| 1. Name of respondent: | First: __________________________ |
|------------------------|----------------------------------|
|                        | Middle: __________________________ |
|                        | Surname: __________________________ |
| 2. Phone numbers: | home: __________________________ |
|                     | work: __________________________ |
|                     | cell: __________________________ |
|                     | other: __________________________ |
| 3. What is your physical address? | House No. ________________ |
|                          | Road/Street __________________________ |
|                          | City __________________________ |
|                          | Postal Code __________________________ |
| 4. How old are you? | ________ years |
| 5. What is your date of birth? | ____/____/____ |
|                          | day  month  year |
|                          | □ Refused |
| 6. What is your marital status? | □ Married |
|                          | □ Living together |
|                          | □ Single |
|                          | □ Divorced |
|                          | □ Separated |
|                          | □ Widow |
|                          | □ Other __________________________ |
[INTRODUCTION: INTERVIEWER READS TO RESPONDENT]

The purpose of this questionnaire is to collect information about your pregnancy and reproductive health. If there is a question you do not want to answer, please let me know and we can skip it. All of your responses are confidential and will not shown to anyone outside the study team without your written consent. If you wish to stop the interview at anytime, please advise me. We can continue at a later time at your convenience.

| A. HOUSEHOLD CONDITIONS |
|--------------------------|
| 9. With whom do you live? (Fill in one or several boxes.) |
| ☐ 1 Spouse |
| ☐ 2 Partner |
| ☐ 3 Parents |
| ☐ 4 Parents-in-law |
| ☐ 5 Children |
| ☐ 6 No one |
| ☐ 8 Others, describe ____________ |

| 10. How many people including you live in your home? |
| ☐ 1 Number of people over 18 years |
| ☐ 2 Number of people between 12 and 18 years |
| ☐ 3 Number of people between 6 and 11 years |
| ☐ 4 Number of people under 6 years |

| 11. Usual language spoken at home: |
| ☐ 1 English |
| ☐ 2 Zulu |
| ☐ 3 Xhosa |
| ☐ 4 Afrikaans |
| ☐ 8 Other |
| (Specify:____________________) |

| 12. How many of your children are at nursery school? |
| ______ |
| no. of children |

7. What is the highest grade or year of school you completed? [READ CHOICES – select only one] |
| ☐ 1 Never attended school or only pre-school |
| ☐ 2 Class 1 – Std 5 (Grades 1 through 7) |
| ☐ 3 Std 6 – Std 9 (Grades 9 through 11- Some high school) |
| ☐ 4 Std 10 / Matric (Grade 12 - High school graduate) |
| ☐ 5 Non-degree training |
| ☐ 6 College / technikon / university (1 year to 3 years) |
| ☐ 7 Refused to answer |

8. What is the highest grade or year of school your baby’s father completed? [READ CHOICES] |
| ☐ 1 Never attended school or only pre-school |
| ☐ 2 Class 1 – Std 5 (Grades 1 through 7) |
| ☐ 3 Std 6 – Std 9 (Grades 9 through 11- Some high school) |
| ☐ 4 Std 10 / Matric (Grade 12 - High school graduate) |
| ☐ 5 Non-degree training |
| ☐ 6 College / technikon / university (1 year to 3 years) |
| ☐ 7 Refused to answer |
| Question                                                                 | Options                                                                                     |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| 13. What is your yearly gross income? (Include child support, unemployment benefits and other allowances.) | No income, Less than R2 000, R10 001–30 000, R30 001–75 000, R75 001–150 000, R150 001 and above, Refused to answer |
| 14. What is the baby’s father’s yearly gross income? (Include child support, unemployment benefits and other allowances.) | No income, Less than R2 000, R10 001–30 000, R30 001–75 000, R75 001–150 000, R150 001 and above, Refused to answer |
| 15. What type of housing do you live in?                               | Detached house, Semidetached, Farm, Flat, Terraced flat, Apartment building, Refused to answer, Other |
| 16. Has there been water damage, visible signs of fungus/mildew or a smell of mildew in your home in the past 3 months? (Fill in one or several boxes.) | No, water damage, signs of fungus and mould, a smell of mildew |
| 17. What year was this house/structure originally built?               | Year, don't know, Other |
| 18. Would you say it was built:                                        | Before 1970, between 1970 and 1985, after 1985 |
| 19. How many rooms are there in your home? (counting the kitchen, but not the bathroom or toilet) | Rooms |
| 20. How long have you lived at this address?                          | Years, less than 1 year |
| 21. Is your home drinking water from the tap or from a river or dam?   | Tap, river or dam, well, other, please specify: |
| 22. Do any pets live in this home?                                     | Yes, No [If no, skip to Q24] |
23. What kind of pets live here?

(a). a dog? □ 1 Yes □ 2 No
(b). a cat? □ 1 Yes □ 2 No
(c). a bird? □ 1 Yes □ 2 No
(d). any other pet(s) □ 1 Yes □ 2 No □ 88 please specify: ____________________

24. During the past 12 months was a room heater used to heat one or more rooms in this house?

□ 1 Yes □ 2 No [If no, skip to Q25] □ 99 don't know [If don't know, skip to Q25]

(a). Was this heater fueled by □ 0 not applicable – no furnace □ 1 paraffin □ 2 gas □ 3 electricity □ 4 wood □ 5 coal □ 6 Gel □ 88 other, please specify: ____________________ □ 99 don't know

25. During the past 12 months was one or more wood stoves used in this house?

□ 1 Yes □ 2 No □ 99 Don't know

26. During the past 12 months was a fireplace used to heat the rooms in this house?

□ 1 Yes □ 2 No □ 99 Don't know

27. During the past 12 months was the stove or oven ever used to heat this house?

□ 1 Yes □ 2 No □ 99 Don't know

28. Is a stove or oven used for cooking in this house?

□ 1 Yes □ 2 No □ 99 Don't know

(a). What is the primary source of heat for this stove or oven?

□ 1 paraffin □ 2 gas □ 3 electricity □ 4 wood □ 5 coal □ 6 Gel □ 88 other, please specify: ____________________ □ 99 don't know

B. FAMILY SMOKING CHARACTERISTICS

29. Does anyone who lives here smoke cigarettes in the home? □ 1 Yes □ 2 No [If no, skip to Q30]

If yes, for each member of the household who smokes, please indicate

Cigarettes smoked per day in the home
### C. MENSTRUAL HISTORY

| Q.                                      | Answer |
|-----------------------------------------|--------|
| 30. How old were you when you had your first menstrual period? | __________ years |
| 31. How many days between each menstrual cycle? | ☐ 1: 28 days  
☐ 2: 35 days  
☐ 3: > 40 days  
☐ 99: don’t know |
| 32. Were your periods regular the year before you became pregnant? | ☐ 1: Yes  
☐ 2: No |
| 33. During the last year before you became pregnant, did you miss your period for more than three months without being pregnant? | ☐ 1: Yes, due to another pregnancy  
☐ 2: Yes, due to other reasons  
☐ 3: No |
| 34. Date of first day of last menstrual period | ____/_____/20____ |
| 35. Did your last menstrual period come at the expected time | ☐ 1: Yes  
☐ 2: No |
| 36. Are you certain about the date of first day of last menstrual period? | ☐ 1: Certain  
☐ 2: Uncertain |
| 37. Describe the duration, amount of bleeding and period pains of your last period |  
(a). Was the duration | ☐ 1: Usual  
☐ 2: More than usual  
☐ 3: Less than usual |
| (b). Was the bleeding | ☐ 1: Usual  
☐ 2: More than usual  
☐ 3: Less than usual |
| (c). Was the pain | ☐ 1: Usual  
☐ 2: More than usual  
☐ 3: Less than usual |

### D. CONTRACEPTION AND REPRODUCTIVE HISTORY

| Q.                                      | Answer |
|-----------------------------------------|--------|
| 38. Have you/your partner at any time during the last year used the following methods to avoid becoming pregnant? *(Fill in all that apply.)* | ☐ 1: Condom  
☐ 2: Diaphragm  
☐ 3: IUD  
☐ 5: Hormone injection  
☐ 7: Pill  
☐ 11: No such methods  
☐ 88: Other |
| 39. If you have used the pill, how long have you used them? | Pill  
☐ 0: never used  
☐ 1: Less than one year  
☐ 2: 1-3 years  
☐ 3: 4-6 years  
☐ 4: 7-9 years  
☐ 5: 10 years or more |
| If Pill never used, skip to Q43 |
| 40. If you have used the pill, how old were you when you first used it? | __________ years old |
| 41. Were you taking the pill during the last 4 months before this pregnancy? | ☐ 1: Yes  
☐ 2: No [If no, skip to Q43] |
| 42. If yes, how long before your last menstrual period did you stop taking the pill | ____ weeks |
| 43. Was this pregnancy planned? | ☐ 1: Yes  
☐ 2: No [If no, skip to Q44] |
(a). If yes, how many months did you have regular intercourse without contraception before you became pregnant?

☐ 1. Less than 1 month
☐ 2. 1-2 months
☐ 3. 3 months or more
☐ 4. Number of months if more than 3

44. Did you become pregnant even though you or your partner used contraceptives

☐ 1. Yes
☐ 2. No [If no, skip to Q46]

45. If yes, which type of contraceptives were used? (Fill in all that apply.)

☐ 1. Condom [skip to Q47]
☐ 2. Diaphragm [skip to Q47]
☐ 3. IUD
☐ 4. Hormone injection [skip to Q47]
☐ 5. Pill [skip to Q47]
☐ 6. Other

46. If you became pregnant while using an IUD, has it now been removed?

☐ 1. Yes
☐ 2. No

47. How long have you and the baby’s father had a sexual relationship?

☐ months or ☐ years

48. How often did you have sexual intercourse during the four weeks before you became pregnant?

☐ 1. Every day
☐ 2. 5-6 times a week
☐ 3. 3-4 times a week
☐ 4. 1-2 times a week
☐ 5. 1-2 times every two weeks
☐ 6. Less than 1-2 times every 2 weeks
☐ 7. Refused to answer

49. Have you ever been treated for infertility?

☐ 1. Yes
☐ 2. No [If no, skip to Q52]

50. If yes, was it in connection with this pregnancy or an earlier pregnancy?

☐ 1. This pregnancy
☐ 2. Previous pregnancy

51 (a) What type of treatment did you have?

☐ 1. Fallopian tube surgery
☐ 2. Other surgery
☐ 3. Medication for endometriosis
☐ 4. Hormone treatment
☐ 5. Insemination (injection of sperm)
☐ 6. Test-tube method
☐ 8. Other

52. Have you been given information about amniocentesis?

☐ 1. Yes
☐ 2. No

E. PREVIOUS PREGNANCIES

53. Have you been pregnant before? (Include all pregnancies that ended in abortion, miscarriage or stillbirth)

☐ 1. Yes
☐ 2. No [If no, skip to Q62]

If yes, fill in for all earlier pregnancies. [Include all pregnancies that ended in abortion, miscarriage or stillbirth as well as ectopic pregnancies].

54. Pregnancy No. 1

(a). Year of pregnancy ________ year

(b). Pregnancy outcome

☐ 1. Live infant born
☐ 2. Spontaneous abortion
☐ 3. Termination of pregnancy
☐ 4. Ectopic pregnancy

(c). Week of pregnancy for abortion/still birth

☐ weeks

(d). Did you breastfeed during this pregnancy?

☐ 1. Yes
|   |   |
|---|---|
| (e). No. of months breast feeding | □ 2 No  [If No, skip to Q f) |
| (f). Weight gain during pregnancy | months |
| (g). Smoked during pregnancy | □ 1 Yes □ 2 No |

**55. Pregnancy No. 2**

(a). Year of pregnancy _______ year

(b). Pregnancy outcome □ 1 Live infant born □ 2 Spontaneous abortion □ 3 Termination of pregnancy □ 4 Ectopic pregnancy

(c). Week of pregnancy for abortion/still birth weeks

(d) Did you breastfeed during this pregnancy? □ 1 Yes □ 2 No  [If No, skip to Q f)

(e). No. of months breast feeding

(f). Weight gain during pregnancy kg

(g). Smoked during pregnancy □ 1 Yes □ 2 No

**56. Pregnancy No. 3**

(a). Year of pregnancy _______ year

(b). Pregnancy outcome □ 1 Live infant born □ 2 Spontaneous abortion □ 3 Termination of pregnancy □ 4 Ectopic pregnancy

(c). Week of pregnancy for abortion/still birth weeks

(d) Did you breastfeed during this pregnancy? □ 1 Yes □ 2 No  [If No, skip to Q f)

(e). No. of months breast feeding

(f). Weight gain during pregnancy kg

(g). Smoked during pregnancy □ 1 Yes □ 2 No

**57. Pregnancy No. 4**

(a). Year of pregnancy _______ year

(b). Pregnancy outcome □ 1 Live infant born □ 2 Spontaneous abortion □ 3 Termination of pregnancy □ 4 Ectopic pregnancy

(c). Week of pregnancy for abortion/still birth weeks

(d) Did you breastfeed during this pregnancy? □ 1 Yes □ 2 No  [If No, skip to Q f)

(e). No. of months breast feeding

(f). Weight gain during pregnancy
| Table | Description |
|-------|-------------|
| 58. Pregnancy No. 5 | (a). Year of pregnancy ________ year  
(b). Pregnancy outcome  
☑️ 1 Live infant born  
☐ 2 Spontaneous abortion  
☐ 3 Termination of pregnancy  
☐ 4 Ectopic pregnancy  
(c). Week of pregnancy for abortion/still birth  
☐ 1 Yes  
☐ 2 No  
(d). Did you breastfeed during this pregnancy?  
☐ 1 Yes  
☐ 2 No [If No, skip to Q f]  
(e). No. of months breast feeding  
☐ 1 Yes  
☐ 2 No  
(f). Weight gain during pregnancy  
☐ 1 Yes  
☐ 2 No  
(g). Smoked during pregnancy |
| 59. Pregnancy No. 6 | (a). Year of pregnancy ________ year  
(b). Pregnancy outcome  
☑️ 1 Live infant born  
☐ 2 Spontaneous abortion  
☐ 3 Termination of pregnancy  
☐ 4 Ectopic pregnancy  
(c). Week of pregnancy for abortion/still birth  
☐ 1 Yes  
☐ 2 No [If No, skip to Q f]  
(d). Did you breastfeed during this pregnancy?  
☐ 1 Yes  
☐ 2 No [If No, skip to Q f]  
(e). No. of months breast feeding  
☐ 1 Yes  
☐ 2 No  
(f). Weight gain during pregnancy  
☐ 1 Yes  
☐ 2 No  
(g). Smoked during pregnancy |
| 60. Pregnancy No. 7 | (a). Year of pregnancy ________ year  
(b). Pregnancy outcome  
☑️ 1 Live infant born  
☐ 2 Spontaneous abortion  
☐ 3 Termination of pregnancy  
☐ 4 Ectopic pregnancy  
(c). Week of pregnancy for abortion/still birth  
☐ 1 Yes  
☐ 2 No [If No, skip to Q f]  
(d). Did you breastfeed during this pregnancy?  
☐ 1 Yes  
☐ 2 No [If No, skip to Q f]  
(e). No. of months breast feeding  
☐ 1 Yes  
☐ 2 No  
(f). Weight gain during pregnancy  
☐ 1 Yes  
☐ 2 No  
(g). Smoked during pregnancy |
| 61. Pregnancy No. 8 | (a). Year of pregnancy ________ year  
(b). Pregnancy outcome  
☑️ 1 Live infant born  
☐ 2 Spontaneous abortion  
☐ 3 Termination of pregnancy  
☐ 4 Ectopic pregnancy  
(c). Week of pregnancy for abortion/still birth  
☐ 1 Yes  
☐ 2 No [If No, skip to Q f]  
(d). Did you breastfeed during this pregnancy?  
☐ 1 Yes  
☐ 2 No [If No, skip to Q f]  
(e). No. of months breast feeding  
☐ 1 Yes  
☐ 2 No  
(f). Weight gain during pregnancy  
☐ 1 Yes  
☐ 2 No  
(g). Smoked during pregnancy |
(b). Pregnancy outcome

- ☐ 1. Live infant born
- ☐ 2. Spontaneous abortion
- ☐ 3. Termination of pregnancy
- ☐ 4. Ectopic pregnancy

(c). Week of pregnancy for abortion/still birth

- ____________ weeks

(d) Did you breastfeed during this pregnancy?

- ☐ 1. Yes
- ☐ 2. No  [If No, skip to Q f)

(e). No. of months breast feeding

- ____________ months

(f). Weight gain during pregnancy

- ____________ kg

(g). Smoked during pregnancy

- ☐ 1. Yes
- ☐ 2. No

62. Have you had any of the following problems during previous pregnancies? *(Fill in all that apply.)*

- ☐ 1. Severe nausea and vomiting
- ☐ 2. No
- ☐ 1. Eclampsia during pregnancy
- ☐ 2. No
- ☐ 1. Diabetes during pregnancy
- ☐ 2. No
- ☐ 1. Sugar in urine
- ☐ 2. No
- ☐ 1. Problems with incontinence
- ☐ 2. No

- NONE OF THE ABOVE

F. ILLNESSES AND HEALTH PROBLEMS DURING THIS PREGNANCY

63. Have you had bleeding from the vagina once or more during this pregnancy?

- ☐ 1. Yes
- ☐ 2. No  [If no, skip to Q69]

64. Number of episodes:

*If yes, describe from the first to the last bleeding episode. Give the date the bleeding started, how many days the bleeding lasted and how much you bled for each episode.*

65. First Bleeding Episode:

- (a). Date when bleeding started
- (b). No. of days bleeding
- (c). Amount

- ☐ 1. Spotting
- ☐ 2. Light bleeding
- ☐ 3. Heavy bleeding

66. Second Bleeding Episode:

- (a). Date when bleeding started
- (b). No. of days bleeding
- (c). Amount

- ☐ 1. Spotting
- ☐ 2. Light bleeding
- ☐ 3. Heavy bleeding

67. Third Bleeding Episode:

- (a). Date when bleeding started
- (b). No. of days bleeding
- (c). Amount

- ☐ 1. Spotting
- ☐ 2. Light bleeding
- ☐ 3. Heavy bleeding

68. Fourth Bleeding Episode:

- (a). Date when bleeding started
- (b). No. of days bleeding
Have you experienced any of the following illnesses or problems during this pregnancy? If you have used medication in connection with these problems give the name of the medicine, the weeks you took the medicines and how many days you took them. *(Include all types of medication, both prescription and over the counter medicines in addition to alternative and herbal remedies. Do not include vitamins and dietary supplements as these are discussed elsewhere.)*

| Question | Yes | No |
|----------|-----|----|
| 69. Abdominal Pain | □ | □ |
| (a). Week of pregnancy | □ | □ |
| (b). Medication taken | □ | □ |
| (i). Name of medication | □ | □ |
| (ii). Do you have the bottle or package that you could show? | □ | □ |
| [Interview to indicate whether bottle or package seen: Seen: Yes /No ] | □ | □ |
| 70. Back Pain | □ | □ |
| (a). Week of pregnancy | □ | □ |
| (b). Medication taken | □ | □ |
| (i). Name of medication | □ | □ |
| (ii). Do you have the bottle or package that you could show? | □ | □ |
| [Interview to indicate whether bottle or package seen: Seen: Yes /No ] | □ | □ |
| (iii). Was this prescribed by: | □ | □ | □ | □ |
| (iv). Was this over the counter medication | □ | □ |
| (v). No. of days taken | □ | □ |
| 71. Neck and Shoulder Pain | □ | □ |
| (a). Week of pregnancy | □ | □ |
| (b). Medication taken | □ | □ |
| (i). Name of medication | □ | □ |
| (ii). Do you have the bottle or package that you could show? | □ | □ |
| [Interview to indicate whether bottle or package seen: Seen: Yes /No ] | □ | □ |
| (iii). Was this prescribed by: | □ | □ | □ | □ |
| (iv). Was this over the counter medication | □ | □ |
| Question | Yes | No | If No, Skip to Q73 |
|----------|-----|----|--------------------|
| No. of days taken | | | |

72. Nausea

(a). Week of pregnancy

(b). Medication taken

(i). Name of medication

(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes / No ]

(iii). Was this prescribed by:

(iv). Was this over the counter medication

(v). No. of days taken

73. Nausea with Vomiting

(a). Week of pregnancy

(b). Medication taken

(i). Name of medication

(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes / No ]

(iii). Was this prescribed by:

(iv). Was this over the counter medication

(v). No. of days taken

74. Vaginal Thrush

(a). Week of pregnancy

(b). Medication taken

(i). Name of medication

(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes / No ]

(iii). Was this prescribed by:

(iv). Was this over the counter medication

(v). No. of days taken
### 75. Vaginal Discharge

- **(a). Week of pregnancy**
  - [ ] Yes
  - [ ] No
  - **[If no, skip to Q76]**

- **(b). Medication taken**
  - [ ] Yes
  - [ ] No
  - **[If no, skip to Q76]**

- **(i). Name of medication**

- **(ii). Do you have the bottle or package that you could show?**
  - [ ] Yes
  - [ ] No
  - **Interview to indicate whether bottle or package seen:**
    - [ ] Yes
    - [ ] No

- **(iii). Was this prescribed by:**
  - [ ] Doctor
  - [ ] Clinic nurse
  - [ ] None of the above
  - [ ] Don’t know

- **(iv). Was this over the counter medication**
  - [ ] Yes
  - [ ] No

- **(v). No. of days taken**
  - [ ] days

### 76. Itchy rash

- **(a). Week of pregnancy**
  - [ ] Yes
  - [ ] No
  - **[If no, skip to Q77]**

- **(b). Medication taken**
  - [ ] Yes
  - [ ] No
  - **[If no, skip to Q77]**

- **(i). Name of medication**

- **(ii). Do you have the bottle or package that you could show?**
  - [ ] Yes
  - [ ] No
  - **Interview to indicate whether bottle or package seen:**
    - [ ] Yes
    - [ ] No

- **(iii). Was this prescribed by:**
  - [ ] Doctor
  - [ ] Clinic nurse
  - [ ] None of the above
  - [ ] Don’t know

- **(iv). Was this over the counter medication**
  - [ ] Yes
  - [ ] No

- **(v). No. of days taken**
  - [ ] days

### 77. Constipation

- **(a). Week of pregnancy**
  - [ ] Yes
  - [ ] No
  - **[If no, skip to Q78]**

- **(b). Medication taken**
  - [ ] Yes
  - [ ] No
  - **[If no, skip to Q78]**

- **(i). Name of medication**

- **(ii). Do you have the bottle or package that you could show?**
  - [ ] Yes
  - [ ] No
  - **Interview to indicate whether bottle or package seen:**
    - [ ] Yes
    - [ ] No

- **(iii). Was this prescribed by:**
  - [ ] Doctor
  - [ ] Clinic nurse
  - [ ] None of the above
  - [ ] Don’t know

- **(iv). Was this over the counter medication**
  - [ ] Yes
  - [ ] No

- **(v). No. of days taken**
  - [ ] days

### 78. Diarrhoea

- [ ] Yes
| Question | Yes | No | Comment |
|----------|-----|----|---------|
| 79. Unusual tiredness or sleepiness | ☐ Yes | ☐ No | [If no, skip to Q80] |
| (a). Week of pregnancy | ☐  | ☐  |  |
| (b). Medication taken | ☐  | ☐  | [If no, skip to Q80] |
| (i). Name of medication | ☐  | ☐  |  |
| (ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes /No] | ☐  | ☐  |  |
| (iii). Was this prescribed by: | ☐ Doctor | ☐ Clinic nurse | ☐ None of the above | ☐ Don't know |
| (iv). Was this over the counter medication | ☐  | ☐  |  |
| (v). No. of days taken | ☐  | ☐  |  |

80. Sleeping Problems

| Question | Yes | No | Comment |
|----------|-----|----|---------|
| (a). Week of pregnancy | ☐  | ☐  |  |
| (b). Medication taken | ☐  | ☐  | [If no, skip to Q81] |
| (i). Name of medication | ☐  | ☐  |  |
| (ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes /No] | ☐  | ☐  |  |
| (iii). Was this prescribed by: | ☐ Doctor | ☐ Clinic nurse | ☐ None of the above | ☐ Don't know |
| (iv). Was this over the counter medication | ☐  | ☐  |  |
| (v). No. of days taken | ☐  | ☐  |  |

81. Heartburn

| Question | Yes | No | Comment |
|----------|-----|----|---------|
| (a). Week of pregnancy | ☐  | ☐  |  |
| (b). Medication taken | ☐  | ☐  | [If no, skip to Q82] |
| (i). Name of medication | ☐  | ☐  |  |
| (ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes /No] | ☐  | ☐  |  |
| (iii). Was this prescribed by: | ☐ Doctor | ☐ Clinic nurse | ☐ None of the above | ☐ Don't know |
| (iv). Was this over the counter medication | ☐  | ☐  |  |
| (v). No. of days taken | ☐  | ☐  |  |
(b). Medication taken

| 1 | Yes [If no, skip to Q82] | 2 | No |

(i). Name of medication

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen: Seen: Yes _____/No _____]

(iii). Was this prescribed by:

| 1 | Doctor | 2 | Clinic nurse | 3 | None of the above | 4 | Don’t know |

(iv). Was this over the counter medication

| 1 | Yes | 2 | No |

(v). No. of days taken

_________ days

82. Swelling of the legs and feet

| 1 | Yes | 2 | No [If no, skip to Q83] |

(a). Week of pregnancy

_________ week of pregnancy

(b). Medication taken

| 1 | Yes | 2 | No [If no, skip to Q83] |

(i). Name of medication

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen: Seen: Yes _____/No _____]

(iii). Was this prescribed by:

| 1 | Doctor | 2 | Clinic nurse | 3 | None of the above | 4 | Don’t know |

(iv). Was this over the counter medication

| 1 | Yes | 2 | No |

(v). No. of days taken

_________ days

83. Fever with rash

| 1 | Yes | 2 | No [If no, skip to Q84] |

(a). Week of pregnancy

_________ week of pregnancy

(b). Medication taken

| 1 | Yes | 2 | No [If no, skip to Q84] |

(i). Name of medication

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen: Seen: Yes _____/No _____]

(iii). Was this prescribed by:

| 1 | Doctor | 2 | Clinic nurse | 3 | None of the above | 4 | Don’t know |

(iv). Was this over the counter medication

| 1 | Yes | 2 | No |

(v). No. of days taken

_________ days

84. High fever (over 38.5 degrees C)

| 1 | Yes | 2 | No [If no, skip to Q85] |

(a). Week of pregnancy

_________ week of pregnancy

(b). Medication taken

| 1 | Yes | 2 | No [If no, skip to Q85] |
| Question | Options |
|----------|---------|
| (i). Name of medication | ________ |
| (ii). Do you have the bottle or package that you could show? | ☐ Yes  ☐ 2 No |
| Interview to indicate whether bottle or package seen: |  Yes /No  |
| (iii). Was this prescribed by: | ☐ 1 Doctor  ☐ 2 Clinic nurse  ☐ 3 None of the above  ☐ 4 Don't know |
| (iv). Was this over the counter medication | ☐ 1 Yes  ☐ 2 No |
| (v). No. of days taken | ________ days |
| 85. Common cold | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q 86] |
| (a). Week of pregnancy | ________ week of pregnancy |
| (b). Medication taken | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q86] |
| (i). Name of medication | ________ |
| (ii). Do you have the bottle or package that you could show? | ☐ 1 Yes  ☐ 2 No |
| Interview to indicate whether bottle or package seen: |  Yes /No  |
| (iii). Was this prescribed by: | ☐ 1 Doctor  ☐ 2 Clinic nurse  ☐ 3 None of the above  ☐ 4 Don't know |
| (iv). Was this over the counter medication | ☐ 1 Yes  ☐ 2 No |
| (v). No. of days taken | ________ days |
| 86. Throat infection | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q87] |
| (a). Week of pregnancy | ________ week of pregnancy |
| (b). Medication taken | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q87] |
| (i). Name of medication | ________ |
| (ii). Do you have the bottle or package that you could show? | ☐ 1 Yes  ☐ 2 No |
| Interview to indicate whether bottle or package seen: |  Yes /No  |
| (iii). Was this prescribed by: | ☐ 1 Doctor  ☐ 2 Clinic nurse  ☐ 3 None of the above  ☐ 4 Don’t know |
| (iv). Was this over the counter medication | ☐ 1 Yes  ☐ 2 No |
| (v). No. of days taken | ________ days |
| 87. Sinusitis with ear infection | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q88] |
| (a). Week of pregnancy | ________ week of pregnancy |
| (b). Medication taken | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q88] |
| (i). Name of medication | ________ |
| Question | Choices | Notes |
|----------|---------|-------|
| (ii). Do you have the bottle or package that you could show? | □ 1 Yes □ 2 No | |
| [Interview to indicate whether bottle or package seen: Seen: Yes ______/No ______] | | |
| (iii). Was this prescribed by: | □ 1 Doctor □ 2 Clinic nurse □ 3 None of the above □ 4 Don’t know | |
| (iv). Was this over the counter medication | □ 1 Yes □ 2 No | |
| (v). No. of days taken | □ 1 Yes □ 2 No | |

88. The 'Flu

| | Choices | Notes |
|---|---|---|
| □ 1 Yes □ 2 No | [If no, skip to Q89] | |
| (a). Week of pregnancy | | |
| (b). Medication taken | □ 1 Yes □ 2 No | [If no, skip to Q89] |
| (i). Name of medication | | |
| (ii). Do you have the bottle or package that you could show? | □ 1 Yes □ 2 No | |
| [Interview to indicate whether bottle or package seen: Seen: Yes ______/No ______] | | |
| (iii). Was this prescribed by: | □ 1 Doctor □ 2 Clinic nurse □ 3 None of the above □ 4 Don’t know | |
| (iv). Was this over the counter medication | □ 1 Yes □ 2 No | |
| (v). No. of days taken | □ 1 Yes □ 2 No | |

89. Pneumonia or bronchitis

| | Choices | Notes |
|---|---|---|
| □ 1 Yes □ 2 No | [If no, skip to Q90] | |
| (a). Week of pregnancy | | |
| (b). Medication taken | □ 1 Yes □ 2 No | [If no, skip to Q90] |
| (i). Name of medication | | |
| (ii). Do you have the bottle or package that you could show? | □ 1 Yes □ 2 No | |
| [Interview to indicate whether bottle or package seen: Seen: Yes ______/No ______] | | |
| (iii). Was this prescribed by: | □ 1 Doctor □ 2 Clinic nurse □ 3 None of the above □ 4 Don’t know | |
| (iv). Was this over the counter medication | □ 1 Yes □ 2 No | |
| (v). No. of days taken | □ 1 Yes □ 2 No | |

90. Sugar in the urine

| | Choices | Notes |
|---|---|---|
| □ 1 Yes □ 2 No | [If no, skip to Q91] | |
| (a). Week of pregnancy | | |
| (b). Medication taken | □ 1 Yes □ 2 No | [If no, skip to Q91] |
| (i). Name of medication | | |
| (ii). Do you have the bottle or package that you could show? | □ 1 Yes □ 2 No | |
| Question                                                                 | Options                                                                 |
|------------------------------------------------------------------------|------------------------------------------------------------------------|
| (i). Name of medication                                                | ☐ 1 Yes                                                                  |
|                                                                        | ☐ 2 No [If no, skip to Q92]                                              |
| (ii). Do you have the bottle or package that you could show?           | ☐ 1 Yes                                                                  |
|                                                                        | ☐ 2 No                                                                   |
| [Interview to indicate whether bottle or package seen:                 |                                                                          |
| Seen: Yes _____/No _____ ]                                              |                                                                          |
| (iii). Was this prescribed by:                                         | ☐ 1 Doctor                                                               |
|                                                                        | ☐ 2 Clinic nurse                                                         |
|                                                                        | ☐ 3 None of the above                                                    |
|                                                                        | ☐ 4 Don’t know                                                           |
| (iv). Was this over the counter medication                             | ☐ 1 Yes                                                                  |
|                                                                        | ☐ 2 No                                                                   |
| (v). No. of days taken                                                 |                                                                        |
|                                                                        |                                                                        |
| 91. Protein in the urine                                               | ☐ 1 Yes                                                                  |
|                                                                        | ☐ 2 No [If no, skip to Q92]                                              |
| (a). Week of pregnancy                                                 |                                                                        |
|                                                                        |                                                                        |
| (b). Medication taken                                                  | ☐ 1 Yes                                                                  |
|                                                                        | ☐ 2 No [If no, skip to Q92]                                              |
| (i). Name of medication                                                |                                                                        |
| (ii). Do you have the bottle or package that you could show?           | ☐ 1 Yes                                                                  |
|                                                                        | ☐ 2 No                                                                   |
| [Interview to indicate whether bottle or package seen:                 |                                                                        |
| Seen: Yes _____/No _____ ]                                              |                                                                        |
| (iii). Was this prescribed by:                                         | ☐ 1 Doctor                                                               |
|                                                                        | ☐ 2 Clinic nurse                                                         |
|                                                                        | ☐ 3 None of the above                                                    |
|                                                                        | ☐ 4 Don’t know                                                           |
| (iv). Was this over the counter medication                             | ☐ 1 Yes                                                                  |
|                                                                        | ☐ 2 No                                                                   |
| (v). No. of days taken                                                 |                                                                        |
|                                                                        |                                                                        |
| 92. In the last three months, have you had diarrhea that lasted for    | ☐ 1 Yes                                                                  |
| more than three days?                                                  | ☐ 2 No                                                                   |
| 93. In the last three months did you have fever for more than one     | ☐ 1 Yes                                                                  |
| month on end?                                                          | ☐ 2 No                                                                   |
| 94. Have you had white sores in your mouth over the last three         | ☐ 1 Yes                                                                  |
| months?                                                                | ☐ 2 No                                                                   |
| 95. Do you have swollen lymph nodes in your neck, under your arms or   | ☐ 1 Yes                                                                  |
| in your groin?                                                         | ☐ 2 No                                                                   |
| 96. Have you had shingles (painful blisters or sores usually in a    | ☐ 1 Yes                                                                  |
| narrow band on one side of the head or body) over the last 12 months?  | ☐ 2 No                                                                   |
### G. PAST AND PRESENT ILLNESSES AND HEALTH PROBLEMS

Do you have or have you had any of the following illnesses or health problems? If you have taken medication (tablets, mixtures, suppositories, inhalers, creams, etc.) in conjunction with the illness or health problem give the name(s) of the medication(s) and when you took them.

#### Respiratory, Allergy and Skin Disorders

| Question                                                                 | Yes | No |
|--------------------------------------------------------------------------|-----|----|
| 97. Have you ever been told by a doctor that you have asthma?            |     |    |
| (a). Were you told this more than six months before this pregnancy?       |     |    |
| (b). Were you told this in the last six months before this pregnancy?    |     |    |
| (c). Were you told this during this pregnancy?                           |     |    |
| (i). If yes, in what week of the pregnancy?                             |     |    |
| (d). Have you taken any medication for this problem                      |     |    |
| (i). Name of medication                                                 |     |    |
| (ii). Do you have the bottle or package that you could show?             |     |    |
| [Interview to indicate whether bottle or package seen:                   |     |    |
| Seen: Yes /No                                                           |     |    |
| (iii). Was this prescribed by:                                          |     |    |
| (iv). Was this over the counter medication                              |     |    |
| (v). No. of days taken                                                  |     |    |

| Question                                                                 | Yes | No |
|--------------------------------------------------------------------------|-----|----|
| 98. Have you ever been told by a doctor that you have chronic bronchitis |     |    |
| (a). Were you told this more than six months before this pregnancy?      |     |    |
| (b). Were you told this in the last six months before this pregnancy?    |     |    |
| (c). Were you told this during this pregnancy?                           |     |    |
| (i). If yes, in what week of the pregnancy?                             |     |    |
| (d). Have you taken any medication for this problem                      |     |    |
| (i). Name of medication                                                 |     |    |
| (ii). Do you have the bottle or package that you could show?             |     |    |
| [Interview to indicate whether bottle or package seen:                   |     |    |
| Seen: Yes /No                                                           |     |    |
| (iii). Was this prescribed by:                                          |     |    |

---

1. Yes
2. No
| Question                                                                 | Options         |
|-------------------------------------------------------------------------|-----------------|
| (iv). Was this over the counter medication                              | □ 4 Don’t know  |
|                                                                         | □ 1 Yes         |
|                                                                         | □ 2 No          |
| (v). No. of days taken                                                  | __________ days |

99. Have you ever been told by a doctor that you have emphysema          | □ 1 Yes         |
|                                                                         | □ 2 No          |

(a). Were you told this more than six months before this pregnancy?      | □ 1 Yes         |
|                                                                         | □ 2 No          |

(b). Were you told this in the last six months before this pregnancy?    | □ 1 Yes         |
|                                                                         | □ 2 No          |

(c). Were you told this during this pregnancy?                           | □ 1 Yes         |
|                                                                         | □ 2 No          |

   (i). If yes, in what week of the pregnancy?                            | □ 1 0-4 weeks   |
|                                                                         | □ 2 5-8 weeks   |
|                                                                         | □ 3 9-12 weeks  |
|                                                                         | □ 4 13+ weeks   |

(d). Have you taken any medication for this problem                      | □ 1 Yes         |
|                                                                         | □ 2 No          |

   (i). Name of medication                                                | ________________|

   (ii). Do you have the bottle or package that you could show?          | □ 1 Yes         |
| [Interview to indicate whether bottle or package seen:                 | □ 2 No          |
| Seen: Yes ____ /No ____]                                               |                |

   (iii). Was this prescribed by:                                        | □ 1 Doctor      |
|                                                                         | □ 2 Clinic nurse |
|                                                                         | □ 3 None of the above |
|                                                                         | □ 4 Don’t know  |

(v). No. of days taken                                                  | __________ days |

100. Have you ever been told by a doctor that you have TB (or tuberculosis) | □ 1 Yes         |
|                                                                         | □ 2 No          |

(a). Were you told this more than six months before this pregnancy?      | □ 1 Yes         |
|                                                                         | □ 2 No          |

(b). Were you told this in the last six months before this pregnancy?    | □ 1 Yes         |
|                                                                         | □ 2 No          |

(c). Were you told this during this pregnancy?                           | □ 1 Yes         |
|                                                                         | □ 2 No          |

   (i). If yes, in what week of the pregnancy?                            | □ 1 0-4 weeks   |
|                                                                         | □ 2 5-8 weeks   |
|                                                                         | □ 3 9-12 weeks  |
|                                                                         | □ 4 13+ weeks   |

(d). Have you taken any medication for this problem                      | □ 1 Yes         |
|                                                                         | □ 2 No          |

   (i). Name of medication                                                | ________________|

   (ii). Do you have the bottle or package that you could show?          | □ 1 Yes         |
| [Interview to indicate whether bottle or package seen:                 | □ 2 No          |
| Seen: Yes ____ /No ____]                                               |                |

   (iii). Was this prescribed by:                                        | □ 1 Doctor      |
|                                                                         | □ 2 Clinic nurse |
|                                                                         | □ 3 None of the above |
| Question                                                                 | Yes | No | If no, skip to Q102 |
|------------------------------------------------------------------------|-----|----|---------------------|
| (iv). Was this over the counter medication                             |     |    |                     |
| (v). No. of days taken                                                  |     |    |                     |
| 101. Have you ever been told by a doctor that you have hayfever?       |     |    |                     |
| (a). Were you told this more than six months before this pregnancy?    |     |    |                     |
| (b). Were you told this in the last six months before this pregnancy?  |     |    |                     |
| (c). Were you told this during this pregnancy?                         |     |    |                     |
| (i). If yes, in what week of the pregnancy?                            |     |    |                     |
| (d). Have you taken any medication for this problem                    |     |    |                     |
| (i). Name of medication                                                |     |    |                     |
| (ii). Do you have the bottle or package that you could show?           |     |    |                     |
| (iii). Was this prescribed by:                                         |     |    |                     |
| (v). No. of days taken                                                  |     |    |                     |
| 102. Have you ever been told by a doctor that you have an allergy?     |     |    |                     |
| (a). Were you told this more than six months before this pregnancy?    |     |    |                     |
| (b). Were you told this in the last six months before this pregnancy?  |     |    |                     |
| (c). Were you told this during this pregnancy?                         |     |    |                     |
| (i). If yes, in what week of the pregnancy?                            |     |    |                     |
| (d). Have you taken any medication for this problem                    |     |    |                     |
| (i). Name of medication                                                |     |    |                     |
| (ii). Do you have the bottle or package that you could show?           |     |    |                     |
| (iii). Was this prescribed by:                                         |     |    |                     |
(iv). Was this over the counter medication

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |

(v). No. of days taken

|   |
|---|
|   days |

(e). What were you told you were allergic too?

|   |
|---|
| 1 | food |
| 2 | pollen |
| 3 | animal hair |
| 4 | medication |
| 88 | other:       |

103. Have you ever been told by a doctor that you have one or more of the following skin problems

|   |
|---|
| 1 | Eczema |
| 2 | Urticaria (hives) |
| 3 | Psoriasis |
| 4 | Cold sores (herpes) |
| 5 | Acne |
| 6 | Other:       |
| 7 | No [If no, skip to Q104] |

(a). Were you told this more than six months before this pregnancy?

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |

(b). Were you told this in the last six months before this pregnancy?

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |

(c). Were you told this during this pregnancy?

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |

(i). If yes, in what week of the pregnancy?

|   |
|---|
| 0-4 weeks |
| 5-8 weeks |
| 9-12 weeks |
| 13+ weeks |

(d). Have you taken any medication for this problem

|   |   |
|---|---|
| 1 | Yes [If no, skip to Q104] |
| 2 | No  |

(i). Name of medication

|   |   |   |   |
|---|---|---|---|
|   |   |   |   |

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen:

|   |
|---|
| 1 | Doctor |
| 2 | Clinic nurse |
| 3 | None of the above |
| 4 | Don’t know |

(iii). Was this prescribed by:

|   |
|---|
| 1 | Yes |
| 2 | No  |

(iv). Was this over the counter medication

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |

(v). No. of days taken

|   |
|---|
|   days |

104. Have you ever been told by a doctor that you have diabetes

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |

(a). Were you told this more than six months before this pregnancy?

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |

(i). If yes, was this in a previous pregnancy?

|   |   |
|---|---|
| 1 | Yes |
| 2 | No  |
(ii) If yes, was your blood sugar normal after the pregnancy? □ Yes □ No

(b). Were you told this in the last six months before this pregnancy? □ Yes □ No

(c). Were you told this during this pregnancy? □ Yes □ No

(i). If yes, in what week of the pregnancy? □ 0-4 weeks □ 5-8 weeks □ 9-12 weeks □ 13+ weeks

(ii). Are you now taking insulin? □ Yes □ No

(iii). Was this prescribed by: □ Doctor □ Clinic nurse □ None of the above □ Don’t know

(iv). Name of medication

(v). Do you have the bottle or package that you could show? □ Yes □ No

[Interview to indicate whether bottle or package seen: See: Yes / No]

(vi). Was this prescribed by a doctor □ Yes □ No

(vii). Was this over the counter medication □ Yes □ No

(viii). No. of days taken ___________ days

Heart / Blood / Metabolism / Blood vessels

105. Have you ever been told by a doctor that you have heart defect since birth (a congenital heart defect)? □ Yes □ No [If no, skip to Q106]

(a). Were you told this more than six months before this pregnancy? □ Yes □ No

(b). Were you told this in the last six months before this pregnancy? □ Yes □ No

(c). Were you told this during this pregnancy? □ Yes □ No

(i). If yes, in what week of the pregnancy? □ 0-4 weeks □ 5-8 weeks □ 9-12 weeks □ 13+ weeks

(d). Have you taken any medication for this problem □ Yes □ No [If no, skip to Q106]

(i). Name of medication

(ii). Do you have the bottle or package that you could show? □ Yes □ No

[Interview to indicate whether bottle or package seen: See: Yes / No]

(iii). Was this prescribed by: □ Doctor □ Clinic nurse □ None of the above □ Don’t know

(iv). Was this over the counter medication □ Yes □ No

(v). No. of days taken ___________ days
106. Have you ever been told by a doctor that you have any other heart disease?

- Yes
- No [If no, skip to Q107]

(a). If yes, please describe __________________

(b). Were you told this more than six months before this pregnancy?

- Yes
- No

(c). Were you told this in the last six months before this pregnancy?

- Yes
- No

(d). Were you told this during this pregnancy?

- Yes
- No

(i). If yes, in what week of the pregnancy?

- 0-4 weeks
- 5-8 weeks
- 9-12 weeks
- 13+ weeks

(e). Have you taken any medication for this problem?

- Yes
- No [If no, skip to Q107]

(i). Name of medication

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen:

- Yes
- No]

(iii). Was this prescribed by:

- Doctor
- Clinic nurse
- None of the above
- Don’t know

(iv). Was this over the counter medication?

- Yes
- No

(v). No. of days taken ___________ days

107. Have you ever been told by a doctor that you have high cholesterol?

- Yes
- No [If no, skip to Q108]

(a). Were you told this more than six months before this pregnancy?

- Yes
- No

(b). Were you told this in the last six months before this pregnancy?

- Yes
- No

(c). Were you told this during this pregnancy?

- Yes
- No

(i). If yes, in what week of the pregnancy?

- 0-4 weeks
- 5-8 weeks
- 9-12 weeks
- 13+ weeks

(d). Have you taken any medication for this problem?

- Yes
- No [If no, skip to Q108]

(i). Name of medication

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen:

- Yes
- No]

(iii). Was this prescribed by:

- Doctor
- Clinic nurse
- None of the above
- Don’t know

(iv). Was this over the counter medication?

- Yes
- No

(v). No. of days taken ___________ days
108. Have you ever been told by a doctor that you have high blood pressure?  
☐ 1 Yes  
☐ 2 No  
[If no, skip to Q109]

(a). Were you told this more than six months before this pregnancy?  
☐ 1 Yes  
☐ 2 No

(i). If yes, was this in a previous pregnancy?  
☐ 1 Yes  
☐ 2 No

(ii). If yes, was your blood pressure normal after the pregnancy?  
☐ 1 Yes  
☐ 2 No

(b). Were you told this in the last six months before this pregnancy?  
☐ 1 Yes  
☐ 2 No

(c). Were you told this during this pregnancy?  
☐ 1 Yes  
☐ 2 No

(i). If yes, in what week of the pregnancy?  
☐ 1 0-4 weeks  
☐ 2 5-8 weeks  
☐ 3 9-12 weeks  
☐ 4 13+ weeks

(d). Have you taken any medication for this problem  
☐ 1 Yes  
☐ 2 No  
[If no, skip to Q109]

(i). Name of medication  
____________

(ii). Do you have the bottle or package that you could show?  
[Interview to indicate whether bottle or package seen:  
Seen: Yes _____/No _____]

☐ 1 Yes  
☐ 2 No

(iii). Was this prescribed by:  
☐ 1 Doctor  
☐ 2 Clinic nurse  
☐ 3 None of the above  
☐ 4 Don't know

(iv). Was this over the counter medication  
☐ 1 Yes  
☐ 2 No

(v). No. of days taken  
__________ days

109. Have you ever been told by a doctor that you have hypothyroidism or hyperthyroidism  
☐ 1 Yes  
☐ 2 No  
[If no, skip to Q110]

(a). Were you told this more than six months before this pregnancy?  
☐ 1 Yes  
☐ 2 No

(b). Were you told this in the last six months before this pregnancy?  
☐ 1 Yes  
☐ 2 No

(c). Were you told this during this pregnancy?  
☐ 1 Yes  
☐ 2 No

(i). If yes, in what week of the pregnancy?  
☐ 1 0-4 weeks  
☐ 2 5-8 weeks  
☐ 3 9-12 weeks  
☐ 4 13+ weeks

(d). Have you taken any medication for this problem  
☐ 1 Yes  
☐ 2 No  
[If no, skip to Q110]

(i). Name of medication  
____________

(ii). Do you have the bottle or package that you could show?  
[Interview to indicate whether bottle or package seen:  
Seen: Yes _____/No _____]

☐ 1 Yes  
☐ 2 No

(iii). Was this prescribed by:  
☐ 1 Doctor  
☐ 2 Clinic nurse  
☐ 3 None of the above  
☐ 4 Don't know
| Question                                                                 | Yes | No | Don’t know |
|-------------------------------------------------------------------------|-----|----|------------|
| (iv). Was this over the counter medication?                             | ☐₁  | ☐₂ | ☐₄         |
| (v). No. of days taken                                                  |     |    |            |

110. Have you ever been told by a doctor that you have anaemia

(a). Were you told this more than six months before this pregnancy?     | ☐₁  | ☐₂ | [If no, skip to Q111] |
(b). Were you told this in the last six months before this pregnancy?   | ☐₁  | ☐₂ |
(c). Were you told this during this pregnancy?                          | ☐₁  | ☐₂ |

(i). If yes, in what week of the pregnancy?                             | ☐₁  | ☐₂  | ☐₃  | ☐₄ |

(d). Have you taken any medication for this problem?                    | ☐₁  | ☐₂  | [If no, skip to Q111] |

(i). Name of medication                                                 |     |    |            |

(ii). Do you have the bottle or package that you could show?            | ☐₁  | ☐₂ |
[Interview to indicate whether bottle or package seen:                 |     |    |
Seen: Yes ☐/No ☐                                                      |

(iii). Was this prescribed by:                                         | ☐₁  | ☐₂  | ☐₃  | ☐₄ |

(iv). Was this over the counter medication?                             | ☐₁  | ☐₂ |
(v). No. of days taken                                                  |     |    |            |

111. Have you ever been told by a doctor that you have B-12/folic acid insufficiency

(a). Were you told this more than six months before this pregnancy?     | ☐₁  | ☐₂ | [If no, skip to Q112] |
(b). Were you told this in the last six months before this pregnancy?   | ☐₁  | ☐₂ |
(c). Were you told this during this pregnancy?                          | ☐₁  | ☐₂ |

(i). If yes, in what week of the pregnancy?                             | ☐₁  | ☐₂  | ☐₃  | ☐₄ |

(d). Have you taken any medication for this problem?                    | ☐₁  | ☐₂  | [If no, skip to Q112] |

(i). Name of medication                                                 |     |    |            |

(ii). Do you have the bottle or package that you could show?            | ☐₁  | ☐₂ |
[Interview to indicate whether bottle or package seen:                 |     |    |
Seen: Yes ☐/No ☐                                                      |

(iii). Was this prescribed by:                                         | ☐₁  | ☐₂  | ☐₃  | ☐₄ |
| Question | Options |
|----------|---------|
| (iv). Was this over the counter medication | ☐ 1 Yes  ☐ 2 No |
| (v). No. of days taken | _______ days |

**Gastrointestinal**

112. Have you ever been told by a doctor that you have Hepatitis/jaundice? | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q113] |
| (a). Were you told this more than six months before this pregnancy? | ☐ 1 Yes  ☐ 2 No |
| (b). Were you told this in the last six months before this pregnancy? | ☐ 1 Yes  ☐ 2 No |
| (c). Were you told this during this pregnancy? | ☐ 1 Yes  ☐ 2 No |
| (i). If yes, in what week of the pregnancy? | ☐ 1 0-4 weeks  ☐ 2 5-8 weeks  ☐ 3 9-12 weeks  ☐ 4 13+ weeks |
| (d). Have you taken any medication for this problem | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q113] |
| (i). Name of medication | |
| (ii). Do you have the bottle or package that you could show?  [Interview to indicate whether bottle or package seen:  Seen: Yes  ☐ Yes  ☐ No] | ☐ 1 Yes  ☐ 2 No |
| (iii). Was this prescribed by: | ☐ 1 Doctor  ☐ 2 Clinic nurse  ☐ 3 None of the above  ☐ 4 Don’t know |
| (v). No. of days taken | _______ days |

113. Have you ever been told by a doctor that you have Gall stones | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q114] |
| (a). Were you told this more than six months before this pregnancy? | ☐ 1 Yes  ☐ 2 No |
| (b). Were you told this in the last six months before this pregnancy? | ☐ 1 Yes  ☐ 2 No |
| (c). Were you told this during this pregnancy? | ☐ 1 Yes  ☐ 2 No |
| (i). If yes, in what week of the pregnancy? | ☐ 1 0-4 weeks  ☐ 2 5-8 weeks  ☐ 3 9-12 weeks  ☐ 4 13+ weeks |
| (d). Have you taken any medication for this problem | ☐ 1 Yes  ☐ 2 No  [If no, skip to Q114] |
| (i). Name of medication | |
| (ii). Do you have the bottle or package that you could show?  [Interview to indicate whether bottle or package seen:  Seen: Yes  ☐ Yes  ☐ No] | ☐ 1 Yes  ☐ 2 No |
| (iii). Was this prescribed by: | ☐ 1 Doctor  ☐ 2 Clinic nurse  ☐ 3 None of the above |
(iv). Was this over the counter medication

| ☐ 1. Yes | ☐ 2. No |

(v). No. of days taken

| _______ days |

114. Have you ever been told by a doctor that you have stomach ulcer

| ☐ 1. Yes | ☐ 2. No | [If no, skip to Q115] |

(a). Were you told this more than six months before this pregnancy?

| ☐ 1. Yes | ☐ 2. No |

(b). Were you told this in the last six months before this pregnancy?

| ☐ 1. Yes | ☐ 2. No |

(c). Were you told this during this pregnancy?

| ☐ 1. Yes | ☐ 2. No |

(i). If yes, in what week of the pregnancy?

| ☐ 1. 0-4 weeks | ☐ 2. 5-8 weeks | ☐ 3. 9-12 weeks | ☐ 4. 13+ weeks |

(d). Have you taken any medication for this problem

| ☐ 1. Yes | ☐ 2. No | [If no, skip to Q115] |

(i). Name of medication

| _______ |

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen:

| Seen: Yes /No |

(iii). Was this prescribed by:

| ☐ 1. Doctor | ☐ 2. Clinic nurse | ☐ 3. None of the above | ☐ 4. Don’t know |

(v). Was this over the counter medication

| ☐ 1. Yes | ☐ 2. No |

(v). No. of days taken

| _______ days |

115. Have you ever been told by a doctor that you have other gastro-intestinal problems

| ☐ 1. Yes | ☐ 2. No | [If no, skip to Q116] |

(a). If yes, please describe

| _______ |

(b). Were you told this more than six months before this pregnancy?

| ☐ 1. Yes | ☐ 2. No |

(c). Were you told this in the last six months before this pregnancy?

| ☐ 1. Yes | ☐ 2. No |

(d). Were you told this during this pregnancy?

| ☐ 1. Yes | ☐ 2. No |

(i). If yes, in what week of the pregnancy?

| ☐ 1. 0-4 weeks | ☐ 2. 5-8 weeks | ☐ 3. 9-12 weeks | ☐ 4. 13+ weeks |

(e). Have you taken any medication for this problem

| ☐ 1. Yes | ☐ 2. No | [If no, skip to Q116] |

(i). Name of medication

| _______ |

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen:

| Seen: Yes /No |

(iii). Was this prescribed by:

| ☐ 1. Doctor | ☐ 2. Clinic nurse |
Musculoskeletal or Connective tissue

116. Have you ever been told by a doctor that you have Rheumatoid arthritis/□ Yes □ No

(a). Were you told this more than six months before this pregnancy? □ Yes □ No

(b). Were you told this in the last six months before this pregnancy? □ Yes □ No

(c). Were you told this during this pregnancy? □ Yes □ No

(i). If yes, in what week of the pregnancy? □ 0-4 weeks □ 5-8 weeks □ 9-12 weeks □ 13+ weeks

(d). Have you taken any medication for this problem □ Yes □ No

(i). Name of medication __________

(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes Yes /No No]

(iii). Was this prescribed by: □ Doctor □ Clinic nurse □ None of the above □ Don't know

(iv). Was this over the counter medication □ Yes □ No

(v). No. of days taken ________ days

117. Have you ever been told by a doctor that you have Lupus (SLE)/□ Yes □ No

(a). Were you told this more than six months before this pregnancy? □ Yes □ No

(b). Were you told this in the last six months before this pregnancy? □ Yes □ No

(c). Were you told this during this pregnancy? □ Yes □ No

(i). If yes, in what week of the pregnancy? □ 0-4 weeks □ 5-8 weeks □ 9-12 weeks □ 13+ weeks

(d). Have you taken any medication for this problem □ Yes □ No

(i). Name of medication __________

(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes Yes /No No]

(iii). Was this prescribed by: □ Doctor □ Clinic nurse
| Question                                                                 | Option 1 | Option 2 | Option 3 | Option 4 |
|------------------------------------------------------------------------|----------|----------|----------|----------|
| (iv). Was this over the counter medication                             |          |          |          |          |
|                                                                         | Yes      | No       | None of the above | Don't know |
| (v). No. of days taken                                                 |          |          |          |          |
|                                                                         |          |          |          |          |
| 118. Have you ever been told by a doctor that you have Sciatica        |          |          |          |          |
| (a). Were you told this more than six months before this pregnancy?    |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (b). Were you told this in the last six months before this pregnancy?  |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (c). Were you told this during this pregnancy?                         |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (i). If yes, in what week of the pregnancy?                            |          |          |          |          |
|                                                                         | 0-4 weeks | 5-8 weeks | 9-12 weeks | 13+ weeks |
| (d). Have you taken any medication for this problem                    |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (i). Name of medication                                               |          |          |          |          |
| (ii). Do you have the bottle or package that you could show?           |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| [Interview to indicate whether bottle or package seen:                |          |          |          |          |
| Seen: Yes _____/No _____]                                              |          |          |          |          |
| (iii). Was this prescribed by:                                         |          |          |          |          |
|                                                                         | Doctor   | Clinic nurse | None of the above | Don't know |
| (iv). Was this over the counter medication                             |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (v). No. of days taken                                                 |          |          |          |          |
|                                                                         |          |          |          |          |
| 119. Have you ever been told by a doctor that you have myalgia         |          |          |          |          |
| (a). Were you told this more than six months before this pregnancy?    |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (b). Were you told this in the last six months before this pregnancy?  |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (c). Were you told this during this pregnancy?                         |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (i). If yes, in what week of the pregnancy?                            |          |          |          |          |
|                                                                         | 0-4 weeks | 5-8 weeks | 9-12 weeks | 13+ weeks |
| (d). Have you taken any medication for this problem                    |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| (i). Name of medication                                               |          |          |          |          |
| (ii). Do you have the bottle or package that you could show?           |          |          |          |          |
|                                                                         | Yes      | No       |          |          |
| [Interview to indicate whether bottle or package seen:                |          |          |          |          |
| Seen: Yes _____/No _____]                                              |          |          |          |          |
| (iii). Was this prescribed by:                                         |          |          |          |          |
|                                                                         | Doctor   | Clinic nurse | None of the above | Don't know |
Genital and urinary tract

120. Have you ever been told by a doctor that you have Ovary/fallopian tube infection

(a). Were you told this more than six months before this pregnancy?

(b). Were you told this in the last six months before this pregnancy?

(c). Were you told this during this pregnancy?

(i). If yes, in what week of the pregnancy?

(d). Have you taken any medication for this problem

(i). Name of medication

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen:
Seen: Yes ____/No ____]

(iii). Was this prescribed by:

(iv). Was this over the counter medication

(v). No. of days taken

121. Have you ever been told by a doctor that you have Endometriosis

(a). Were you told this more than six months before this pregnancy?

(b). Were you told this in the last six months before this pregnancy?

(c). Were you told this during this pregnancy?

(i). If yes, in what week of the pregnancy?

(d). Have you taken any medication for this problem

(i). Name of medication

(ii). Do you have the bottle or package that you could show?

[Interview to indicate whether bottle or package seen:
Seen: Yes ____/No ____]

(iii). Was this prescribed by:
| Question                                                                 | Options                                                                 |
|------------------------------------------------------------------------|------------------------------------------------------------------------|
| (iv). Was this over the counter medication                              | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No [If no, skip Q123]                                             |
| (v). No. of days taken                                                  | ___________ days                                                      |
| 122. Have you ever been told by a doctor that you have ovarian cyst?   | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No [If no, skip to Q123]                                          |
| (a). Were you told this more than six months before this pregnancy?    | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| (b). Were you told this in the last six months before this pregnancy?  | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| (c). Were you told this during this pregnancy?                         | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| (i). If yes, in what week of the pregnancy?                            | ☐ 1. 0-4 weeks                                                        |
|                                                                         | ☐ 2. 5-8 weeks                                                        |
|                                                                         | ☐ 3. 9-12 weeks                                                       |
|                                                                         | ☐ 4. 13+ weeks                                                        |
| (d). Have you taken any medication for this problem                    | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No [If no, skip to Q123]                                          |
| (i). Name of medication                                                | ___________                                                            |
| (ii). Do you have the bottle or package that you could show?           | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| [Interview to indicate whether bottle or package seen:                 |                                                                         |
|                         Seen: Yes _____ /No _____]                           |                                                                         |
| (iii). Was this prescribed by:                                         | ☐ 1. Doctor                                                           |
|                                                                         | ☐ 2. Clinic nurse                                                      |
|                                                                         | ☐ 3. None of the above                                                |
|                                                                         | ☐ 4. Don't know                                                       |
| (iv). Was this over the counter medication                              | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| (v). No. of days taken                                                  | ___________ days                                                      |
| 123. Have you ever been told by a doctor that you have any cervical disease | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No [If no, skip to Q124]                                          |
| (a). Were you told this more than six months before this pregnancy?    | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| (b). Were you told this in the last six months before this pregnancy?  | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| (c). Were you told this during this pregnancy?                         | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| (i). If yes, in what week of the pregnancy?                            | ☐ 1. 0-4 weeks                                                        |
|                                                                         | ☐ 2. 5-8 weeks                                                        |
|                                                                         | ☐ 3. 9-12 weeks                                                       |
|                                                                         | ☐ 4. 13+ weeks                                                        |
| (d). Have you taken any medication for this problem                    | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No [If no, skip to Q124]                                          |
| (i). Name of medication                                                | ___________                                                            |
| (ii). Do you have the bottle or package that you could show?           | ☐ 1. Yes                                                               |
|                                                                         | ☐ 2. No                                                               |
| [Interview to indicate whether bottle or package seen:                 |                                                                         |
|                         Seen: Yes _____ /No _____]                           |                                                                         |
| (iii). Was this prescribed by:                                         | ☐ 1. Doctor                                                           |
|                                                                         | ☐ 2. Clinic nurse                                                      |
| (iv). Was this over the counter medication | □ 1 Yes  □ 2 No  [If no, skip to Q125] |
| (v). No. of days taken | □ 1 0-4 weeks  □ 2 5-8 weeks  □ 3 9-12 weeks  □ 4 13+ weeks |
| (d). Have you taken any medication for this problem | □ 1 Yes  □ 2 No  [If no, skip to Q125] |
| (i). Name of medication |  |
| (ii). Do you have the bottle or package that you could show? | □ 1 Yes  □ 2 No  [Interview to indicate whether bottle or package seen: Seen: Yes ____ /No ____] |
| (iii). Was this prescribed by: | □ 1 Doctor  □ 2 Clinic nurse  □ 3 None of the above  □ 4 Don’t know |
| (iv). Was this over the counter medication | □ 1 Yes  □ 2 No |
| (v). No. of days taken | □ 1 0-4 weeks  □ 2 5-8 weeks  □ 3 9-12 weeks  □ 4 13+ weeks |
| (e). What was this disease? | □ 1 herpes  □ 2 chlamydia  □ 3 gonorrhoea  □ 4 syphillis  □ 5 venereal warts  □ 68 other, please describe: __________ |
| Question                                                                 | Options                                                                                     |
|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| (ii). Do you have the bottle or package that you could show?            | ☐ Yes / ☐ No                                                                                  |
| [Interview to indicate whether bottle or package seen:                  |                                                                                             |
|   Seen: Yes _____ / No _____]                                          |                                                                                             |
| (iii). Was this prescribed by:                                         | ☐ Doctor / ☐ Clinic nurse / ☐ None of the above / ☐ Don’t know                              |
| (iv). Was this over the counter medication                              | ☐ Yes / ☐ No                                                                                  |
| (v). No. of days taken                                                  | ☐ 0-4 weeks / ☐ 5-8 weeks / ☐ 9-12 weeks / ☐ 13+ weeks                                   |
| 126. Have you ever been told by a doctor that you have kidney infection | ☐ Yes / ☐ No [If no, skip to Q127]                                                          |
| (a). Were you told this more than six months before this pregnancy?    | ☐ Yes / ☐ No                                                                                  |
| (b). Were you told this in the last six months before this pregnancy?  | ☐ Yes / ☐ No                                                                                  |
| (c). Were you told this during this pregnancy?                         | ☐ Yes / ☐ No                                                                                  |
|   (i). If yes, in what week of the pregnancy?                          | ☐ 0-4 weeks / ☐ 5-8 weeks / ☐ 9-12 weeks / ☐ 13+ weeks                                   |
|   (d). Have you taken any medication for this problem                  | ☐ Yes / ☐ No [If no, skip to Q127]                                                          |
|   (i). Name of medication                                              | ☐                                                                                           |
| (ii). Do you have the bottle or package that you could show?           | ☐ Yes / ☐ No                                                                                  |
|   [Interview to indicate whether bottle or package seen:               |                                                                                             |
|     Seen: Yes _____ / No _____]                                        |                                                                                             |
| (iii). Was this prescribed by:                                         | ☐ Doctor / ☐ Clinic nurse / ☐ None of the above / ☐ Don’t know                              |
| (iv). Was this over the counter medication                              | ☐ Yes / ☐ No                                                                                  |
| (v). No. of days taken                                                  | ☐ 0-4 weeks / ☐ 5-8 weeks / ☐ 9-12 weeks / ☐ 13+ weeks                                   |
| 127. Have you ever been told by a doctor that you have urinary tract   | ☐ Yes / ☐ No [If no, skip to Q128]                                                          |
|   infection?                                                            |                                                                                             |
| (a). Were you told this more than six months before this pregnancy?    | ☐ Yes / ☐ No                                                                                  |
| (b). Were you told this in the last six months before this pregnancy?  | ☐ Yes / ☐ No                                                                                  |
| (c). Were you told this during this pregnancy?                         | ☐ Yes / ☐ No                                                                                  |
|   (i). If yes, in what week of the pregnancy?                          | ☐ 0-4 weeks / ☐ 5-8 weeks / ☐ 9-12 weeks / ☐ 13+ weeks                                   |
|   (d). Have you taken any medication for this problem                  | ☐ Yes / ☐ No [If no, skip to Q128]                                                          |
|   (i). Name of medication                                              | ☐                                                                                           |
| Question                                                                 | Yes | No |
|-------------------------------------------------------------------------|-----|----|
| (ii). Do you have the bottle or package that you could show?            |     |    |
| [Interview to indicate whether bottle or package seen:                  |     |    |
| Seen: Yes ____ /No ____]                                                 |     |    |
| (iii). Was this prescribed by:                                         |     |    |
| □ 1 Doctor                                                             |     |    |
| □ 2 Clinic nurse                                                       |     |    |
| □ 3 None of the above                                                  |     |    |
| □ 4 Don’t know                                                         |     |    |
| (iv). Was this over the counter medication                              |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No                                                                 |     |    |
| (v). No. of days taken                                                 |     |    |
| _____ days                                                              |     |    |

128. Have you ever been told by a doctor that you have incontinence?    |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No [If no, skip to Q129]                                           |     |    |
| (a). Were you told this more than six months before this pregnancy?    |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No                                                                 |     |    |
| (b). Were you told this in the last six months before this pregnancy?  |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No                                                                 |     |    |
| (c). Were you told this during this pregnancy?                         |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No                                                                 |     |    |
| (i). If yes, in what week of the pregnancy?                            |     |    |
| □ 1 0-4 weeks                                                           |     |    |
| □ 2 5-8 weeks                                                           |     |    |
| □ 3 9-12 weeks                                                          |     |    |
| □ 4 13+ weeks                                                          |     |    |
| (d). Have you taken any medication for this problem                    |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No [If no, skip to Q129]                                           |     |    |
| (i). Name of medication                                                |     |    |
| _____                                                                   |     |    |

Other illnesses/health problems

129. Have you ever been told by a doctor that you have anorexia, bulimia or other eating disorders |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No [If no, skip to Q130]                                           |     |    |
| (a). Were you told this more than six months before this pregnancy?    |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No                                                                 |     |    |
| (b). Were you told this in the last six months before this pregnancy?  |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No                                                                 |     |    |
| (c). Were you told this during this pregnancy?                         |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No                                                                 |     |    |
| (i). If yes, in what week of the pregnancy?                            |     |    |
| □ 1 0-4 weeks                                                           |     |    |
| □ 2 5-8 weeks                                                           |     |    |
| □ 3 9-12 weeks                                                          |     |    |
| □ 4 13+ weeks                                                          |     |    |
| (d). Have you taken any medication for this problem                    |     |    |
| □ 1 Yes                                                                |     |    |
| □ 2 No [If no, skip to Q130]                                           |     |    |
| (i). Name of medication                                                |     |    |
| _____                                                                   |     |    |
(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen:
×Yes__/No__]

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(iii). Was this prescribed by:

|   | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
|   | Doctor | Clinic nurse | None of the above | Don't know |

(iv). Was this over the counter medication

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(v). No. of days taken

|   |   |
|---|---|
|   |   |

130. Have you ever been told by a doctor that you have Migraine

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(a). Were you told this more than six months before this pregnancy?

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(b). Were you told this in the last six months before this pregnancy?

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(c). Were you told this during this pregnancy?

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(i). If yes, in what week of the pregnancy?

|   | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
|   | 0-4 weeks | 5-8 weeks | 9-12 weeks | 13+ weeks |

(d). Have you taken any medication for this problem

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(i). Name of medication

|   |   |
|---|---|
|   |   |

131. Have you ever been told by a doctor that you have Epilepsy

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(a). Were you told this more than six months before this pregnancy?

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(b). Were you told this in the last six months before this pregnancy?

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(c). Were you told this during this pregnancy?

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(i). If yes, in what week of the pregnancy?

|   | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
|   | 0-4 weeks | 5-8 weeks | 9-12 weeks | 13+ weeks |

(d). Have you taken any medication for this problem

|   | 1 | 2 |
|---|---|---|
|   | Yes | No |

(i). Name of medication

|   |   |
|---|---|
|   |   |
(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: See: Yes ___ /No ___]

|   | 1 | 2 |
|---|---|---|
| Yes | No |

(iii). Was this prescribed by:

- 1. Doctor
- 2. Clinic nurse
- 3. None of the above
- 4. Don't know

(iv). Was this over the counter medication

- 1. Yes
- 2. No

(v). No. of days taken

__________ days

132. Have you ever been told by a doctor that you have Cancer

- 1. Yes [If no, skip to Q133]
- 2. No

(a). Were you told this more than six months before this pregnancy?
- 1. Yes
- 2. No

(b). Were you told this in the last six months before this pregnancy?
- 1. Yes
- 2. No

(c). Were you told this during this pregnancy?
- 1. Yes
- 2. No

(i). If yes, in what week of the pregnancy?

- 1. 0-4 weeks
- 2. 5-8 weeks
- 3. 9-12 weeks
- 4. 13+ weeks

(d). Have you taken any medication for this problem

- 1. Yes [If no, skip to Q133]
- 2. No

(i). Name of medication

__________

(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: See: Yes ___ /No ___]

(iii). Was this prescribed by:

- 1. Doctor
- 2. Clinic nurse
- 3. None of the above
- 4. Don't know

(iv). Was this over the counter medication

- 1. Yes
- 2. No

(v). No. of days taken

__________ days

133. Have you ever been told by a doctor that you have Depression or Anxiety

- 1. Yes [If no, skip to Q134]
- 2. No

(a). Were you told this more than six months before this pregnancy?
- 1. Yes
- 2. No

(b). Were you told this in the last six months before this pregnancy?
- 1. Yes
- 2. No

(c). Were you told this during this pregnancy?
- 1. Yes
- 2. No

(i). If yes, in what week of the pregnancy?

- 1. 0-4 weeks
- 2. 5-8 weeks
- 3. 9-12 weeks
- 4. 13+ weeks

(d). Have you taken any medication for this problem

- 1. Yes [If no, skip to Q134]
- 2. No

(i). Name of medication

__________
(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes /No ]

☐ 1 Yes
☐ 2 No

(iii). Was this prescribed by:

☐ 1 Doctor
☐ 2 Clinic nurse
☐ 3 None of the above
☐ 4 Don’t know

(iv). Was this over the counter medication

☐ 1 Yes
☐ 2 No

(v). No. of days taken

_________ days

134. Have you ever been told by a doctor that you have any other long illnesses or health problems [If no, skip to Q135]

☐ 1 Yes
☐ 2 No

If so, please describe ____________________

(a). Were you told this more than six months before this pregnancy?

☐ 1 Yes
☐ 2 No

(b). Were you told this in the last six months before this pregnancy?

☐ 1 Yes
☐ 2 No

(c). Were you told this during this pregnancy?

☐ 1 Yes
☐ 2 No

(i). If yes, in what week of the pregnancy?

☐ 1 0-4 weeks
☐ 2 5-8 weeks
☐ 3 9-12 weeks
☐ 4 13+ weeks

(d). Have you taken any medication for this problem [If no, skip to Q135]

☐ 1 Yes
☐ 2 No

(i). Name of medication

_____________________

(ii). Do you have the bottle or package that you could show? [Interview to indicate whether bottle or package seen: Seen: Yes /No ]

☐ 1 Yes
☐ 2 No

(iii). Was this prescribed by:

☐ 1 Doctor
☐ 2 Clinic nurse
☐ 3 None of the above
☐ 4 Don’t know

(iv). Was this over the counter medication

☐ 1 Yes
☐ 2 No

(v). No. of days taken

_________ days

Other diseases

135. Do you have a congenital deformity or birth defect? [If no, skip to Q135]

☐ 1 Yes
☐ 2 No

136. If yes, please describe?

________________________

137. Do your gums bleed when you brush your teeth at present?

☐ 1 No, rarely or never
☐ 2 Yes, sometimes
☐ 3 Yes, often
☐ 4 Yes, almost always

H. OTHER MEDICATION

138. Have you used other medication not previously mentioned? [If no, skip to Q145]

☐ 1 Yes
☐ 2 No

139. If yes, please state these medication

Medication 1:
| Question                                                                 | Medication 2:                                                                 | Medication 3:                                                                 | Medication 4:                                                                 | Medication 5:                                                                 |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 140. Do you have the bottle or package that you could show              | ☐ Yes                                                                            | ☐ Yes                                                                            | ☐ Yes                                                                            | ☐ Yes                                                                            |
| for medication 1?                                                     | ☐ 1 Yes                                                                          | ☐ 1 Doctor                                                                       | ☐ 1 Doctor                                                                       | ☐ 1 Doctor                                                                       |
| [Interview to indicate whether bottle or package seen:                 | ☐ 2 No                                                                           | ☐ 2 Clinic nurse                                                                  | ☐ 2 Clinic nurse                                                                  | ☐ 2 Clinic nurse                                                                  |
| Seen: Yes ____/No ____]                                                | ☐ 3 None of the above                                                              | ☐ 3 None of the above                                                              | ☐ 3 None of the above                                                              | ☐ 3 None of the above                                                              |
| (a). Was this prescribed by:                                          | ☐ 4 Don't know                                                                    | ☐ 4 Don't know                                                                    | ☐ 4 Don't know                                                                    | ☐ 4 Don't know                                                                    |
| ☐ 1 Yes                                                               | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don't know                                                                    | ☐ 4 Don't know                                                                    |
| (b). Was this over the counter medication                              | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don't know                                                                    |
| ☐ 2 No                                                               | ☐ 3 None of the above                                                              | ☐ 4 Don't know                                                                    | ☐ 4 Don't know                                                                    | ☐ 4 Don’t know                                                                    |
| (c). No. of days taken                                                | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| ☐ 1 Yes                                                               | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don't know                                                                    | ☐ 4 Don’t know                                                                    |
| (d). Did you take this more than six months                           | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| before this pregnancy?                                                | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| (e). Did you take this during this                                   | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| pregnancy?                                                            | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| (f). If yes, in what week of the pregnancy?                           | ☐ 1 0-4 weeks                                                                     | ☐ 2 5-8 weeks                                                                     | ☐ 3 9-12 weeks                                                                   | ☐ 4 13+ weeks                                                                     |
| ☐ 1 Yes                                                               | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| ☐ 2 No                                                               | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| 141. Do you have the bottle or package that you could show             | ☐ Yes                                                                            | ☐ Yes                                                                            | ☐ Yes                                                                            | ☐ Yes                                                                            |
| for medication 2?                                                     | ☐ 1 Yes                                                                          | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| [Interview to indicate whether bottle or package seen:                 | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| Seen: Yes ____/No ____]                                                | ☐ 1 Doctor                                                                       | ☐ 2 Clinic nurse                                                                  | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| (a). Was this prescribed by:                                          | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| ☐ 1 Yes                                                               | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| (b). Was this over the counter medication                              | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| ☐ 2 No                                                               | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| (c). No. of days taken                                                | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| ☐ 1 Yes                                                               | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| (d). Did you take this more than six months                           | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| before this pregnancy?                                                | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| (e). Did you take this during this                                   | ☐ 1 Yes                                                                           | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| pregnancy?                                                            | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| (f). If yes, in what week of the pregnancy?                           | ☐ 1 0-4 weeks                                                                     | ☐ 2 5-8 weeks                                                                     | ☐ 3 9-12 weeks                                                                   | ☐ 4 13+ weeks                                                                     |
| ☐ 1 Yes                                                               | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| ☐ 2 No                                                               | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| 142. Do you have the bottle or package that you could show             | ☐ Yes                                                                            | ☐ Yes                                                                            | ☐ Yes                                                                            | ☐ Yes                                                                            |
| for medication 3?                                                     | ☐ 1 Yes                                                                          | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| [Interview to indicate whether bottle or package seen:                 | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| Seen: Yes ____/No ____]                                                | ☐ 1 Doctor                                                                       | ☐ 2 Clinic nurse                                                                  | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    |
| (a). Was this prescribed by:                                          | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| ☐ 1 Yes                                                               | ☐ 2 No                                                                           | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
| ☐ 2 No                                                               | ☐ 3 None of the above                                                              | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    | ☐ 4 Don’t know                                                                    |
### Medication History

| Question                                                                 | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  |
|--------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| (b). Was this over the counter medication                                | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (c). No. of days taken                                                   |     |     |     |     |     |     |     |     |     |     |
| (d). Did you take this more than six months before this pregnancy?      | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (e). Did you take this during this pregnancy?                           | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (f). If yes, in what week of the pregnancy?                             | ☐  | 0-4 weeks | 5-8 weeks | 9-12 weeks | 13+ weeks |

143. Do you have the bottle or package that you could show for medication 4?  
[Interview to indicate whether bottle or package seen: Seen: Yes ☐/No ☐]

| Question                                                                 | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  |
|--------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| (a). Was this prescribed by:                                             | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (b). Was this over the counter medication                                | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (c). No. of days taken                                                   |     |     |     |     |     |     |     |     |     |     |
| (d). Did you take this more than six months before this pregnancy?      | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (e). Did you take this during this pregnancy?                           | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (f). If yes, in what week of the pregnancy?                             | ☐  | 0-4 weeks | 5-8 weeks | 9-12 weeks | 13+ weeks |

144. Do you have the bottle or package that you could show for medication 5?  
[Interview to indicate whether bottle or package seen: Seen: Yes ☐/No ☐]

| Question                                                                 | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  |
|--------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| (a). Was this prescribed by:                                             | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (b). Was this over the counter medication                                | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (c). No. of days taken                                                   |     |     |     |     |     |     |     |     |     |     |
| (d). Did you take this more than six months before this pregnancy?      | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (e). Did you take this during this pregnancy?                           | ☐  | ☐   |     |     |     |     |     |     |     |     |
| (f). If yes, in what week of the pregnancy?                             | ☐  | 0-4 weeks | 5-8 weeks | 9-12 weeks | 13+ weeks |

### Work and Leisure

145. What was your work situation when you became pregnant? *(Fill on one or several boxes for each.)*

| Question                                                                 | 1   | 2   | 3   | 4   |
|--------------------------------------------------------------------------|-----|-----|-----|-----|
| ☐  | Student [skip to Q162] | ☐  | At home [skip to Q162] | ☐  | Intern/apprentice |
| ☐  | Military service |
| Question                                                                 | Options                                                                 |
|-------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 146. What kind of work do/did you do?                                   | ☐ 1. general assistant  
☐ 2. clerical/administrative  
☐ 3. machine operator  
☐ 4. farm assistant  
☐ 5. supervisor/manager  
☐ 6. engineering, designer or planning  
☐ 88. Other, please specify: ______________________________________ |
| 147. Did you have an extra job (with or without salary) when you became pregnant? | ☐ 1. Yes  
☐ 2. No  
Describe: __________________________________________________________ |
| 148. Have you been absent from work more than two weeks during this pregnancy? | ☐ 1. Yes  
☐ 2. No |
| 149. Are you absent from your work at the present time?                 | ☐ 1. Yes  
☐ 2. No |
| 150. If yes, what is the reason for your absence? (Fill in one or several boxes.) | ☐ 1. Medical leave  
☐ 2. Leave of absence  
☐ 3. Sick child  
☐ 88. Other: __________________________________________________________ |
| 151 The usual number of paid working hours a week before you became pregnant and at present. | Before the pregnancy hours ______________________  
During the pregnancy hours ______________________ |
| 152. Describe the type of work carried out at your place of work as accurately as possible. (Write for example, hospital department for children with cancer, body shop at a garage for diesel vehicles, farming with grain and swine, work in the home.) | ______________________________________________________________________ |

Indicate the appropriate answer for each of the following questions concerning your present work situation, using the following score:  
1 = yes, everyday, more than half of the working day  
2 = yes, everyday, less than half of the working day  
3 = yes, periodically, but not daily  
4 = seldom or never  
(Fill in only one box in each line.)
If the respondent is not involved in any occupational activity, then **skip to Q162.** For the purposes of these questions, housework is included as occupational activity.

| Question                                                                 | Options                                                                                   |
|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| 153. Too much to do, that the work situation is taxing                  | 1️⃣ Permanent day work 2️⃣ Permanent afternoon or evening work 3️⃣ Permanent night work 4️⃣ Shift work (day and night) or shift rotations 5️⃣ No set times (extra work, extra shifts, temporary employment, etc.)/ Other |
| 154. Bending and turning many times in an hour                           |                                                                                                                                                  |
| 155. Working with hands above shoulder level                           |                                                                                                                                                  |
| 156. Working in a standing or walking position                          |                                                                                                                                                  |
| 157. Can choose to work faster on some days, and slower on some days     |                                                                                                                                                  |
| 158. Have a lot of uncomfortable background noise                       |                                                                                                                                                  |
| 159. Have a lot of background noise that causes you to raise your voice when talking to others even within a distance of one metre |                                                                                                                                                  |
| 160. When are your working hours? *(Fill in one or several boxes.)*      | 1️⃣ Infrequently or never 2️⃣ Yes, less than 20 times a week 3️⃣ Yes, more than 20 times a week 4️⃣ Yes, 10-20 times a day 5️⃣ Yes, more than 20 times a day |
| 161. During your pregnancy do you lift anything that weighs more than 10 kg at work? *(10 kilos is the equivalent of a full bucket of water.)* |                                                                                                                                                  |
| 162. During your pregnancy do you lift anything that weighs more than 10 kg at home? *(10 kilos is the equivalent of a full bucket of water.)* |                                                                                                                                                  |
| 163. What was the baby’s father work situation when you became pregnant? *(Fill on one or several boxes for each.)* | 1️⃣ Student [skip to Q166] 2️⃣ At home [skip to Q166] 3️⃣ Intern/apprentice 4️⃣ Military service 5️⃣ Unemployed/laid off 6️⃣ Rehabilitation/disabled [skip to Q166] 7️⃣ Employed in public sector 8️⃣ Self-employed 9️⃣ Family member without steady income in family company 10️⃣ manufacturing 11️⃣ chemical 12️⃣ mining 13️⃣ commercial and retail 14️⃣ agricultural and farming 8️⃣ Other |
| 164. Describe the type of work carried out at the baby’s father’s place of work as accurately as possible. *(Write for example, hospital department for children)* |                                                                                                                                                  |
with cancer, body shop at a garage for diesel vehicles, farming with grain and swine, work in the home.

165. How often do you use a cell phone?

- □ 1. Infrequently
- □ 2. Never
- □ 3. A few times a week
- □ 4. Daily
- □ 5. On average more than an hour daily

166. How often do you work with a computer, laser printer or copying machine (at a distance of less than two metres) after you became pregnant?

- □ 1. Never
- □ 2. A few times a week
- □ 3. Daily
- □ 4. On average more than an hour daily

167. How often have you worked with x-ray equipment (at a distance of less than two metres) after you became pregnant? (*This does not include treatment as a patient*)

- □ 1. Never
- □ 2. A few times a week
- □ 3. Daily
- □ 4. On average more than an hour daily

**Have you been in contact with any of the following substances either at work or in your leisure time during the last six months, and if yes, for how many days?**

| 168. Lead vapors, lead dust, lead particles or lead alloys | □ 1. Yes |
| --------------------------------------------------------- | _______ |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 169. Chrome, arsenic, cadmium or combinations of these   | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 170. petrol or exhaust vapour (does not apply to filling gasoline in your own car) | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 171. Mercury vapors, mercury or work with amalgam fillings (does not apply to your own dental treatment) | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 172. Disinfectants, vermin poisons                      | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 173. Weed killers, insecticides, fungicides             | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 174. Oil-based paint                                    | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 175. Substances used in welding                          | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 176. Substances used in soldering                        | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 177. Formalin/ formaldehyde                             | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 178. Photographic chemicals (fixatives or developers)   | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
| 179. Motor oil, lubrication oil or other types of oil    | □ 1. Yes |
| (a). If yes, for how many days (daily = 180 days)        | _______ |
(a). If yes, for how many days (daily = 180 days)

| Question                                                                 | Yes | No |
|--------------------------------------------------------------------------|-----|----|
| 180. Industrial dyes or ink                                              |     |    |
| 181. Chemotherapeutic substances/chemotherapy treatment (does not apply |     |    |
| 182. Laughing gas or other anesthetic gases (does not apply to your own |     |    |
| 183. Water-based or latex paint                                          |     |    |
| 184. Paint thinner, paint-lacquer-glue remover or other solvents (ex.   |     |    |
| 185. Other substances and conditions, describe:                          |     |    |
| 186. How often have you been to a night club since you became pregnant? |     |    |
| 187. Are you in contact with animals either at work or in your leisure?  |     |    |

If yes, what sort of animals?
Please indicate how often are you in contact with them on a weekly basis, using the following code:

- 0 = never
- 1 = daily
- 2 = 3-6 times a week
- 3 = 1-2 times a week
- 4 = less than once a week

|    | 0 | 1 | 2 | 3 | 4 |
|----|---|---|---|---|---|
| Dog|   |   |   |   |   |
| Cat|   |   |   |   |   |
| Guinea Pig|   |   |   |   |   |
| Hamster|   |   |   |   |   |
| Rabbit|   |   |   |   |   |
| Bird|   |   |   |   |   |
| Aquarium Fish|   |   |   |   |   |
| Cow|   |   |   |   |   |
| Pig|   |   |   |   |   |
| Sheep, goat|   |   |   |   |   |
| Horse|   |   |   |   |   |
| Poultry|   |   |   |   |   |
| Other: |   |   |   |   |   |

J. HABITS

202. Did your mother smoke when she was pregnant with you?  
- 1 = Yes
- 2 = No
- Don’t know

203. Are you exposed to passive smoking at home?  
- 1 = Yes
204. If yes, how many hours a day are you exposed to passive smoking?   □ 2 No

205. Are you exposed to passive smoking at work?  □ 1 Yes  □ 2 No

206. If yes, how many hours a day are you exposed to passive smoking?   ________________ hours a day

207. Did the baby’s father smoke before you became pregnant?  □ 1 Yes  □ 2 No

208. Does he smoke now?  □ 1 Yes  □ 2 No

209. Have you ever smoked?  □ 1 Yes  □ 2 No (proceed question 104)

210. Do you smoke now (after you became pregnant)?  □ 1 No  □ 2 Sometimes  □ 3 Daily

(a). If yes, how many  ___________ cigarettes per week  ___________ cigarettes per day

211. Did you smoke during the last 3 months before you became pregnant this time?  □ 1 No  □ 2 Sometimes  □ 3 Daily

(a). If yes, how many  ___________ cigarettes per week  ___________ cigarettes per day

212. How old were you when you started to smoke on a daily basis?   ____________ years

213. Have you stopped smoking completely?  □ 1 Yes  □ 2 No

214. If yes, how old were you when you stopped smoking?   ____________ years

215. If you stopped smoking after you became pregnant, in which week of pregnancy did you stop?   ____________ week of pregnancy

Have you used any of the following substances?  
If yes, please indicate when you used them, using the following code:  
1 = never  
2 = previously  
3 = last month before this pregnancy  
4 = during this pregnancy

216. Hash  1  2  3  4
217. Ecstasy
218. Heroin
219. Cocaine
220. Amphetamine
221. Other:           

222. Have you ever consumed alcohol?   □ 1 Yes  □ 2 No  [If no, skip to Q230]

Alcohol units are used to compare the different types of alcoholic beverages. 1 alcohol unit (= 1.5 cl. pure alcohol) is equivalent to:  
1 bottle/can energy drink or cider  
1 glass (1/3 liter) of beer  
1 wine glass red or white wine  
1 wine glass sherry or other fortified wine
1 snaps glass spirits or liqueur

223. How often did you consume alcohol in the 3 months before you became pregnant?
- □ 1. Approximately 6-7 time a week
- □ 2. Approximately 4-5 times a week
- □ 3. approximately 2-3 times a week
- □ 4. approximately once a week
- □ 5. approximately 1-3 times a month
- □ 6. less than once a month
- □ 7. Never

224. How often do you consume alcohol during this pregnancy?
- □ 1. Approximately 6-7 time a week
- □ 2. Approximately 4-5 times a week
- □ 3. approximately 2-3 times a week
- □ 4. approximately once a week
- □ 5. approximately 1-3 times a month
- □ 6. less than once a month
- □ 7. Never

225. What type of alcohol do you usually drink? *(Fill in one or several boxes.)*
- □ 1. Light beer
- □ 2. Beer
- □ 3. Red wine
- □ 4. White wine
- □ 5. Low alcohol sodas
- □ 6. Fortified wines *(sherry, port wine, Madeira)*
- □ 7. Spirits *(vodka, gin, snaps, cognac, whisky, liqueur)*

226. Did you drink 5 units or more at least once during the last 3 months before this pregnancy?
- □ 1. Several times per week
- □ 2. Once a week
- □ 3. 1-3 times a month
- □ 4. Less than once a month
- □ 5. Never

227. Did you drink 5 units or more at least once during this pregnancy?
- □ 1. Several times per week
- □ 2. Once a week
- □ 3. 1-3 times a month
- □ 4. Less than once a month
- □ 5. Never

228. How many units of alcohol did you usually drink when you consume alcohol in the last 3 months before pregnancy?
- □ 1. 10 or more
- □ 2. 7-9
- □ 3. 5-6
- □ 4. 3-4
- □ 5. 1-2
- □ 6. Less that 1

229. How many units of alcohol do you usually drink when you consume alcohol during this pregnancy?
- □ 1. 10 or more
- □ 2. 7-9
- □ 3. 5-6
- □ 4. 3-4
- □ 5. 1-2
- □ 6. Less that 1

K. WEIGHT AND WEIGHT CONTROL

230. Do you think you were overweight before this pregnancy?
- □ 1. Yes, a lot
- □ 2. Yes, a little
- □ 3. No

231. Are you worried about putting on more weight than necessary during this pregnancy?
- □ 1. Yes, very worried
- □ 2. Somewhat worried
- □ 3. No, not especially worried

232. Has anyone said that you were too thin while you felt that you were too fat during the last 2 years?
- □ 1. Yes, often/
- □ 2. Yes, occasionally
- □ 3. No
Have you ever used any of the following to control your weight in the last 6 months **before this pregnancy**? If yes, please state how often, using the following codes:

1 = at least once a week  
2 = seldom  
3 = never

| Activity            | 1 | 2 | 3 | 4 | 5 |
|---------------------|---|---|---|---|---|
| 233. Vomiting       |   |   |   |   |   |
| 234. Laxatives      |   |   |   |   |   |
| 235. Fasting        |   |   |   |   |   |
| 236. Hard physical exercise |   |   |   |   |   |

Have you ever used any of the following to control your weight **during this pregnancy**? If yes, please state how often, using the following codes:

1 = at least once a week  
2 = seldom  
3 = never

| Activity            | 1 | 2 | 3 | 4 | 5 |
|---------------------|---|---|---|---|---|
| 237. Vomiting       |   |   |   |   |   |
| 238. Laxatives      |   |   |   |   |   |
| 239. Fasting        |   |   |   |   |   |
| 240. Hard physical exercise |   |   |   |   |   |

**L. PHYSICAL ACTIVITY**

How often did you usually exercise in the last 3 months **before this pregnancy**? For each exercise, please indicate if you do this, and if yes, please indicate how often, using the following code:

1 = never  
2 = 1-3 times per month  
3 = once a week  
4 = twice a week  
5 = 3 times or more week

*(Fill in each line, both before and during this pregnancy.)*

| Activity                         | 1 | 2 | 3 | 4 | 5 |
|----------------------------------|---|---|---|---|---|
| 241. Walking                     |   |   |   |   |   |
| 242. Brisk walking               |   |   |   |   |   |
| 243. Running/jogging/cross-country running |   |   |   |   |   |
| 244. Bicycling                   |   |   |   |   |   |
| 245. weight training             |   |   |   |   |   |
| 246. Special gymnastics/aerobics for pregnant women |   |   |   |   |   |
| 247. Aerobics/gymnastics/dance without running and jumping |   |   |   |   |   |
| 248. Aerobics/gymnastics with running and jumping |   |   |   |   |   |
| 249. Dancing                     |   |   |   |   |   |
| 2450. Team sports                |   |   |   |   |   |
| 251. Swimming                    |   |   |   |   |   |
| 252. Water aerobics              |   |   |   |   |   |
| 253. Riding                      |   |   |   |   |   |
| 254. Other                       |   |   |   |   |   |

How often do you usually exercise **during this pregnancy**?  
For each exercise, please indicate if you do this, and if yes, please indicate how often, using the following code:

1 = never  
2 = 1-3 times per month  
3 = once a week  
4 = twice a week  
5 = 3 times or more week

*(Fill in each line, both before and during this pregnancy.)*

| Activity                        | 1 | 2 | 3 | 4 | 5 |
|---------------------------------|---|---|---|---|---|
| 255. Walking                    |   |   |   |   |   |
| 256. Brisk walking              |   |   |   |   |   |
| Question | Options |
|----------|---------|
| 257. Running/jogging/cross-country running |  |
| 258. Bicycling |  |
| 259. weight training |  |
| 260. Special gymnastics/aerobics for pregnant women |  |
| 261. Aerobics/gymnastics/dance without running and jumping |  |
| 262. Aerobics/gymnastics with running and jumping |  |
| 263. Dancing |  |
| 264. Team sports |  |
| 265. Swimming |  |
| 266. Water aerobics |  |
| 267. Riding |  |
| 268. Other |  |
| 269. How often were you so physically active in your leisure time that you get out of breath or sweat in the last 3 months before this pregnancy? | □ 1. Never □ 2. Less than once a week □ 3. Once a week □ 4. 2 times a week □ 5. 3-4 times a week □ 6. 5 times a week or more |
| 270. How often are you currently so physically active in your leisure time that you get out of breath or sweat during this pregnancy? | □ 1. Never □ 2. Less than once a week □ 3. Once a week □ 4. 2 times a week □ 5. 3-4 times a week □ 6. 5 times a week or more |
| 271. How often were you so physically active at work that you get out of breath or sweat in the last 3 months before this pregnancy? | □ 1. Never □ 2. Less than once a week □ 3. Once a week □ 4. 2 times a week □ 5. 3-4 times a week □ 6. 5 times a week or more |
| 272. How often are you currently so physically active at work that you get out of breath or sweat during this pregnancy? | □ 1. Never □ 2. Less than once a week □ 3. Once a week □ 4. 2 times a week □ 5. 3-4 times a week □ 6. 5 times a week or more |

We would be grateful if you would write anything else you would like to tell us about this pregnancy or previous births/pregnancies that are not addressed in this questionnaire on the next page.

COMMENTS

273. Are your contact numbers the same? □ 1. Yes [if yes, skip to Q274] □ 2. No

274. If NO, what is your new contact number/s? Home:_________________ Cell:___________________ Other:__________________

275. Are you living at the same address? □ 1. Yes [if yes, skip to Q283] □ 2. No □ 99 Refused to answer [skip to Q283]

276. If No, What is your new address? _______________
House No._____________________________________
Road/Street_____________________________________
City_____________________________________
Postal Code

277. When did you move to your new address? ___________ month ___________ year

278. What type of new house do you currently live in?
☐ 1 Detached house, Semidetached
☐ 2 Farm
☐ 3 Flat, Terraced flat, Apartment building
☐ 4 Refused to answer
☐ 99 Other____________________

279. Has there been water damage, visible signs of fungus/mildew or a smell of mildew in your new home? (Fill in one or several boxes.)
☐ 1 No
☐ 2 Yes, water damage
☐ 3 Yes, signs of fungus and mould
☐ 4 Yes, a smell of mildew
☐ 99 don't know

280. Is your new home drinking water from the tap or from a river or dam?
☐ 1 tap
☐ 2 river or dam
☐ 3 well
☐ 99 other, please specify: ______________________

281. Have you used a room heater in one or more rooms in this house?
☐ 1 Yes
☐ 2 No [if No, skip to Q281]
☐ 99 don't know [skip to Q281]

(a). Was this heater fueled by
☐ 1 paraffin
☐ 2 gas
☐ 3 electricity
☐ 4 wood
☐ 5 coal
☐ 99 other, please specify: ______________________
☐ 99 don't know

282. Is a stove or oven used for cooking in this house?
☐ 1 Yes [if No, skip to Q282]
☐ 2 No [skip to Q282]
☐ 99 Don't know [skip to Q282]

(a). What is the primary source of heat for this stove or oven?
☐ 1 paraffin
☐ 2 gas
☐ 3 electricity
☐ 4 wood
☐ 5 coal
☐ 99 other, please specify: ______________________
☐ 99 don't know

283. Have you been scanned by ultrasound during the pregnancy?
☐ 1 Yes [if No, skip to Q286]
☐ 2 No [skip to Q286]
☐ 99 Don't know [skip to Q286]

284. If Yes, At what week of pregnancy were you scanned? ____________ weeks

285. Did the ultrasound show normal conditions?
☐ 1 Yes [if yes, skip to Q286]
☐ 2 No
☐ 99 Don't know [skip to Q286]

286. If No, please explain
287. Have you had bleedings from the vagina at anytime during this pregnancy?

- [ ] 1. Yes
- [ ] 2. No [If No, skip to Q288]
- [ ] 99. Don't know [skip to Q288]

288. What is the reason for your bleeding?

Explain:

289. Did you have any contractions?

- [ ] 1. Yes
- [ ] 2. No
- [ ] 99. Don't know

Thank you!