Please complete the following questions about your baby's recent delivery and medical history. If you had a set of twins, triplets or quadruplets, a separate questionnaire is included for each baby, with the baby's name printed at the top.

This questionnaire should take about 10-15 minutes to complete. Please try to answer each question. For check boxes with one option, please place an 'X' in the box that best fits your answer. For check boxes with more than one option, please place an 'X' in all the boxes that best fit your answer. If none of the options apply, please leave the question blank.

Please note that the final questions on this questionnaire refer to information we suggested you record in the Child Health Journal that we recently provided you. Prior to completing each of the questionnaires about your baby (both now and in the future), it will be helpful if you have filled out the Child Health Journal first.

If you have any questions or concerns, please call our toll-free number: 1-888-870-0247.
1. Where did the delivery of your baby take place? (Select one answer using an 'X')

- Hospital delivery room, operating room or birthing suite
- Free standing birth center
- Clinic or doctor's office
- Home (intended)
- Home (unintended)
- Motor vehicle

2. Please fill in the date grids below for your baby's:
   a. Birth date
   b. Estimated length of pregnancy or gestation
   c. Final due date

Please use the grids below to check your baby's birth date, your length of pregnancy or gestation, and your baby's final due date. Please mark the corresponding grid boxes in each column for month, day, year, or weeks. Provide as much of the information as you can remember. If you cannot remember the entire date or the exact number of weeks, mark the box that says "Check here if you don't know." Please mark all of your selections using an 'X'.

<table>
<thead>
<tr>
<th>a. Baby's birth date</th>
<th>b. Length of pregnancy (in weeks)</th>
<th>c. Baby's final due date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
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<tr>
<td>January</td>
<td>0</td>
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<td>May</td>
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<td>October</td>
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<td>November</td>
<td></td>
<td></td>
</tr>
<tr>
<td>December</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Check here if you don't know ☐ Check here if you don't know ☐ Check here if you don't know
3. Were you told that your baby was born pre-term (more than 3 weeks early) or before 37 weeks? (Select one answer using an 'X')
   - Yes
   - No

4. What is your baby’s gender?
   - Boy
   - Girl

5. Please fill in your baby’s:
   - Birth weight: __ lbs __ oz
   - Birth length: __ Inches
   - Birth head circumference: __ Inches

6. Was your baby a single birth or multiple birth (twins, triplets or more)? (Select one answer using an 'X')
   - Single birth
     (If single birth marked, skip to question 9)
   - Twin
   - Triplet or higher order (quadruplet, quintuplet)
     (If triplet or higher marked, skip to question 8)

7. Please indicate if your baby was born as part of a same-sex pair of twins (one of two boys or two girls) and whether or not the pair was identical (from one egg) or fraternal (from two eggs). (Mark all that apply using an 'X')
   - Non same-sex member (twin is of the opposite sex)
   - Identical twin (twins from one egg)
   - Fraternal or non-identical twin (twins from two eggs)
   - Don't know

8. If your baby was a twin, triplet or higher order multiple, what was the baby’s birth order? (Select one answer using an 'X')
   - First born
   - Second born
   - Third born
   - Fourth or fifth born

9. During this pregnancy, if you had any of the tests or medical procedures listed below, please indicate whether the results were normal or abnormal. (Select the best answers for rows a-j using an 'X')
   - a. Triple screen, Quad screen or Alpha-fetoprotein test
      - Normal
      - Abnormal
      - No test/unknown
   - b. Nuchal translucency (NT) ultrasound exam
      - Normal
      - Abnormal
      - No test/unknown
   - c. Chorionic villus sampling (CVS)
      - Normal
      - Abnormal
      - No test/unknown
   - d. Genetic testing for sickle cell anemia
      - Normal
      - Abnormal
      - No test/unknown
   - e. Genetic testing for cystic fibrosis
      - Normal
      - Abnormal
      - No test/unknown
   - f. Amniocentesis (taking a sample of amniotic fluid)
      - Normal
      - Abnormal
      - No test/unknown
   - g. Group B Streptococcus
      - Normal
      - Abnormal
      - No test/unknown
   - h. Preimplantation genetic diagnosis
      - Normal
      - Abnormal
      - No test/unknown
   - i. Ultrasound testing to measure baby’s size
      - Normal
      - Abnormal
      - No test/unknown
   - j. Ultrasound testing for congenital anomalies or birth defects
      - Normal
      - Abnormal
      - No test/unknown

Upstate KIDS: The New York State Infant Development Screening Program
10. Please mark the appropriate boxes below to tell us if your baby was diagnosed by a doctor or health provider with any of the following medical conditions or birth defects either before delivery (in the womb by blood testing or ultrasound) or after delivery? (Mark all that apply using an 'X')

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Before Delivery</th>
<th>After Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Intrauterine growth restriction (failure to grow in the womb)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Twin to twin transfusion syndrome (donor gave blood to twin)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Twin to twin transfusion syndrome (recipient received blood from twin)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Spina bifida or Meningomyelocele</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Congenital heart disease or defect</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. Patent ductus arteriosis (PDA), a hole between the walls of two heart chambers</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Congenital diaphragmatic hernia</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h. Omphalocele (bowel growing in sac outside abdomen)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>i. Gastroschisis (failure of abdominal wall to close &amp; bowel growing outside)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>j. Limb reduction defect (part of a limb missing)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>k. Cleft lip with or without cleft palate</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>l. Cleft palate alone</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>m. Hypospadias</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>n. Down's syndrome (Trisomy 21)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>o. Edward's syndrome (Trisomy 18)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>p. None</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

11. What was the first sign that made you think that you were going to deliver? (Select one answer using an 'X')
- Contraction (went into labor)
- Rupture of membranes (water broke)
- Did not labor, emergency Cesarean delivery (C-section)
- Did not labor, planned or scheduled Cesarean delivery (C-section)

12. What was your baby's presentation position at delivery? (Select one answer using an 'X')
- Cephalic (head first)
- Shoulder
- Breech (bottom or feet first)
- Don't know, delivered by Cesarean

13. How was your baby delivered? (Select one answer using an 'X')
- Spontaneous vaginal delivery, no special equipment or procedures used during delivery
- Forceps delivery
- Vacuum extraction
- Emergency Cesarean delivery
- Planned or scheduled Cesarean delivery
14. Was your baby transferred or admitted to the neonatal intensive care unit (NICU)? (Select one answer using an 'X')

☐ No, Skip to question 18 (on page 6)

☐ Yes

Write in the number of days your baby was in NICU

[ ] [ ] [ ]

15. Please check the boxes below if your baby was admitted to the NICU for any of the reasons listed: (Mark all that apply using an 'X')

☐ Baby was one of a set of twins, triplets or quadruplets

☐ Baby was born too early

☐ Baby had a birth defect of the gastrointestinal (GI) tract

☐ Baby had gastrointestinal (GI) problems not related to a birth defect

☐ Baby had a birth defect of the heart requiring surgery (either in the hospital after birth or scheduled for later)

☐ Baby was too small

☐ Baby had breathing problem and needed to be intubated and/or placed on a mechanical ventilator

☐ Baby had breathing problems needing ECMO (cardiac bypass)

☐ Baby had an infection or fever

☐ I had fever and baby was isolated

☐ Tramatic birth (For example, baby born with broken or dislocated shoulders, Erb's palsy)

16. Did your baby have any of the following while admitted to the NICU? (Mark all that apply using an 'X')

☐ Baby got some or all feedings through a feeding tube (tube inserted into a vein) for more than two weeks

☐ Baby had severe bleeding in the brain (Grade 3 or 4 intraventricular hemorrhage [IVH])

☐ Baby had mild bleeding in the brain (Grade 1 or 2 intraventricular hemorrhage [IVH])

☐ Baby had an abnormal head ultrasound or MRI

☐ Baby was diagnosed with PVL (periventricular leukomalacia)

☐ Baby had swelling of the ventricles in the brain (hydrocephalus)

☐ Baby got an infection and needed a week or more of antibiotics

☐ Baby had retinopathy of prematurity that needed eye surgery

☐ Baby got medicine or steroids to help with the lungs after being born

☐ Baby had necrotizing enterocolitis (NEC) that needed surgery

☐ Baby had a patent ductus arteriosis (hole between the walls of the two heart chambers) that needed heart surgery

17. How was your baby fed while in the NICU? (Mark all that apply using an 'X')

☐ Intravenous (IV or tube inserted into a vein)

☐ Feeding tube

☐ Bottle fed

☐ Breast fed

☐ Fed expressed breast milk
18. Around the time of birth, your baby's heel was pricked to collect a blood spot on a piece of filter paper. The baby's blood was then tested by the New York State Newborn Screening Program for a number of rare disorders that, if caught early, can be treated to prevent life-threatening complications. Since these blood tests at birth, were you ever asked to have this baby evaluated further by a physician or health provider for any other blood test? (Select one answer using an 'X')

☐ No, Skip to question 20a

☐ Yes

19. If yes, were you told by a physician or health care provider that your baby had any of the following? (Mark all that apply using an 'X')

☐ Congenital adrenal hyperplasia (lack of enzyme regulating salt, treated with steroids and mineral supplements)

☐ Congenital hypothyroidism (low thyroid hormone, treated with thyroid pills or liquid)

☐ Maple syrup urine disease (treated with special diet)

☐ Phenylketonuria (PKU, inability to digest a food protein, treated with a special diet)

☐ Cystic fibrosis (disorder characterized by a build up of mucus in the lungs and salty sweat)

20a. Is your baby still in the hospital?

☐ No, please continue with the questionnaire

☐ Yes

STOP

If you answered YES, you do NOT need to complete the rest of this questionnaire booklet. Thank you for your participation. Please mail this form out to us soon in the enclosed postage-paid envelope (see page 14 for the mailing address).

20b. Was your baby discharged from the hospital or birthing center with you? (Select one answer)

☐ No, baby came home after me

☐ No, baby went home before me

☐ Yes, we went home together

☐ Does not apply, was never admitted to a hospital or birthing center

21. Was your baby sent home from the hospital with any of the following equipment? (Mark all that apply)

☐ Oxygen

☐ Pulse oximeter

☐ Home apnea monitor (to monitor breathing)

☐ Equipment for tube feeding (flexible feeding tubes, syringes)

☐ Equipment for feeding (breast pump, special bottles or nipples)

☐ No equipment

22. Was your baby sent home from the hospital with any of the following types of medications? (Mark all that apply)

☐ Caffeine or other stimulant

☐ Inhaled steroid

☐ Diuretic (medicine to help get rid of extra water)

☐ Anti-reflux medication

☐ Antibiotics

☐ No medications

23. How much did your baby weigh when discharged from the hospital or sent home from the birthing center? (Write in Pounds and Ounces)
24. Has your baby ever had wheezing or whistling in the chest? (By wheezing, we mean breathing that sounds like a high-pitched whistling or squeaking sound coming from the baby's chest and not his/her throat.)

☐ No
☐ Yes, Mark all that apply:
☐ During or soon after a cold or flu
☐ Without a cold or flu

25. Please indicate how many times your baby has experienced any of the following conditions since being home from the hospital: (Select the best answer in each row using an 'X')

<table>
<thead>
<tr>
<th>Condition</th>
<th>Never</th>
<th>1-3 times</th>
<th>More than 3 times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itchy rash (other than a diaper rash)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cold or Flu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attacks of wheezing or whistling in the chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disturbed sleep because of wheezing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever (102° or higher)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sneezing, runny, or blocked nose NOT associated with cold or flu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colic (excessive crying)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Jaundice (baby's skin and whites of the eyes looked yellow)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea (for two or more days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thrush (a yeast infection, also referred to as candidiasis)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. At the time you brought your baby home, how did you feed him/her? (Select one answer using an 'X')

☐ Only breast fed
☐ Only bottle fed
☐ Both breast and bottle fed
☐ Other; specify

27. Did you ever attempt to breastfeed your baby?

☐ No ➔ Please mark the box below that best describes the reason you did not attempt to breastfeed your baby, then proceed to Question #29:
☐ Did not want to breastfeed
☐ Not allowed due to a medical condition for which breastfeeding is not advised
☐ Yes
28. Are you currently breastfeeding your baby?

☐ Yes ➔ Please mark the box below that best describes your current breastfeeding practices:

☐ I am exclusively breastfeeding (not giving any formula or food)

☐ I am partially breastfeeding (supplementing with formula or food)

☐ No ➔ Please mark the box below that best describes why and when you stopped breastfeeding your baby:

☐ Baby had difficulty latching on or sucking properly

☐ I tried breastfeeding but could not establish a milk supply

☐ I tried breastfeeding but stopped due to pain or infection in my breast (s); please specify the date you stopped. Please provide as much of the date as you remember.

mm / dd / yyyy

☐ I have stopped breastfeeding for other reasons; please specify the date you stopped. Please provide as much of the date as you remember.

mm / dd / yyyy

29. How would you describe your baby's appetite? (Select one answer using an 'X')

☐ Very good

☐ Good

☐ Medium

☐ Poor

☐ Very Poor

30. Do you have any concerns about feeding your baby? (Mark all that apply using an 'X')

☐ Has difficulty staying alert

☐ Is easily distracted from feeding

☐ Falls asleep during sucking

☐ Has weak sucking, brief bursts of sucking and goes to sleep

☐ Sleeps 'all the time' or too much so that no time for feeding

☐ None

31. Have you sought any medical advice about an eating problem for your baby? (Select one answer using an 'X')

☐ No, Skip to question 33

☐ Yes

32. Have you sought medical advice or treatment for any of these specific eating conditions? (Mark all that apply using an 'X')

☐ Spitting up, mild expulsion of swallowed food or liquid (regurgitation)

☐ Reflux, stomach contents backing up into baby's throat after a meal (gastroesophageal reflux)

☐ Vomiting (forceful expulsion of stomach contents)

33. What types of milk are you using to feed your baby? (Mark all that apply using an 'X')

☐ Breast milk

☐ Goat's milk

☐ Hypo-allergenic formula

☐ Soy milk or soy formula

☐ Cow's milk

☐ Unpasteurized milk

☐ Formula

☐ Follow-on or stage 2 formula fortified with calcium and iron

34. If your baby is being fed a commercial formula, what is your preferred brand or manufacturer? (Select one answer using an 'X')

☐ Not being fed formula

☐ Mead Johnson (Enfamil ®, Enfamil LIPIL ®, iProSobee ®, Nutramigen ®)

☐ Ross (Similac ®, Similac Advance ®, Isomil ®, Alimentum®)

☐ Nestle Carnation (Good Start ®, Alsoy ®, Follow-up ®)

☐ Store brands (for example, Wal-Mart, Target)

☐ Other; specify
35. What is the source of the water that is usually used to prepare your baby's formula?  (Select one answer using an 'X')
   - Not being fed formula
   - Does not apply, fed already prepared formula
   - Bottled water
   - Tap water from a private well
   - Tap water from the public water system
   - Filtered tap water

36. Are you giving your baby plain water to drink?
   - No, Skip to question 38
   - Yes

37. What is the usual source of drinking water for your baby?  (Select one answer using an 'X')
   - Bottled water
   - Tap water from a private well
   - Tap water from the public water system

38. Have you introduced juice into your baby's diet?
   - No
   - Yes, please tell us your baby's age when you introduced juice. Place an 'X' in the appropriate box indicating your baby's age in weeks.

39. Have you introduced strained or solid foods into your baby's diet?
   - No
   - Yes, Please tell us what types of strained/solid foods you have introduced into your baby's diet. Mark all that apply using an 'X' in the boxes below.
     - Cereal in baby bottle
     - Rice or other cereal fed by mouth
     - Strained fruit or vegetables
     - Finger foods, for example Cheerios, biscuits
     - Pureed table food
     - Meat, eggs, cheese or other dairy food

40. Does your baby get multivitamin drops (including vitamins A, C and D)? (Select one answer using an 'X')
   - No, Skip to question 43 on page 10
   - Yes, multivitamins only
   - Yes, multivitamins plus extra iron
   - Yes, multivitamins plus extra fluoride
   - Yes, multivitamins plus extra iron and extra fluoride

41. Please mark an 'X' in the box below to tell us how many times per week your baby gets multivitamin drops (on average).
   - Times Per Week
     - 1
     - 2
     - 3
     - 4
     - 5
     - 6
     - 7
42. Please tell us how old your baby was when you started giving him/her multivitamin drops. Please place an 'X' in the appropriate box indicating your baby's age in weeks.

<table>
<thead>
<tr>
<th>Age in Weeks</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
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<td>8</td>
<td>9</td>
<td>10</td>
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<td>11</td>
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<td>15</td>
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<td></td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
</tbody>
</table>

**Your Baby’s General Health and Wellness**

43. How would you best describe your baby's mood or temperament? *(Select one answer using an 'X')*

- **DIFFICULT/IRRITABLE** - This baby cries a lot, is highly sensitive to any stimulation - from the texture of clothing to the temperature of the room - and has a hard time adapting to change. A trip to the supermarket, with its bright lights and jarring noises, can easily send him or her into howls of panic, and this baby is likely to have trouble settling into a regular sleep or feeding schedule.

- **SLOW TO WARM** - Generally less irritable than a "difficult" baby, this baby still needs some space and time to get used to people and situations that are unfamiliar.

- **EASY** - Generally cheerful, this baby adapts well to new people and places, handles changes easily, and has no problem sleeping through the night and feeding on a regular schedule. This baby can go out to dinner, fall asleep peacefully in a car seat or carrier if it gets too late, and happily take in crowds, noise, and other stimulation.

44. Is your baby seeing a physician or health care provider because of a specific medical concern? *(Select one answer using an 'X')*

- No
- Yes, for birth defect or medical condition
- Yes, because of early delivery (prematurity)
- Yes, for failure-to-thrive (poor growth)
- Yes, other reason; specify:

45. Has your baby ever been re-admitted to the hospital for illness or surgery since birth? *(Select one answer using an 'X')*

- No
- Yes, for illness; specify:
- Yes, for surgery; specify:

46. When your baby uses his or her hands to grasp objects, does he or she appear to be using one hand more often than the other? *(Select one answer using an 'X')*

- Does not yet grasp objects or toys
- No, uses both hands equally
- Yes, uses right hand more often
- Yes, uses left hand more often
Questions 47 thru 50 are based on information you may have collected in the Upstate KIDS Child Health journal recently provided to you in your initial survey packet.

Like this one 📜 (but in color)
47. Please complete the grid below to tell us which vaccinations your baby has received since birth. For each vaccine your baby received, please indicate the age range the vaccines were received by checking the corresponding check box in the received column. Then please fill in the date the vaccine was received. If you cannot remember the complete date, please provide as much of the date as you can remember. Note that if this baby received a combined vaccine, such as Pediarix® or Comvax®, you do not also have to mark the individual vaccines were received.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose</th>
<th>Recommended Age Range</th>
<th>Received</th>
<th>Date of Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1</td>
<td>Birth</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1-2 months</td>
<td>☐ 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6-18 months</td>
<td>☐ 3</td>
<td></td>
</tr>
<tr>
<td>Diphtheria, Tetanus, Acellular Pertussis (DTaP)</td>
<td>1</td>
<td>2 months</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4 months</td>
<td>☐ 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6 months</td>
<td>☐ 3</td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenza type b (Hib, flu)</td>
<td>1</td>
<td>2 months</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4 months</td>
<td>☐ 2</td>
<td></td>
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<tr>
<td></td>
<td>3</td>
<td>6 months</td>
<td>☐ 3</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PCV)</td>
<td>1</td>
<td>2 months</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4 months</td>
<td>☐ 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6 months</td>
<td>☐ 3</td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>1</td>
<td>2 months</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4 months</td>
<td>☐ 2</td>
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<td></td>
<td>3</td>
<td>6 months</td>
<td>☐ 3</td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus (IPV, polio)</td>
<td>1</td>
<td>2 months</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4 months</td>
<td>☐ 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6-18 months</td>
<td>☐ 3</td>
<td></td>
</tr>
<tr>
<td>Combined vaccine (Pediarix®)</td>
<td>1</td>
<td>2 months</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td>Combines DTaP, Hepatitis B, IPV (polio)</td>
<td>2</td>
<td>4 months</td>
<td>☐ 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6 months</td>
<td>☐ 3</td>
<td></td>
</tr>
<tr>
<td>Combined vaccine (Comvax®)</td>
<td>1</td>
<td>2 months</td>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td>Combines Hepatitis B and Hib (flu)</td>
<td>2</td>
<td>4 months</td>
<td>☐ 2</td>
<td></td>
</tr>
<tr>
<td>Other combined vaccine</td>
<td>1</td>
<td></td>
<td>☐ 1</td>
<td></td>
</tr>
</tbody>
</table>

Please specify the vaccine name

TIP: If you have begun completing the Upstate KIDS Child Health Journal recently provided to you, this information would be listed on pages 2-7 of the Journal.
48. Have any of your baby's teeth come in? (TIP: If you have begun completing the Upstate KIDS Child Health Journal recently provided to you, this information would be listed on pages 10-11 of the Journal) (Choose one answer using an 'X')

- No
- Yes, bottom central incisor, on baby's right side
- Yes, bottom central incisor, on baby's left side
- Yes, both bottom central incisors
- Yes, other tooth

49. Please complete the grid below to tell us if your baby has achieved any of the developmental milestones listed. We do not necessarily expect your baby to have achieved these milestones yet (every baby is different, so some will achieve these tasks earlier and some will achieve them later). If your baby has achieved any of the milestones, please indicate this by checking the box in the column labeled "Achieved" and then write in the actual date the milestone was achieved. If you cannot remember the complete date, please provide as much of the date as you can remember. (TIP: If you have begun completing the Upstate KIDS Child Health Journal recently provided to you, this information would be listed on pages 8-9 of the Journal) (Mark 'Achieved' using an 'X' and give dates for all that apply).

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Definition</th>
<th>Achieved</th>
<th>Date of Achievement mm/dd/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting without support</td>
<td>Infant can sit up straight with head erect for at least 10 seconds without using arms or hands to balance body or support the position.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands-and-knees crawling</td>
<td>Infant alternately moves forward or backward on hands and knees. The stomach does not touch the supporting surface, and there are at least three movements in a row.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing with assistance</td>
<td>Child can stand in upright position on both feet, holding onto a stable object (like, furniture), for at least 10 seconds without leaning on it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking with assistance</td>
<td>Child can take at least five steps sideways or forward while in an upright position and holding onto a stable object (like, furniture).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing alone</td>
<td>Child can stand in an upright position on both feet (not on the toes) for at least 10 seconds with no contact with a person or object.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking alone</td>
<td>Child can take at least five steps independently in an upright position with no contact with a person or object.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
50. Please use the grid below to list all of your baby's measurements from the well-baby check-ups that your baby has had since birth. For each visit, please also include your baby's age (in months or weeks) and the actual date of the check-up. If you cannot remember the complete date, please provide as much of the date as you can remember. (TIP: If you have begun completing the Upstate KIDS Child Health Journal recently provided to you, this information would be listed on pages 13-28 of the Journal.)

(Write numbers in boxes where appropriate)

<table>
<thead>
<tr>
<th>Age at Visit (months or weeks)</th>
<th>Date of Visit (mm/dd/yyyy)</th>
<th>Length (inches or centimeters)</th>
<th>Weight (pounds or grams)</th>
<th>Head Circumference (inches or centimeters)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>in or cm</td>
<td>lbs oz or grams</td>
<td>in or cm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in or cm</td>
<td>lbs oz or grams</td>
<td>in or cm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in or cm</td>
<td>lbs oz or grams</td>
<td>in or cm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in or cm</td>
<td>lbs oz or grams</td>
<td>in or cm</td>
</tr>
</tbody>
</table>

THANK YOU FOR YOUR PARTICIPATION IN **Upstate KIDS**

Please mail this form out to us soon!

If you misplaced the postage-paid envelope that was mailed with this questionnaire, please call us and we will mail you another return envelope.

1-888-870-0247 (Toll-free)

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