

Participant ID: _____

Visit: _____

Staff's Initials

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Date:

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Month Day Year

Airways – Middle Childhood

Notes:

- This questionnaire is to be administered when the participant is between 5 and 10 years of age (up to child's 11th birthday). Questions are designed to be answered by the caretaker.
- This questionnaire should be administered before the Childhood Asthma Control Test (CACT) and Patient Oriented Eczema Measure (POEM)
- Study staff should emphasize the importance of trying to answer all questions as best the caretaker can, and if the caretaker has questions regarding medical terminology, study staff should provide answers to ensure the caretaker understands the question. If the caretaker is unsure at what age an event occurred, staff are to suggest the caretaker make their best guess from the age range options.

"The following questions ask about symptoms and conditions related to asthma, wheezing, and cough; respiratory infections and related surgeries; rhinitis; medications for hay fever, allergic rhinitis, allergies in the nose, asthma, wheezing, or cough; eczema (atopic dermatitis); food allergy; and anaphylaxis."

Asthma, Wheezing, and Cough

1. Has [PARTICIPANT] ever had wheezing or whistling in the chest at any time in the past?*

¹ Yes

⁰ No → SKIP TO Q2

1a. At what age did [PARTICIPANT] first have wheezing or whistling in the chest?

___ ___ years or if unsure of age, was it...

¹ Before 5 years old (before elementary school)

² Between about 5-10 years old (in elementary or middle school)

1b. Has [PARTICIPANT] had wheezing or whistling in the chest in the past 12 months?*

¹ Yes

⁰ No → SKIP TO Q2

1c. How many attacks of wheezing has [PARTICIPANT] had in the past 12 months?**

¹ None

² 1

³ 2

⁴ 3

⁵ 4 to 12

⁶ More than 12

1d. In the past 12 months, how often, on average, has [PARTICIPANT'S] sleep been disturbed due to wheezing?*

¹ Never woken with wheezing

2 Less than one time per week

3 One or more times per week

1e. In the past 12 months, has wheezing ever been severe enough to limit [PARTICIPANT'S] speech to only one or two words at a time between breaths?*

1 Yes

0 No

2. Has [PARTICIPANT] ever had asthma?*

1 Yes

0 No

3. In the past 12 months, has [PARTICIPANT'S] chest sounded wheezy during or after exercise?*

1 Yes

0 No

4. In the past 12 months, has [PARTICIPANT] had a dry cough at night, apart from a cough associated with a cold or chest infection?*

1 Yes

0 No → **SKIP TO Q5**

4a. In which of the past month(s) did this cough occur? [Select all that apply]

1 January

5 May

9 September

2 February

6 June

10 October

3 March

7 July

11 November

4 April

8 August

12 December

5. Has a doctor or other health care provider ever diagnosed [PARTICIPANT] with **asthma**?

1 Yes

0 No → **SKIP TO Q6**

5a. At what age was [PARTICIPANT] diagnosed with asthma?

___ ___ years or if unsure of age, was it...

1 Before 5 years old (before elementary school)

2 Between about 5-10 years old (in elementary or middle school)

5b. Does [PARTICIPANT] still have asthma?

1 Yes [**Complete CACT form**]

0 No

6. Has [PARTICIPANT] ever been hospitalized overnight for asthma or a severe episode of wheezing or whistling in the chest at any time in the past? *Do not include emergency room visits.*

1 Yes

0 No → **SKIP TO Q7**

6a. How many times has [PARTICIPANT] been hospitalized overnight for asthma or a severe episode of wheezing or whistling in the chest? *Do not include emergency room visits.*

___ ___ ___ times

6b. In the past 12 months, has [PARTICIPANT] been hospitalized for asthma or a severe episode of wheezing or whistling in the chest? *Do not include emergency room visits.*

- ¹ Yes
- ⁰ No

7. In the past 12 months, has [PARTICIPANT] had to visit an emergency room or urgent care center because of [PARTICIPANT'S] asthma or a severe episode of wheezing or whistling in the chest?

- ¹ Yes
- ⁰ No

8. Has [PARTICIPANT] ever been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

- ¹ Yes
- ⁰ No → **SKIP TO Q9**

8a. How many times has [PARTICIPANT] been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

- ¹ 1 times
- ² 2-4 times
- ³ 5 or more times

8b. In the past 12 months, has [PARTICIPANT] been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

- ¹ Yes
- ⁰ No → **SKIP TO Q9**

8b1. In the past 12 months, how many times has [PARTICIPANT] been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

___ ___ ___ times

9. In the following list, what sets off or triggers any of [PARTICIPANT'S] asthma or wheezing symptoms?

	Possible Symptom Triggers	Yes	No	Don't know
9a.	Cats	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9b.	Dogs	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9c.	Mice	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9d.	Other animals	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9d1.	Specify:			
9e.	Cockroaches	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9f.	Dusty places	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9g.	Moldy places	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9h.	Cigarette or cigar smoke	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9i.	Strong odors	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9j.	Indoor wood smoke (e.g., fireplaces, wood stoves)	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}
9k.	Outdoor wood smoke	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> ^{.d}

9l.	Pollen/grass/trees	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
9m.	Weather changes	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
9n.	Cold air	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
9o.	Exercise	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
9p.	Common cold or sinus infection	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
9q.	Aspirin	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
9r.	Foods	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
9r1.	Specify:			
10r.	Other	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.0 <input type="checkbox"/>
10r1.	Specify:			

10. During which months does [PARTICIPANT] get asthma, wheezing, or whistling in the chest symptoms? [Select all that apply.]

- 1 January
- 2 February
- 3 March
- 4 April
- 5 May
- 6 June
- 7 July
- 8 August
- 9 September
- 10 October
- 11 November
- 12 December

Respiratory Infections

1. Has [PARTICIPANT] ever been diagnosed with **bronchiolitis** (bronchiolitis is an infection in the lungs with wheezing and rapid breathing that only occurs in children under 24 months old)?

- 1 Yes
- 0 No → SKIP TO Q2
- .0 Don't know → SKIP TO Q2

1a. How many times has bronchiolitis been diagnosed?

- 1 1 times
- 2 2-4 times
- 3 5 or more times

1b. At what age was [PARTICIPANT] first diagnosed with bronchiolitis?

___ ___ years or if unsure of age, was it...

- 1 0-11 months
- 2 12-24 months

1c. Has [PARTICIPANT] ever been hospitalized overnight for bronchiolitis? *Do not include emergency room visits.*

- 1 Yes
- 0 No → SKIP TO Q2
- .0 Don't know → SKIP TO Q2

1c1. How many times has [PARTICIPANT] been hospitalized for bronchiolitis? *Do not include emergency room visits.*

- 1 1 times

- 2 2-4 times
- 3 5 or more times

2. Has [PARTICIPANT] had any of the following surgeries?

		*Yes	No	Don't know		*If yes, at what age? (select one)		
						Less than 2 years old	2-4 years old (before elementary school)	Between about 5-10 years old
2a	Tonsils removed	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>	2a1.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2b	Adenoids removed	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>	2a2.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2c	Ear tubes placed	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>	2a3.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

[*If ear tubes were placed more than once, record time frame of first placement.]

3. Has [PARTICIPANT] ever been diagnosed with a sinus infection?

- 1 Yes
- 0 No → SKIP TO Q4
- .d Don't know → SKIP TO Q4

3a. How many times has a sinus infection been diagnosed?

- 1 1 time
- 2 2-4 times
- 3 5 or more times

4. Has [PARTICIPANT] ever been diagnosed with an ear infection (also called otitis media)?

- 1 Yes
- 0 No → SKIP TO Q5
- .d Don't know → SKIP TO Q5

4a. How many times has an ear infection been diagnosed?

- 1 1 time
- 2 2-4 times
- 3 5 or more times

5. Has [PARTICIPANT] ever been diagnosed with croup?

- 1 Yes
- 0 No → SKIP TO Q6
- .d Don't know → SKIP TO Q6

5a. How many times has croup been diagnosed?

- 1 1 time
- 2 2-4 times
- 3 5 or more times

5b. Has [PARTICIPANT] ever been hospitalized overnight for croup? *Do not include emergency room*

visits.

- 1 Yes
- 0 No → **SKIP TO Q6**

5b1. How many times has [PARTICIPANT] been hospitalized for croup?

- 1 1 time
- 2 2-4 times
- 3 5 or more times

6. Has [PARTICIPANT] ever been diagnosed with **pneumonia or bronchitis**?

- 1 Yes
- 0 No → **SKIP TO RHINITIS SECTION**
- 0 Don't know → **SKIP TO RHINITIS SECTION**

6a. How many times has pneumonia or bronchitis been diagnosed?

- 1 1 time
- 2 2-4 times
- 3 5 or more times

6b. Has [PARTICIPANT] ever been hospitalized overnight for pneumonia or bronchitis? *Do not include emergency room visits.*

- 1 Yes
- 0 No → **SKIP TO RHINITIS SECTION**

6b1. How many times has [PARTICIPANT] been hospitalized for pneumonia or bronchitis?

- 1 1 time
- 2 2-4 times
- 3 5 or more times

Rhinitis

"The next questions are about [PARTICIPANT's] nose and about what symptoms [PARTICIPANT] may experience when [PARTICIPANT] does not have a cold or the flu. Some of the questions will ask about whether the symptoms occur all year long, are limited to certain months, or are always there but are worse during certain months.

1. Has [PARTICIPANT] ever had a problem with sneezing or a runny or blocked (stuffy) nose, when [PARTICIPANT] DID NOT have a cold or the flu?*

- 1 Yes
- 0 No → **SKIP TO Q6**

2. In the past 12 months, has [PARTICIPANT] had a problem with sneezing or a runny or blocked (stuffy) nose when [PARTICIPANT] DID NOT have a cold or the flu?*

- 1 Yes
- 0 No → **SKIP TO Q6**

2a. In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?*

- 1 Yes
- 0 No

"The next five questions ask about specific symptoms [PARTICIPANT] may have experienced in the past year."

- 3. Over the past 12 months, did [PARTICIPANT] **sneeze** when [PARTICIPANT] did not have a cold or the flu?
 - 1 Yes
 - 0 No
- 4. Over the past 12 months, did [PARTICIPANT] get a **stuffy nose** when [PARTICIPANT] did not have a cold or the flu?
 - 1 Yes
 - 0 No
- 5. Over the past 12 months, did [PARTICIPANT] get a **runny nose** when [PARTICIPANT] did not have a cold or the flu?
 - 1 Yes
 - 0 No
- 6. Over the past 12 months, did [PARTICIPANT] have **post nasal drip** (secretions dripping in the back of the throat) when [PARTICIPANT] did not have a cold or the flu?
 - 1 Yes
 - 0 No
- 7. Over the past 12 months, did [PARTICIPANT] get **sinus pressure or sinus headaches** when [PARTICIPANT] did not have a cold or the flu?
 - 1 Yes
 - 0 No

➔ [IF A "YES" RESPONSE IS GIVEN TO ANY QUESTIONS FOR Q1-Q7, CONTINUE WITH Q8 BELOW. OTHERWISE, SKIP TO MEDICATIONS FOR HAY FEVER, ALLERGIC RHINITIS, ALLERGIES IN THE NOSE, ASTHMA, WHEEZING, OR COUGH SECTION]

- 8. Does [PARTICIPANT] have nose and/or sinus symptoms all year round?
 - 1 Yes
 - 0 No ➔ SKIP TO Q9
- 8a. Are any months worse for [PARTICIPANT's] nose and/or sinus symptoms?
 - 1 Yes
 - 0 No ➔ SKIP TO Q10

8a1. **If yes, which months? [Select all that apply, then SKIP TO Q10]**

- | | | |
|-------------------------------------|-----------------------------------|--------------------------------------|
| 1 <input type="checkbox"/> January | 5 <input type="checkbox"/> May | 9 <input type="checkbox"/> September |
| 2 <input type="checkbox"/> February | 6 <input type="checkbox"/> June | 10 <input type="checkbox"/> October |
| 3 <input type="checkbox"/> March | 7 <input type="checkbox"/> July | 11 <input type="checkbox"/> November |
| 4 <input type="checkbox"/> April | 8 <input type="checkbox"/> August | 12 <input type="checkbox"/> December |

- 9. During which months does [PARTICIPANT] get these nose and/or sinus symptoms? [Select all that apply]**

1 <input type="checkbox"/> January	5 <input type="checkbox"/> May	9 <input type="checkbox"/> September
2 <input type="checkbox"/> February	6 <input type="checkbox"/> June	10 <input type="checkbox"/> October
3 <input type="checkbox"/> March	7 <input type="checkbox"/> July	11 <input type="checkbox"/> November
4 <input type="checkbox"/> April	8 <input type="checkbox"/> August	12 <input type="checkbox"/> December

10. In the following list, what sets off or triggers any of the nose problems that [PARTICIPANT] reported above?

	Possible Symptom Triggers	Yes	No	Don't know
10a.	Cats	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10b.	Dogs	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10c.	Mice	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10d.	Other animals	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10d1.	Specify:			
10e.	Cockroaches	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10f.	Dusty places	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10g.	Moldy places	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10h.	Cigarette or cigar smoke	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10i.	Strong odors	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10j.	Indoor wood smoke (e.g., fireplaces, wood stoves)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10k.	Outdoor wood smoke	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10l.	Pollen/grass/trees	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10m.	Weather changes	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10n.	Cold air	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10o.	Exercise	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10p.	Common cold or sinus infection	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10q.	Aspirin	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10r.	Foods	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10r1.	Specify:			
10s.	Other	1 <input type="checkbox"/>	0 <input type="checkbox"/>	.d <input type="checkbox"/>
10s1.	Specify:			

11. In the past 12 months, how much did this nose problem interfere with [PARTICIPANT's] daily activities?*

- 1 Not at all
- 2 A little
- 3 A moderate amount
- 4 A lot

12. At what age did [PARTICIPANT] first have nose problems?

____ years or if unsure of age, was it...

- 1 Before 5 years old (before elementary school)
- 2 Between about 5-10 years old (in elementary or middle school)

13. Has [PARTICIPANT] ever had hay fever? *This can also be called allergic rhinitis or allergies in the nose.***

- 1 Yes

No → **SKIP TO MEDICATIONS FOR HAY FEVER, ALLERGIC RHINITIS, ALLERGIES IN THE NOSE, ASTHMA, WHEEZING, OR COUGH SECTION**

14. Has a doctor or health care provider ever diagnosed [PARTICIPANT] with hay fever, allergic rhinitis, or allergies in the nose?

Yes

No

Medications for Hay Fever, Allergic Rhinitis, Allergies in the Nose, Asthma, Wheezing, or Cough

1. Does [PARTICIPANT] use any medications for treatment of hay fever, allergic rhinitis, or allergies in the nose?

Yes

No → **SKIP TO Q2**

1a. Which ones?

Oral antihistamine (e.g., Loratadine [Claritin], Cetirizine [Zyrtec], Diphenhydramine [Benadryl], Fexofenadine [Allegra])

Nasal steroid (e.g., Fluticasone [Flonase], Triamcinolone [Nasacort], Budesonide [Rhinocort])

Nasal Antihistamine (e.g., Azelastine [Astelin, Astepro], Olopatadine [Patanase])

Montelukast (e.g., Singulair)

Other, please list: _____

2. Does [PARTICIPANT] use any medications for treatment of recurrent cough, recurrent wheezing, or asthma?

Yes

No → **SKIP TO ECZEMA SECTION**

2a. Which ones?

Bronchodilator (e.g., Albuterol, Proventil, Proair)

Inhaled steroid (e.g., Flovent, Pulmicort, Asmanex)

Combination inhaled steroid and long-acting beta agonist (e.g., Advair, Dulera, Symbicort)

Montelukast (e.g., Singulair)

Monoclonals or biologics (e.g., Xolair)

Other, please list: _____

EczeMa (Atopic Dermatitis)

1. Has [PARTICIPANT] ever had an itchy rash which was coming and going for at least six months?*

Yes

No → **SKIP TO Q8**

2. Has [PARTICIPANT] had this itchy rash at any time in the past 12 months?**

Yes

No

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

Yes

No

4. At what age did this itchy rash first occur?*

___ ___ years or if unsure of age, was it...

¹ Before 5 years old (before elementary school)

² Between about 5-10 years old (in elementary or middle school)

5. Has this itchy rash resolved?

¹ Yes

⁰ No → **SKIP TO Q6**

5a. At what age did the itchy rash resolve?

___ ___ years or if unsure of age, was it...

¹ Before 5 years old (before elementary school)

² Between about 5-10 years old (in elementary or middle school)

6. Has this itchy rash cleared completely at any time during the past 12 months?*

¹ Yes

⁰ No

7. In the past 12 months, how often, on average, has [PARTICIPANT] been kept awake at night by this itchy rash?*

¹ Never in the past 12 months

² Less than one night per week

³ One or more nights per week

8. Has [PARTICIPANT] ever had eczema (also called **atopic dermatitis**)?***

¹ Yes [Complete POEM form]

⁰ No → **SKIP TO FOOD ALLERGY SECTION**

8a. Has a doctor or health care provider ever diagnosed [PARTICIPANT] with eczema or **atopic dermatitis**?

¹ Yes [Complete POEM form]

⁰ No

Food Allergy

1. Do you believe that [PARTICIPANT] has ever had a **food allergy**?

¹ Yes

⁰ No

2. Has a doctor or other health care provider ever diagnosed [PARTICIPANT] with a food allergy?

¹ Yes

⁰ No

⁰ Don't know

→ [IF NO OR DON'T KNOW TO BOTH Q1 AND Q2, SKIP TO ANAPHYLAXIS SECTION]

3. [For the questions below, indicate if participant has ever tried the listed food (column 1), whether caretaker believes participant has been allergic to the food at any point in participant's life (column 2), whether a doctor or other healthcare provider said participant is allergic to the food (column 3), participant's age in years that the allergy was first noticed (column 4), and whether caretaker believes the participant is still allergic to the food item (column 5).

For each food, if the caretaker selected they believe (column 2) or a doctor or healthcare provider has said the participant is allergic to the food (column 3), complete both the age allergy to the food first noticed (column 4) and still allergic to the food (column 5) questions; otherwise these two questions can be skipped.]

		(1)	(2)	(3)	(4)	(5)
	Food	Has [PARTICIPANT] ever tried the food?	Does caretaker believe [PARTICIPANT] has been allergic to the food?	Has a doctor or healthcare provider said [PARTICIPANT] is allergic to the food?	Age (in years) allergy to food first noticed?	Still allergic to food?
3a.	Egg	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3b.	Cow's Milk	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3c.	Peanut	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3d.	Tree nuts (e.g., walnut, almond, hazelnut, cashew, pistachios)	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3e.	Wheat	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3f.	Soy	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3g.	Shellfish (e.g., shrimp, lobster, crab, mussels)	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3h.	Fish (e.g., salmon, tuna, cod)	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3i.	Other (specify) _____	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No
3j.	Other (specify) _____	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	— —	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No

4. [For each food in Q3 above where caretaker selected they believe or a doctor or healthcare provider has said (columns 2 or 3) participant is allergic to the food, indicate the reaction participant had to the food within 2 hours of eating it. If no food items were selected for these two questions in Q3, SKIP TO ANAPHYLAXIS SECTION.]

	Food	Reaction [Select all that apply]								
		No Reaction	Vomiting or Stomach Pain	Diarrhea	Swelling	Hives	Worsened eczema	Cough, wheeze, or chest tightness	Loss of Consciousness	Other reaction
4a.	Egg	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4b.	Cow's Milk	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4c.	Peanut	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4d.	Tree nuts (e.g., walnut, almond, hazelnut, cashew, pistachio)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4e.	Wheat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4f.	Soy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4g.	Shellfish (e.g., shrimp, lobster, crab, mussels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4h.	Fish (e.g., salmon, tuna, cod)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4i.	Other (specify) _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
4j.	Other (specify) _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>

Anaphylaxis

1. Does [PARTICIPANT] have a history of anaphylaxis (severe allergic reaction)? Symptoms include trouble breathing, swelling of the lips, or low blood pressure. Anaphylaxis may also require treatment with epinephrine, such as an Epinephrine Auto-Injector or EpiPen.

- 1 Yes
- 0 No → [SKIP TO NEXT FORM]

2. What caused any episodes of anaphylaxis? [Select all that apply.]

- 1 Insect sting or bite
- 2 Medication
- 3 Latex
- 4 Exercise
- 5 Medical test
- 6 Other reaction, please specify: _____
- 7 Don't know

The majority of the questions included in the Airways Questionnaire are very slightly modified (based on changing medical terminology) versions of the validated International Study of Asthma and Allergies in Childhood (ISAAC) questionnaires (developed in Europe). Questions with an asterisk are identical to ISAAC; questions with two asterisks are ISAAC questions that have been modified slightly by adding clarifying words reflecting terms more frequently used in recent years and in the United States or to account for the fact that these questions are not required to be asked on an annual basis. These modifications are highlighted in yellow.

More information can be found on the ISAAC website: <http://isaac.auckland.ac.nz/resources/tools.php?menu=tools1>, and the following publications:

- Asher MI, Keil U, Anderson HR, Beasley R, Crane J, Martinez F, Mitchell EA, Pearce N, Sibbald B, Stewart AW, Strachan D, Weiland SK, Williams HC. International study of asthma and allergies in childhood (ISAAC): rationale and methods. *Eur Respir J* 1995; 8: 483-91.
- Weiland SK, Björkstén B, Brunekreef B, Cookson WO, von Mutius E, Strachan DP, and the ISAAC Phase Two Study Group. Phase II of the International Study of Asthma and Allergies in Childhood (ISAAC II): rationale and methods. *Eur Respir J* 2004; 24(3): 406-12.
- Ellwood P, Asher MI, Beasley R, Clayton TO, Stewart AW, and the ISAAC Steering Committee. The International Study of Asthma and Allergies in Childhood (ISAAC): Phase Three rationale and methods. *Int J Tuberc Lung Dis* 2005; 9(1): 10-6.