full name \_\_\_\_\_  
 (BLOCK CAPITALS)

Address \_\_\_\_\_  
 \_\_\_\_\_

Identifying Number

Region Case No.

**Section XII Further information Mother/Father** **Parent ID**  1=Mother  2=Father

**Case Parents Only**

1. When did you first notice .....became unwell before he/she was diagnosed? date

Month	Year
<input type="text"/>	<input type="text"/>

or age

Year	Month
<input type="text"/>	<input type="text"/>

2. From whom did you first seek medical advice? 1=GP   
2=Hospital   
9=Other SPECIFY

3. When was this? date

Month	Year
<input type="text"/>	<input type="text"/>

or age

Month	Year
<input type="text"/>	<input type="text"/>

4. What was the diagnosis made at this visit?

diagnosis 1. \_\_\_\_\_ 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

2. \_\_\_\_\_ 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

3. \_\_\_\_\_ 

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Is there anything else you would like to tell me about..... or do you have any comments on this interview.

---



---



---

**Control Parents Only**

Do you have any comments on this interview.

---

Ex-directory 1=yes  2=no  9=NK

Cases only - 1=yes  2=no  9=NK

Installed after diagnosis

Home telephone number 

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

1=yes  2=no  9=NK

May we have permission to contact you if we need further information or to resolve any queries? 1=yes   
2=no   
9=NK

May we have your permission to send radon detectors to you with instructions as to how to place them? **Please give out information sheet on Radon.** 1=yes   
2=no   
9=NK

Are you planning to move within the next 9 months? hours  mins

*Time completed*

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------

Identifying Number	Region		Case No.			
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Interview Details**    Mother/Father

1=Mother	<input type="text"/>
2=Father	<input type="text"/>

Was this interview taped?

1=yes	<input type="text"/>
2=no	<input type="text"/>
9=NK	<input type="text"/>

Name of interviewer \_\_\_\_\_

Region No.				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Surrogate information**

1=yes 2=no 9=NK

Residential history

*If yes: specify relationship to index* \_\_\_\_\_

Mode of interview \_\_\_\_\_

Job history

*If yes: specify relationship to index* \_\_\_\_\_

Mode of interview \_\_\_\_\_

General health

*If yes: specify relationship to index* \_\_\_\_\_

Mode of interview \_\_\_\_\_

X-ray record

*If yes: specify relationship to index* \_\_\_\_\_

Mode of interview \_\_\_\_\_

Social habits

*If yes: specify relationship to index* \_\_\_\_\_

Mode of interview \_\_\_\_\_

Family illness

*If yes: specify relationship to index* \_\_\_\_\_

Mode of interview \_\_\_\_\_

Place of interview

1=home	<input type="text"/>
2=hospital	<input type="text"/>
3=other	<input type="text"/>

*If other: specify* \_\_\_\_\_

Others present at interview

1=none	<input type="text"/>
2=spouse-partner	<input type="text"/>
3=other	<input type="text"/>

*If other: specify* \_\_\_\_\_