


ENDIA: Environmental Determinants of Islet Autoimmunity 	Version number: 121009	Page 1 of 3
	Maternal Lifestyle Postpartum Questionnaire	
	Date of completion ____/____/____	Affix Participant Clinical Label Here

0. In the past three months, did your child receive any breast milk either through breast feeding or via expressed breast milk?

Yes (procedure to question 1)

No (skip to question 4)

1. In the past three months, on how many days did you consume any of the following drinks:

	Never	Less than one day per month	1-3 days per month	1 day per week	2-5 days per week	More than 5 days per week
1.1 Cow's milk*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2 Other milk including soy, rice, almond, goat or sheep milk*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3 Coffee containing caffeine (includes iced coffee)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4 Decaffeinated coffee (includes iced coffee)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5 Tea containing caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.6 Decaffeinated/herbal tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.7 Other drinks containing caffeine (e.g. cola, Red Bull, V)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Include flavoured milk and milk added to tea, coffee, cereal, etc.

On the days when you did consume these drinks in the past three months, how much on average did you consume based on the suggested average serving sizes:

	Average serving size	Did not consume	Less than 1 serve	1-2 serves	2-3 serves	More than 3 serves
1.8 Cow's milk*	250 mL glass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.9 Other milk including soy, rice, almond, goat or sheep milk*	250 mL glass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.10 Coffee containing caffeine (includes iced coffee)	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.11 Decaffeinated coffee (includes iced coffee)	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.12 Tea containing caffeine	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.13 Decaffeinated/herbal tea	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.14 Other drinks containing caffeine (e.g. cola, Red Bull, V)	250 mL can	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Include flavoured milk and milk added to tea, coffee, cereal, etc. For example, a small amount of cow's milk in tea may represent a ¼ cup. The milk component of white tea/coffee should be recorded in addition to the tea/coffee itself.

Conducting staff member initials _____
Entered into ENDIA database ____/____/____

2. In the past three months, how often did you consumed the following foods:

		Never	Less than once per month	1-3 days per month	1 day per week	2-5 days per week	More than 5 days per week
2.1	Dairy products including butter, cheeses, cream, yoghurt, custard and ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2	Soy containing products including tofu, miso, soy sauce, soy flour and soy-based dairy substitutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.3	Wheat containing products including breads, biscuits, cakes, breakfast cereals, pastries, pasta, couscous, dim sims and wontons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.4	Barley or rye containing products including barley water, many minestrone-style soups and rye bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.5	Rice and/or rice containing products including rice milk, rice cereals, rice cakes, rice noodles and rice flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.6	Corn and/or corn containing products including popcorn, polenta, corn flakes, corn tortillas and corn flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.7	Oats or oat containing products including porridge, oatmeal, muesli, ANZAC biscuits, bran and oat flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please provide details of any dietary supplements you have taken in the past three months, the frequency you took them and size of the dose (for example, 1 tablet, 5 mL, etc.). The frequency is based on the estimated number of days you took the supplement. For example, if you took a multivitamin every 2nd day this would equate to 45 days in the past three months and therefore you would tick the "31-60 days" box.

		Frequency					Amount taken
		Never	0-30 days	31-60 days	61-90 days	Daily	
3.1	Pregnancy/lactation supplement brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.2	Other Multivitamin brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.3	Omega-3/fish oil/cod-liver oil brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.4	Iron brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.5	Other: brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

4. For ENDIA staff only. Refer to maternal antibiotic usage in the Infant Feeding Diary, otherwise leave blank.

5. In the past three months, how many cigarettes did you smoke on average (tick one item only):

	I did not smoke and have never been a smoker	<input type="checkbox"/>
	I did not smoke but have previously been a smoker	<input type="checkbox"/>
	Less than 1 cigarette per week	<input type="checkbox"/>
5.1	2 - 6 cigarettes per week	<input type="checkbox"/>
	1 - 5 cigarettes per day	<input type="checkbox"/>
	6 - 10 cigarettes per day	<input type="checkbox"/>
	More than 10 cigarettes per day	<input type="checkbox"/>

Which one of the following best describes your current household (tick one item only)?

5.2	Members of my household smoke at home, inside the house	<input type="checkbox"/>
	Members of my household smoke at home, only outside the house and never inside	<input type="checkbox"/>
	Members of my household are smokers but they don't smoke at home, inside or outside	<input type="checkbox"/>
	Nobody in my household is a smoker	<input type="checkbox"/>

6. How many of the following people, including yourself, currently reside in your household:

Adults: _____

Children: _____

7. Which of the following describes your household now (tick all that applies):

7.1	We have a dog that comes inside	<input type="checkbox"/>
7.2	We have a dog that lives outside and doesn't come inside	<input type="checkbox"/>
7.3	We have a cat that comes inside	<input type="checkbox"/>
7.4	We have a cat that lives outside and doesn't come inside	<input type="checkbox"/>
7.5	We have a furred pet that is not a cat or dog	<input type="checkbox"/>
7.6	We do not have any furred pets – cats, dogs or otherwise	<input type="checkbox"/>

8. Which of the following best describes your child's **current** sleeping situation over the majority of the night (tick one item only)?

8.1	My child and I co-sleep in the same bed	<input type="checkbox"/>
	My child sleeps in the same room as me but in his/her own bed	<input type="checkbox"/>
	My child sleeps in a different room to me, and co-sleeps with his/her sibling(s) in the same bed	<input type="checkbox"/>
	My child sleeps in a different room to me, in his/her own bed but shares the room with a sibling	<input type="checkbox"/>
	My child sleeps in a different bedroom to me, in his/her own bed and does not share a room	<input type="checkbox"/>

9. In the **past three months**, has your child participated in any of the following activities (tick all that applies)?

9.1	Mother's group	<input type="checkbox"/>
9.2	Playgroup	<input type="checkbox"/>
9.3	Childcare at a dedicated childcare centre	<input type="checkbox"/>
9.4	Childcare in family daycare involving children from other families	<input type="checkbox"/>
9.5	None of the above	<input type="checkbox"/>

This is the end of the questionnaire, thank you for participating.