Azienda Sanitaria Locale di Mantova

# Health in childhood and adolescence and the environment

## QUESTIONNAIRE FOR PARENTS

Dear parents,
In this questionnaire we will ask you for some information about YOUR SON'S OR YOUR DAUGHTER'S HEALTH. The questionnaire also requires information on your lifestyle, on your home environment and on your family.

When you have filled in the questionnaire, we kindly ask you to put it into the enclosed envelope, to bring it back to school, and to give it to your child's teacher within 7 days.

All the data collected will be treated in a highly confidential way, according to current privacy regulations (D.Lgs. 30-6-2003 n.196), they will be managed by medical staff under the obligation of professional secrecy and they will be stored in total security.

The results of this survey will only be reported in a statistical form at the end of the study, and it will be impossible for a participant's identity to be disclosed from them.

WE THANK YOU VERY MUCH FOR YOUR COOPERATION.

## INSTRUCTIONS

- *The questionnaire should be filled in by both parents, if possible.*

- *Some questions differ one from the other because of minor details, and can seem very similar. These details that are <u>underlined</u> or **highlighted** in the text are very important to define your child's health condition. Please, answer these questions very carefully, following the instructions reported inside.*

- ***Many questions can be answered by putting a tick in the appropriate box.***

  *e.g.:* male gender GENDER ☒ MALE ☐ FEMALE

- ***When required, numbers are to be written in the appropriate spaces.***

  *e.g.:* date of birth : 29th MARCH 1997

  DATE OF BIRTH |**2**|**9**| DAY |**0**|**3**| MONTH |**1**|**9**|**9**|**7**| YEAR

- ***You will sometimes be required to write in words on a line - please write in capital letters.***

- ***When a question is followed by a list of possible answers, please choose <u>only one</u> answer, unless there are other indications.***

- ***Some questions have several parts: arrows ( ↓ ) indicate where to answer.***

- ***IN CASE YOU MAKE A MISTAKE, please indicate the box you have wrongly ticked with "NO" above it...***

  male gender GENDER ☒ MALE **NO** ☒ FEMALE

  ***… or cross out the wrong number, and then write the correct number above it.***

  date of birth 29th MARCH 1997

  DATE OF BIRTH |**2**|**9**| DAY |~~**0**|**5**~~ **03**| MONTH |**1**|**9**|**9**|**7**| YEAR

## SOME DATA ON YOUR CHILD

*All the data collected will be treated in a highly confidential way, according to current privacy regulations (D.Lgs. 30-6-2003 n.196 and additional enforcing regulations).*

YOUR CHILD'S SURNAME _____

YOUR CHILD'S FIRST NAME _____

SCHOOL _____

CLASS _____ SECTION _____

AGE |_|_| YEARS

DATE OF BIRTH |_|_| DAY |_|_| MONTH |_|_|_|_| YEAR

GENDER ☐ MALE ☐ FEMALE

YOUR CHILD'S HEIGHT

|_|_|_| CM

YOUR CHILD'S WEIGHT

|_|_| KG

COMMUNE WHERE YOUR CHILD WAS BORN _____

CITY (OR FOREIGN COUNTRY) WHERE YOUR CHILD WAS BORN _____

IF YOUR CHILD WAS NOT BORN IN ITALY, FOR HOW LONG HAS HE/SHE LIVED IN ITALY? |_|_| YEARS

HOME ADDRESS

*If your child lives in more than one house (e.g.: because the child spends much of his/her time at the grandparents' house, or because his/her parents are separated), please refer to the address where your child spends most of his/her time.*

COMMUNE _____

STREET _____ No. _____

*This information is needed for a geographical reference that precisely identifies the area where your child lives.*

DATE OF COMPILATION OF THE QUESTIONNAIRE |_|_| DAY |_|_| MONTH |_|_|_|_| YEAR

## SECTION 1 - YOUR CHILD'S HEALTH CONDITION

### RESPIRATORY PROBLEMS

1. Has your child ever had wheezing or whistling in his/her chest at any time in the past?

☐ No → *go to question number 2*

☐ Yes

1.1 How old was your child when this happened for the first time?
(*if it happened before he/she was 1 year old, please indicate the months)*

|_|_| YEARS / |_|_| MONTHS

1.2 **In the last 12 months**, has your child had wheezing or whistling in his/her chest?

☐ No → *go to question number 1.3*

☐ Yes

1.2.1 How many attacks of wheezing has your child had **in the last 12 months**?

- ☐ None
- ☐ 1 to 3
- ☐ 4 to 12
- ☐ More than 12

1.2.2 **In the last 12 months**, how often, on average, has your child been woken by this wheezing or whistling in the chest during the night?

- ☐ Never
- ☐ Rarely (less than once a month)
- ☐ Sometimes (less than once a week)
- ☐ Often (1 or more times a week)

1.2.3 Has your child had this wheezing or whistling in his/her chest with or without common colds or flu?

- ☐ Only with colds or flu
- ☐ Only without colds or flu
- ☐ Both with and without colds or flu

1.3 **In the last 12 months**, has your child's chest sounded wheezy during or after physical exercise?

☐ No → *go to question number 2*

☐ Yes

1.3.1 How often has it happened?

- ☐ Never
- ☐ Rarely (less than once a month)
- ☐ Sometimes (less than once a week)
- ☐ Often (1 or more times a week)

2. **In the last 12 months**, has your child had a dry cough at night, apart from a cough associated with a cold or a chest infection (e.g.: flu)?

- ☐ No, never
- ☐ Rarely (less than once a month)
- ☐ Sometimes (less than once a week)
- ☐ Often (1 or more times a week)

3. Has your child had attacks of breathlessness **in the last 12 months**?

- ☐ No, never
- ☐ Rarely (less than once a month)
- ☐ Sometimes (less than once a week)
- ☐ Often (1 or more times a week)

4. **In the last 12 months**, has your child ever woken up in the morning with a feeling of tightness or constriction in the chest?

- ☐ No, never
- ☐ Rarely (less than once a month)
- ☐ Sometimes (less than once a week)
- ☐ Often (1 or more times a week)

5. Has your child ever had asthma?

☐ No → *go to question number 6 on the next page*

☐ Yes

5.1 Was this confirmed by a doctor?

☐ No ☐ Yes

5.2 How old was your child when he/she had his/her first attack of asthma?

|_|_| YEARS

5.3 How old was your child when he/she had his/her most recent attack of asthma?

|_|_| YEARS

5.4 Which months of the year does your child usually have attacks of asthma?

| | | | |
|---|---|---|---|
| 5.4.1 | January/February | ☐ No | ☐ Yes |
| 5.4.2 | March/April | ☐ No | ☐ Yes |
| 5.4.3 | May/June | ☐ No | ☐ Yes |
| 5.4.4 | July/August | ☐ No | ☐ Yes |
| 5.4.5 | September/October | ☐ No | ☐ Yes |
| 5.4.6 | November/December | ☐ No | ☐ Yes |

5.5 Has your child had an attack of asthma **in the last 12 months**?

☐ No ☐ Yes

↓

5.5.1 How many attacks of asthma has your child had **in the last 12 months**?

⌊_⌋⌊_⌋ NUMBER OF ATTACKS

5.5.2 How many attacks of asthma has your child had **in the last 3 months**?

⌊_⌋⌊_⌋ NUMBER OF ATTACKS

5.6 How many times has your child woken up because of asthma **in the last 3 months**?

☐ Never
☐ Less than twice a month
☐ At least twice a month, but not more than once a week
☐ More than once a week, but not most nights
☐ Every night or almost every night

5.7 How many times has your child had trouble with his breathing because of asthma **in the last 3 months**?

☐ Never
☐ Less than once a week
☐ At least once a week, but less than once a day
☐ About once a day
☐ Continuously

5.8 **In the last 12 months**, has your child used medicines for the wheezing in his/her chest or for asthma (tablets, inhalers, aerosols or other remedies)?

☐ No ☐ Yes

6. Does your child cough on most days (4 or more days a week) without common colds or flu?

☐ No ☐ Yes, less than 1 month a year ☐ Yes, 1 or 2 months a year ☐ Yes, 3 or more months a year

↓

6.1 For how many years has he/she had this cough? ⌊_⌋⌊_⌋ YEARS

7. Does your child bring up any phlegm on most days (4 or more days a week) without common colds or flu?

☐ No ☐ Yes, less than 1 month a year ☐ Yes, 1 to 2 months a year ☐ Yes, 3 or more months a year

↓

7.1 For how many years has he/she had this phlegm? ⌊_⌋⌊_⌋ YEARS

8. Has your child had a problem with frequent sneezing, or a runny or blocked nose, at any time when he/she did not have a common cold or the flu?

☐ No ☐ Yes

*go to question number 9*

8.1 **In the last 12 months**, has your child had a problem with frequent sneezing, or a runny or blocked nose when he did not have a common cold or the flu?

| No, never | Rarely (less than once a month) | Sometimes (less than once a week) | Often (1 or more times a week) |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

*go to question number 9*

8.1.1 **In the last 12 months**, has this nose problem been accompanied by itching-watery eyes?

☐ No ☐ Yes

8.1.2 What months of the last year did this nose problem occur? *(please, tick the months that apply, even all of them if necessary)*

| | | | |
|---|---|---|---|
| ☐ January | ☐ April | ☐ July | ☐ October |
| ☐ February | ☐ May | ☐ August | ☐ November |
| ☐ March | ☐ June | ☐ September | ☐ December |

8.1.3 **In the last 12 months**, how much has this nose problem interfered with your child's daily activities?

☐ Not at all ☐ A little ☐ Quite a lot ☐ A lot

9. Has your child ever had any nasal allergies (including hay fever)?

☐ No ☐ Yes

*go to question number 10*

9.1 How old was your child when he/she first had this nasal allergy? ⌊_⌊_⌋ YEARS

9.2 Does your child still have this nasal allergy?

☐ No ☐ Yes

9.2.1 How old was your child when he/she had this nasal allergy for the last time?

⌊_⌊_⌋ YEARS

## SKIN PROBLEMS

10. Has your child had an itchy rash on one or more parts of the skin, which was coming and going for at least six months, at any time in the past?

☐ No ☐ Yes

*go to question number 11*

10.1 Has your child had this itchy rash at any time **in the last 12 months**?

☐ No ☐ Yes

*go to question number 10.2*

10.1.1 Has this itchy rash at any time affected any of the following parts of the body: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck, eyes or ears?

☐ No ☐ Yes

10.1.2 Has this rash cleared completely at any time during the last 12 months?

☐ No ☐ Yes

10.1.3 **In the last 12 months,** how often, on average, has your child been kept awake at night by this itchy rash?

☐ Never in the last 12 months
☐ Less than one night a week
☐ 1 or more nights a week

10.2 How old was your child when he/she had this itchy rash for the first time?

☐☐ YEARS

10.3 How old was your child when he/she had this itchy rash for the last time?

☐☐ YEARS

11. Has your child ever had eczema? ☐ No ☐ Yes

12 Has your child had any of the following problems **in the last 3 months**?
*Please answer each question even if your child has not had any of them*

| | | No, never | Rarely (less than once a month) | Sometimes (less than once a week) | Often (1 or more times a week) |
|---|---|---|---|---|---|
| 12.1 | Dry or flushed facial skin | ☐ | ☐ | ☐ | ☐ |
| 12.2 | Scaling/itching scalp or ears | ☐ | ☐ | ☐ | ☐ |
| 12.3 | Hands dry, itching, red skin | ☐ | ☐ | ☐ | ☐ |
| 12.4 | Itchy rash, on one or more parts of the skin | ☐ | ☐ | ☐ | ☐ |

## EYE PROBLEMS

13. Has your child had any of the following eye problems **in the last 3 months**?
*Please answer each question even if your child has not had any of them*

| | | No, never | Rarely (less than once a month) | Sometimes (less than once a week) | Often (1 or more times a week) |
|---|---|---|---|---|---|
| 13.1 | Itchy eyes | ☐ | ☐ | ☐ | ☐ |
| 13.2 | Swelling of the eyelids | ☐ | ☐ | ☐ | ☐ |
| 13.3 | Eye redness | ☐ | ☐ | ☐ | ☐ |
| 13.4 | Tearing or watery eyes | ☐ | ☐ | ☐ | ☐ |
| 13.5 | Eye pain | ☐ | ☐ | ☐ | ☐ |
| 13.6 | Feeling something in his/her eye | ☐ | ☐ | ☐ | ☐ |
| 13.7 | Blinking continuously | ☐ | ☐ | ☐ | ☐ |
| 13.8 | Photophobia (abnormal sensitivity to light) | ☐ | ☐ | ☐ | ☐ |

*If you have indicated "rarely", "sometimes" or "often" in one or more of the above conditions, please answer the following question; otherwise, go to question 14*

13.9 **In the last 3 months**, has your child had the conditions you have ticked above only when he/she was (or only after he/she had been) in the open air?

☐ No ☐ Yes

14. **In the last 3 months**, has your child used oral medicines or eye drops for an eye problem or irritation?

☐ No, never
☐ Rarely (less than once a month)
☐ Sometimes (less than once a week)
☐ Often (1 or more times a week)

## OTHER HEALTH CONDITIONS OF YOUR CHILD

15. Has your child had any of the following problems **in the last 3 months**?

| | | No, never | Rarely (less than once a month) | Sometimes (less than once a week) | Often (1 or more times a week) |
|---|---|---|---|---|---|
| 15.1 | Dry nose | ☐ | ☐ | ☐ | ☐ |
| 15.2 | Dry mouth | ☐ | ☐ | ☐ | ☐ |
| 15.3 | Dry throat | ☐ | ☐ | ☐ | ☐ |
| 15.4 | Hoarse throat | ☐ | ☐ | ☐ | ☐ |
| 15.5 | Irritated or sore nose *(when he/she did not have a common cold or the flu)* | ☐ | ☐ | ☐ | ☐ |
| 15.6 | Stomachache | ☐ | ☐ | ☐ | ☐ |
| 15.7 | Nausea | ☐ | ☐ | ☐ | ☐ |
| 15.8 | Dizziness | ☐ | ☐ | ☐ | ☐ |
| 15.9 | Headache | ☐ | ☐ | ☐ | ☐ |
| 15.10 | Feeling heavy-headed | ☐ | ☐ | ☐ | ☐ |
| 15.11 | Restlessness or nervousness | ☐ | ☐ | ☐ | ☐ |
| 15.12 | Inability to concentrate on something for more than a few seconds | ☐ | ☐ | ☐ | ☐ |
| 15.13 | Fatigue or weakness | ☐ | ☐ | ☐ | ☐ |
| 15.14 | Sleeping problems | ☐ | ☐ | ☐ | ☐ |
| 15.15 | Tasting strange tastes while eating | ☐ | ☐ | ☐ | ☐ |
| 15.16 | Smelling strange or irritating smells | ☐ | ☐ | ☐ | ☐ |

16. Has your child had a cold or the flu **in the last 12 months**?

☐ No ☐ Yes

17. **In the last 12 months**, has your child taken antibiotics prescribed by a doctor?

☐ No ☐ Yes

18. **In the last 3 months**, how many school-days has your child lost because of health problems (including lost days at school because he/she needed to go to the doctor)?

☐ None
☐ Less than 3 days
☐ 3 to 6 days
☐ More than 6 days

19. **In the last 3 months**, has your child been taken to a hospital casualty department or emergency room, for any reason, excluding accidents and injuries?

☐ No, never ☐ Yes, once ☐ Yes, 2 or more times

20. **In the last 3 months**, has your child spent at least one night in hospital, for any reason, excluding accidents and injuries?

☐ No, never ☐ Yes, once ☐ Yes, 2 or more times

## SECTION 2 - PREGNANCY AND THE FIRST YEARS OF LIFE

21. What was your child's weight at birth?

|_|_|_|_| GRAMS

22. With respect to the date when he/she was due, your child was born:

☐ Regularly (no more than 3 weeks before the due date, or no more than 2 weeks after the due date)
☐ More than 3 weeks before the due date
☐ More than 2 weeks after the due date
☐ Don't know

23. Was your child born by:

☐ Natural birth ☐ Caesarian birth

24. Was your child kept in hospital because of health problems after his/her birth?

☐ No
☐ Yes, fewer than 8 days
☐ Yes, 8 to 30 days
☐ Yes, more than 30 days
☐ Don't know

25. Was your child breastfed, or fed with breast milk?

☐ No ☐ Yes

25.1 How long was your child only breastfed, or fed with breast milk?

- ☐ Less than 1 month
- ☐ 1-3 months
- ☐ 4-6 months
- ☐ 7-12 months
- ☐ More than 1 year

26. Has your child ever been in a crêche?

☐ No ☐ Yes

26.1 How old was your child when he/she started attending a crêche? |__|__| MONTHS

27. Did the mother have any of the following problems **during pregnancy**?

27.1 High blood pressure (hypertension) for which she had to take medicines

☐ Yes → 27.1.1 In which trimester of the pregnancy? *(tick as many boxes as you need)*
☐ First trimester ☐ Second trimester ☐ Third trimester
☐ No
☐ Don't know

27.2 Gestosis (pre-eclampsia)

☐ Yes → 27.2.1 In which trimester of the pregnancy? *(tick as many boxes as you need)*
☐ First trimester ☐ Second trimester ☐ Third trimester
☐ No
☐ Don't know

27.3 Risk of premature birth or of miscarriage

☐ Yes → 27.3.1 In which trimester of the pregnancy? *(tick as many boxes as you need)*
☐ First trimester ☐ Second trimester ☐ Third trimester
☐ No
☐ Don't know

27.4 Episodes of fever due to infections

☐ Yes → 27.4.1 In which trimester of the pregnancy? *(tick as many boxes as you need)*
☐ First trimester ☐ Second trimester ☐ Third trimester
☐ No
☐ Don't know

27.5 Gynaecological infection for which she had to take medicines

☐ Yes → 27.5.1 In which trimester of the pregnancy? *(tick as many boxes as you need)*
☐ First trimester ☐ Second trimester ☐ Third trimester
☐ No
☐ Don't know

28. How often did the mother take the following medicines **during pregnancy**?

28.1 Medicines for asthma
- ☐ Never
- ☐ When needed
- ☐ In short courses
- ☐ Continuously

28.2 Oral cortisone (or cortisone-like medicines)
- ☐ Never
- ☐ When needed
- ☐ In short courses
- ☐ Continuously

28.3 Inhaled cortisone (or cortisone-like medicines)
- ☐ Never
- ☐ When needed
- ☐ In short courses
- ☐ Continuously

28.4 Antibiotics
- ☐ Never
- ☐ 1 course of therapy
- ☐ 2 courses of therapy
- ☐ 3 or more courses of therapy

28.4.1 In which trimester of the pregnancy? *(tick as many boxes as you need)*

☐ First trimester ☐ Second trimester ☐ Third trimester

28.5 Medicines containing Acetaminophen (Paracetamol), e.g.: Tachipirina or Efferalgan
- ☐ Never
- ☐ Rarely (less than once a month)
- ☐ Sometimes (less than once a week)
- ☐ Often (1 or more times a week)

28.5.1 In which trimester of the pregnancy? *(tick as many boxes as you need)*

☐ First trimester ☐ Second trimester ☐ Third trimester

29. **During the pregnancy**, did the mother experience any situations of loss or uneasiness (mourning, loss of her job or her husband's job, separation, etc.)?

☐ No ☐ Yes

30. Did the mother have regular contact (at least once a week) with farm animals (like cattle, pigs, sheep, goats, poultry) **during the pregnancy**?

☐ No ☐ Yes

31. Did your child share his/her bedroom with other children **during his/her first year of life**?

☐ No ☐ Yes

32. Did your child have regular contact (at least once a week) with farm animals (like cattle, pigs, sheep, goats, poultry) **during his/her first year of life**?

☐ No ☐ Yes

33. Did your child take any antibiotics **during his/her first year of life**?

- ☐ No, never
- ☐ 1 course of therapy
- ☐ 2 courses of therapy
- ☐ 3 or more courses of therapy

34. Has a doctor ever said that your child had one or more of the following conditions **during his/her first 2 years of life**?

| | | | | |
|---|---|---|---|---|
| 34.1 | Bronchitis | ☐ No | ☐ Yes | ☐ Don't know, don't remember |
| 34.2 | Asthma-like bronchitis | ☐ No | ☐ Yes | ☐ Don't know, don't remember |
| 34.3 | Pneumonia or bronchopneumonia | ☐ No | ☐ Yes | ☐ Don't know, don't remember |
| 34.4 | Bronchiolitis | ☐ No | ☐ Yes | ☐ Don't know, don't remember |

35. **During the first 3 years of your child's life**, did the family experience any situations of loss or uneasiness (mourning, loss of his/her father's/mother's job, parental separation, etc.)?

☐ No ☐ Yes

## SECTION 3 - LIFESTYLE

36. Does your child play, or spend his/her leisure time, in the open air during the warm and hot seasons?

- ☐ Never
- ☐ Only occasionally
- ☐ 1 or 2 times a week
- ☐ 3 or more times a week

37. How many times a week does your child do physical activity, excluding physical education at school?

- ☐ He/she does no physical activity
- ☐ Only occasionally
- ☐ 1 or 2 times a week
- ☐ 3 or more times a week

→ 37.1 What kind of physical activity does your child mainly do?

- ☐ Swimming or other water sports
- ☐ Outdoor sports
- ☐ Indoor sports (in a gym or another building)

38. Is your child exonerated from physical education because of health problems? ☐ No ☐ Yes

39. During a normal week, how many hours a day does your child watch television?

- ☐ Less than 1 hour
- ☐ 1-3 hours
- ☐ 4-5 hours
- ☐ More than 5 hours

## SECTION 4 - THE FAMILY

### THE MOTHER (FOSTER PARENT, RELATIVE OR WHOEVER ACTS ON THE MOTHER'S BEHALF)

40. What year was the mother born? 1 9 ⌊_⌋⌊_⌋

41. Where was the mother born?

☐ In Italy ☐ In another country of the European Union ☐ In a country outside the European Union

42. What is the educational level of the mother?

☐ No educational level
☐ Primary school level
☐ Secondary school level or professional school
☐ High school level
☐ Short-term degree or university diploma
☐ Full-term degree
☐ Other _____ ⌊_⌋⌊_⌋ YEARS
*(specify, also indicating the total number of years of study)*

43. Choose, among the following, the situation that best describes the present working position of the mother.

☐ Manager
☐ Unemployed
☐ White-collar worker
☐ Entrepreneur
☐ Freelance
☐ Blue-collar worker
☐ Retired
☐ Housewife
☐ Student
☐ Other _____
*(specify)*

44. Has the mother ever smoked cigarettes?

☐ No, never → *go to question number 45*

☐ Yes, but she gave up when she was ⌊_⌋⌊_⌋ years old

☐ Yes, she currently smokes

*If she smokes or she smoked in the past:*

44.1 How many cigarettes does she smoke, or did she smoke, per day? ⌊_⌋⌊_⌋ CIGARETTES

44.2 Did she smoke before her pregnancy with this child? ☐ No ☐ Yes

44.2.1 How many cigarettes per day? ⌊_⌋⌊_⌋ CIGARETTES

44.3 Did she smoke during her pregnancy with this child? ☐ No ☐ Yes

44.3.1 How many cigarettes per day? ⌊_⌋⌊_⌋ CIGARETTES

44.4 Did she smoke during her child's first year of life? ☐ No ☐ Yes

44.4.1 How many cigarettes per day? ⌊_⌋⌊_⌋ CIGARETTES

45. Has the mother ever had one of the following conditions? *(tick as many boxes as you need)*

| | | | |
|---|---|---|---|
| 45.1 Asthma | ☐ No | ☐ Yes | ☐ Don't know |
| 45.2 Allergic rhinitis | ☐ No | ☐ Yes | ☐ Don't know |
| 45.3 Eczema | ☐ No | ☐ Yes | ☐ Don't know |
| 45.4 Chronic bronchitis or emphysema | ☐ No | ☐ Yes | ☐ Don't know |

## THE FATHER (FOSTER PARENT, RELATIVE OR WHOEVER ACTS ON THE FATHER'S BEHALF)

46. In which year was the father born? 1 9 ⌊_⌊_⌋

47. Where was the father born?

- ☐ In Italy
- ☐ In another country of the European Union
- ☐ In a country outside the European Union

48. What is the educational level of the father?

- ☐ No educational level
- ☐ Primary school level
- ☐ Secondary school level or professional school
- ☐ High school level
- ☐ Short-term degree or university diploma
- ☐ Full-term degree
- ☐ Other _____ ⌊_⌊_⌋ YEARS
  *(specify, also indicating the total number of years of study)*

49. Choose, among the following, the situation that better describes the present working position of the father.

- ☐ Manager
- ☐ Unemployed
- ☐ White-collar worker
- ☐ Entrepreneur
- ☐ Freelance
- ☐ Blue-collar worker
- ☐ Retired
- ☐ Dealing with housework
- ☐ Student
- ☐ Other _____
  *(specify)*

50. Has the father ever smoked cigarettes?

- ☐ No, never
- ☐ Yes, but he gave up when he was ⌊_⌊_⌋ years old
- ☐ Yes, he currently smokes

*If he smokes or he smoked in the past:*

50.1 How many cigarettes does he smoke, or did he smoke, per day? ⌊_⌊_⌋ CIGARETTES

51. Has the father ever had one of the following conditions? *(tick as many boxes as you need)*

| | | | |
|---|---|---|---|
| 51.1 Asthma | ☐ No | ☐ Yes | ☐ Don't know |
| 51.2 Allergic rhinitis | ☐ No | ☐ Yes | ☐ Don't know |
| 51.3 Eczema | ☐ No | ☐ Yes | ☐ Don't know |
| 51.4 Chronic bronchitis or emphysema | ☐ No | ☐ Yes | ☐ Don't know |

## BROTHERS AND SISTERS

52. How many brothers or sisters has your child got?

⌊_⌊_⌋ NUMBER →

How many of these brothers or sisters are:

52.1 your child's twins ⌊_⌊_⌋ NUMBER

52.2 brothers or sisters older than your child ⌊_⌊_⌋ NUMBER

52.3 brothers or sisters younger than your child ⌊_⌊_⌋ NUMBER

*If your child has got brothers or sisters, answer question 53; otherwise, go to question 54.*

53. Have any of your child's brothers or sisters ever had one of the following conditions? *(tick as many boxes as you need)*

| | | | |
|---|---|---|---|
| 53.1 Asthma | ☐ No | ☐ Yes | ☐ Don't know |
| 53.2 Allergic rhinitis | ☐ No | ☐ Yes | ☐ Don't know |
| 53.3 Eczema | ☐ No | ☐ Yes | ☐ Don't know |
| 53.4 Chronic bronchitis or emphysema | ☐ No | ☐ Yes | ☐ Don't know |

## SECTION 5 - THE HOUSE

*In this section, we will ask you some questions about your house. If your child lives in more than one house (e.g.: because the child spends much of his/her time at the grandparents' house, or because his/her parents are separated, etc), when answering please consider "present house" the one where your child spends most of his/her time.*

54. Has your child being living in the **present house** since he/she was born?

☐ Yes → *go to question number 55*

☐ No

54.1 For how many years has your child being living in the present house?

|_|_| YEARS

54.2 Was **the house where your child lived before** <u>in the same commune</u> where he currently lives?

☐ Yes → *go to question number 55*

☐ No

54.2.1 Among the following, please indicate the commune in which the house where your child lived before was situated:

- ☐ Bozzolo
- ☐ Commessaggio
- ☐ Dosolo
- ☐ Marcaria
- ☐ Gazzuolo
- ☐ Pomponesco
- ☐ Rivarolo Mantovano
- ☐ Sabbioneta
- ☐ San Martino dall'Argine
- ☐ Viadana
- ☐ None of the above

55. When was your child's **present house** built?
*(if you don't remember exactly, indicate an approximate date)* |_|_|_|_| YEAR

56. The present house is:

- ☐ A building made of wood
- ☐ A building partially made of wood (e.g.: mansard or wooden attic)
- ☐ A building made of bricks
- ☐ Other _____
*(specify)*

57. The present house is:

- ☐ A flat
- ☐ A house for two families (semi-detached house)
- ☐ A one-family single house (detached house)
- ☐ Other _____
*(specify)*

58. How many rooms (excluding passages, toilets and kitchens) has **the present house** got? ⌊_⌋⌊_⌋ NUMBER

59. How many people in total live in the present house (including your child)? ⌊_⌋⌊_⌋ NUMBER

60. If you live in a flat, on which floor is the flat situated?
*If the flat is on several floors, please indicate the lowest level. If you do not live in a flat, go to the next question.*

- ☐ Basement
- ☐ Ground floor or mezzanine
- ☐ 1st or 2nd floor
- ☐ 3rd or 4th floor
- ☐ Above the 4th floor

61. How would you describe the area where the house is situated?

- ☐ Countryside or hamlet surrounded by open spaces or fields
- ☐ Town center
- ☐ Industrial area on the outskirts of the town

62. How often do cars pass the house?

- ☐ Never
- ☐ Seldom
- ☐ Frequently
- ☐ Constantly

63. How often do heavy vehicles (e.g. trucks/buses) pass the house?

- ☐ Never
- ☐ Seldom
- ☐ Frequently
- ☐ Constantly

64. Do you usually open the windows every day, even during cold months?

☐ No ☐ Yes

64.1 How long, on average, in a day, do you keep the windows open?

- ☐ About a quarter of an hour
- ☐ About half an hour
- ☐ About one hour
- ☐ Longer than one hour

65. Have you ever noticed damp spots, mould or mildew on the walls or the ceiling of the bedroom where your child sleeps (or slept)? *(tick as many boxes as you need)*

| | | | |
|---|---|---|---|
| 65.1 **During the 1st year of my child's life** | ☐ No | ☐ Yes | ☐ Don't know, don't remember |
| 65.2 **Currently** | ☐ No | ☐ Yes | |

66. Has your child ever kept one of the following animals at home?
*(tick as many boxes as you need)*

| | never | during the 1st year of life | in the last 12 months | another time |
|---|---|---|---|---|
| 66.1 Dog | ☐ | ☐ | ☐ | ☐ |
| 66.2 Cat | ☐ | ☐ | ☐ | ☐ |

67. Does anybody **currently** smoke in the house?

☐ No ☐ Yes

67.1 How many people in total smoke in the house? ⌊_⌋⌊_⌋ NUMBER

68. How many people in total smoked in the house during **the 1st year** of your child's life? ⌊_⌋⌊_⌋ NUMBER

69. What kind of source of heat do you generally use for cooking? *(tick as many boxes as you need)*

☐ Electricity
☐ Gas
☐ Wood or coal
☐ Other _____
*(specify)*

70. How frequently do you use the following products to clean the house?
*(tick as many boxes as you need)*

| | Never | Sometimes (1-3 times a month or less) | Often (1-2 times a week) | Always (3 or more times a week) |
|---|---|---|---|---|
| 70.1 Bleach | ☐ | ☐ | ☐ | ☐ |
| 70.2 Products containing ammonia | ☐ | ☐ | ☐ | ☐ |
| 70.3 Products containing lysoform | ☐ | ☐ | ☐ | ☐ |
| 70.4 Products to remove limescale | ☐ | ☐ | ☐ | ☐ |
| 70.5 Denaturated alcohol | ☐ | ☐ | ☐ | ☐ |
| 70.6 Floor wax | ☐ | ☐ | ☐ | ☐ |

71. How is the house heated?

| Hot water heating | Forced air heating | Air conditioning | Other |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

71.1 Is the hot water boiler situated inside the house?

☐ No ☐ Yes

71.2 What kind of fuel does the boiler run on?

☐ Methane gas ☐ Kerosene ☐ Other _____
*(specify)*
☐ Oil ☐ Liquid gas in cylinders
☐ Electricity ☐ Wood or coal

72. Do you use any of the following additional systems to heat the house during the cold months?

| | | | | |
|---|---|---|---|---|
| 72.1 | Electric heater | ☐ No | ☐ Yes | |
| 72.2 | Fan heater | ☐ No | ☐ Yes | |
| 72.3 | Kerosene stove | ☐ No | ☐ Yes | |
| 72.4 | Oil stove | ☐ No | ☐ Yes | |
| 72.5 | Wood or coal stove | ☐ No | ☐ Yes | |
| 72.6 | Fireplace | ☐ No | ☐ Yes | |
| 72.7 | Gas stove | ☐ No | ☐ Yes | |

73. Has your child's bedroom got:

| | | | |
|---|---|---|---|
| 73.1 | Fitted carpets covering the floor? | ☐ No | ☐ Yes |
| 73.2 | Rugs? | ☐ No | ☐ Yes |
| 73.3 | Double glazed windows? | ☐ No | ☐ Yes |
| 73.4 | Non-solid wooden furniture (chipboard, plywood, ...) | ☐ No | ☐ Yes |

↓

73.4.1 When did you buy the most recent non-solid wooden furniture?

- ☐ Less than 3 months ago
- ☐ More than 3 months ago, but less than 3 years ago
- ☐ More than 3 years ago, but less than 5 years ago
- ☐ More than 5 years ago

74. How much do you think that the following aspects can be a risk for the health of the population?

| | | Not at all | A little | Quite a lot | A lot | Don't know |
|---|---|---|---|---|---|---|
| 74.1 | Exposure to electromagnetic fields | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74.2 | City traffic | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74.3 | Lack of public parks and gardens | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74.4 | Air pollution | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74.5 | Indoor cigarette smoke | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74.6 | Chemical products in food | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74.7 | Excess of fluorine in the water | ☐ | ☐ | ☐ | ☐ | ☐ |

75. Who answered the questionnaire?

- ☐ Mother
- ☐ Father
- ☐ Both
- ☐ Another person

76. The questionnaire was filled in:

| | | | | | |
|---|---|---|---|---|---|
| 76.1 | With the help of a cultural mediator | ☐ | No | ☐ | Yes |
| 76.2 | With the help of relatives, friends or acquietances | ☐ | No | ☐ | Yes |

*THANK YOU FOR YOUR KIND COOPERATION*

*By filling in the present questionnaire I accept that my personal data will be used for statistical purposes. All the data collected will be stored in a strictly anonimous form and they will be treated in a highly confidential way, according to current privacy regulations (D.Lgs. 30-6-2003 n.196).*

***COMMENTS ARE WELCOME***