

Attach identification
label here



Infancia y Medio Ambiente

IDNUM

PARTICIPATING CENTRES

Application time:

INCLUSION VISIT (10-13 SG)	Mother's General Questionnaire Food Frequency Questionnaire n° 1
VISIT 28-32 SG	Changes in the General Questionnaire Food Frequency Questionnaire n° 2 Work Exposure Questionnaire Environmental Exposure and Life style Questionnaire

Mother's General Questionnaire:

- I. IDENTIFICATION DETAILS**
- S. SOCIODEMOGRAPHIC DETAILS**
- L. WORK HISTORY**
- P. DETAILS ABOUT THE FATHER**
 - PL. FATHER'S WORK HISTORY
 - PC. CONSUMPTION HISTORY
- R. REPRODUCTIVE HISTORY**
 - RP. PREVIOUS OBSTETRIC HISTORY
 - RE. PREVIOUS PREGNANCY HISTORY
 - RAC. CONTRACEPTIVES
 - RA. PRESENT PREGNANCY
- M. MEDICAL ANTECEDENTS**
 - MF. FAMILY ILLNESSES
 - MC. MOTHER'S CHRONIC ILLNESSES
 - MM. MEDICAL HISTORY
- A. ALLERGY ANTECEDENTS**
 - F. CONSUMPTION OF MEDICINE
 - V. VACCINES
 - C. COMPLICATIONS
 - E. END OF INCLUSION VISIT (VI)

Mother's Work Exposure Questionnaire:

- PREGNANCY WORK HISTORY**
- TIME WORKING**

Mother's Environment and Lifestyle Questionnaire:

- HOME**
 - BEDROOM
 - KITCHEN
 - HEATING-AIR CONDITIONING
 - EXTERIOR
- TOBACCO**
- LIFE STYLES**
 - COSMETICS AND OTHERS
 - USE AND CONSUMPTION OF WATER
- TIME-ACTIVITY AND TRAVEL**
- PERCEPTIONS ABOUT THE ENVIRONMENT**

Mother's Food Frequency Questionnaire**(CFA)****FOOD GROUPS**

- I. DAIRY PRODUCTS
- II. EGGS, MEAT, FISH
- III. VEGETABLES, PULSES
- IV. FRUIT
- V. BREAD, CEREALS & THE LIKE
- VI. OIL, FAT & SWEETS
- VII. DRINKS & OTHERS

VITAMIN OR MINERAL SUPPLEMENTS**EATING HABITS****PHYSICAL ACTIVITY**

GENERAL QUESTIONNAIRE: INCLUSION VISIT (V₁)

PERSONAL IDENTIFICATION DETAILS

FIRST NAME:

SURNAMES:

DATE OF BIRTH: □□□□□□□□ NATIONAL ID:

HEALTH CARD (SIP):.....

PRIMARY CARE CENTRE you belong to:

NATIONAL HEALTH SERVICE NUMBER (NSS):

LA FE's CLINICAL HISTORY N°:

PRESENT ADDRESS

Street

N°

Floor

Door

Town

PC

Home telephone:

Telephone at work:

Mobile telephone(s):

e-mail address:

Telephone N° of possible contacts (relatives, friends)

Relationship:

Telephone:

Mobile:

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I. IDENTIFICATION DETAILS

Preinclusion ID: _____

LAST MENSTRUATION DATE: _____

PROBABLE DATE OF BIRTH: _____

DATE OF SIGNATURE OF INFORMED CONSENT	
DATE OF INTERVIEW	
TIME OF THE BEGINNING OF THE INTERVIEW	
PLACE OF INTERVIEW	
COMPANION (<i>State Relationship</i>)	
INTERVIEWER'S NAME	

S. SOCIODEMOGRAPHIC DETAILS

S1. Place of birth (town)	S2. Province/Region	S3. Country	S1 _____ S2 _____ S3 _____ S4 _____
S4. Ethnic group: (<i>Do not ask this question, answer considering the person's aspect and check only if not sure</i>) 1 White 2 Asian 3 Black 4 Arab (including North of Africa and Middle East) 5 Gypsy 6 American Indian 7 Others, specify 9 Doesn't know / No answer			S5 _____ S6 _____
S5. How long have you lived in your present town? N° years _____ N° months _____			
S6. When did you start living in your present home? (month, year) _____			
S7. If fewer than 10 years, fill in the information below (go backwards starting from your last address up to 10 years)			
Street, n°	Town/ Province/Country	From (month, year)	To (month, year)
		_____	_____
		_____	_____
		_____	_____
		_____	_____
		_____	_____
		_____	_____
		_____	_____
S8. What area of your town do you live in? 1 Built-up area or suburb 2 Housing development 3 Country 9 Doesn't know / No answer			S8 _____
S9. What's your marital status? 1 Married or with regular partner 2 Unmarried 3 Separated or divorced 4 Widowed 5 Others, specify 9 Doesn't know / No answer			S9 _____

P. DETAILS ABOUT THE FATHER

P1. How old is the father? Date of birth
 or age

P1
 P1a

P2. Where was he born?:

P2a. Town

P2b. Province/Region

P2c. Country

P2a
 P2b
 P2c

P3. What ethnic group does he belong to? (your partner's race)

- 1 White
- 2 Asian
- 3 Black
- 4 Arab (including North of Africa and Middle East)
- 5 Gypsy
- 6 Native American
- 7 Others, state
- 9 Doesn't know / No answer

P3

P4. How tall is the father, approximately? **cm**

P4

P5. How much does the father weigh, approximately? **Kg**

P5

P6. What education level has the father completed? (do not read the options)

- 1 He can't read nor write
- 2 Without education or unfinished primary school
- 3 Primary school (EGB, primary school, ESO)
- 4 Secondary school (BUP, COU, FP)
- 5 University studies
- 6 Others (state).....

P6

PL. FATHER'S WORK HISTORY

PL1. What is the father's present employment situation?

- 1 Worker
- 2 Unemployed IF THE ANSWER IS 1 OR 4 GO TO QUESTION PL3
- 3 Student
- 4 Leave Why?:.....
- 5 Pensioner/allowance Why?:.....
- 6 Others (state):
- 9 Doesn't know / No answer

PL1

PL2. (Only if he isn't working) Has he worked during the last 10 years?

- 1 Yes
- 2 No
- 9 N.A. IF THE ANSWER IS NO or N.A. GO TO QUESTION PC1

PL2

IDNUM

PL3. Regarding the present job or jobs done during the last 10 years by the father, could you give us the following information? (start with the present or last job and go backwards to cover the period of 10 years in case of other jobs)

Term of the contract: Time worked in the firm (starting date, stopping date)
Activity of the firm: What does the firm do?
Post: What is the worker's position in the firm?
Tasks: What sort of tasks does the worker do in his job?
Exposure: Is the worker exposed, at work, to chemicals (metals, solvents, etc.), to physical elements (noise, vibrations, radiations, extreme temperatures) or biological elements (bacteria, virus)? If so, give nature and type of exposure.

Term of the contract	Activity of the firm	Post	Tasks	Exposure
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				
From / To / Month Year				

PC. CONSUMPTION HISTORY

PC1. In a typical week, how many glasses or drinks does your partner usually have?

	During the week	Weekend
a. Beer		
b. Wine or champagne		
c. Brandy, spirits		
d. Whiskey, gin, vodka, rum		

PC1ad		PC1as	
PC1bd		PC1bs	
PC1cd		PC1cs	
PC1dd		PC1ds	

R. REPRODUCTIVE HISTORY

RP. PREVIOUS OBSTETRIC HISTORY

RP1. How many pregnancies - excluding the present one – have you had?

RP1

IF THE ANSWER IS **NONE** GO TO QUESTION RAC1

RP2. Did you notice any increase of hair on your face, breast or other parts of the body in any previous pregnancy?

RP2

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

RP2a. In how many pregnancies?

RP2a

RP3. Has any doctor ever diagnosed any of the complications below in previous pregnancies?

	Number of pregnancy when the problem appeared									
	1	2	3	4	5	6	7	8	9	10
a. No problems										
b. Hypertension during pregnancy										
c. Preeclampsia										
d. Eclampsia										
e. Gestational diabetes										
f. Cervical incompetence										
g. Others, specify										

RP3a

RP3b

RP3c

RP3d

RP3e

RP3f

RP3g

I AM NOW GOING TO ASK YOU SOME QUESTIONS REGARDING YOUR PREVIOUS PREGNANCIES AND BIRTHS

(Please consider all the pregnancies regardless of the way they finished)

IDNUM

RE. HISTORY OF PREVIOUS PREGNANCIES																				
Nº	RE.1 Abortion 1) Spontaneous 2) Induced 3) No		RE.2 Date of birth or end of pregnancy. (Day Month Year)		RE.3 Newborn child 1) Alive 2) Dead		RE.4. Duration of pregnancy (weeks)		RE.5 Child's weight (grams)		RE.6 Sex 1) Boy 2) Girl 9) N.A.		RE.7 Birth type 1) Vaginal 2) Caesarean 3) Forceps 4) Cupping glass		RE.8 Weeks of lactation		RE.9 Child's malformation 1) Yes 2) No		RE.10 Is the child alive? 1) Yes 2) No	
	1	RE1.1	<input type="checkbox"/>	RE2.1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.1	<input type="checkbox"/>	RE4.1	<input type="checkbox"/> <input type="checkbox"/>	RE5.1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.1	<input type="checkbox"/>	RE7.1	<input type="checkbox"/>	RE8.1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.1	<input type="checkbox"/>	RE10.1
2	RE1.2	<input type="checkbox"/>	RE2.2	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.2	<input type="checkbox"/>	RE4.2	<input type="checkbox"/> <input type="checkbox"/>	RE5.2	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.2	<input type="checkbox"/>	RE7.2	<input type="checkbox"/>	RE8.2	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.2	<input type="checkbox"/>	RE10.2	<input type="checkbox"/>
3	RE1.3	<input type="checkbox"/>	RE2.3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.3	<input type="checkbox"/>	RE4.3	<input type="checkbox"/> <input type="checkbox"/>	RE5.3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.3	<input type="checkbox"/>	RE7.3	<input type="checkbox"/>	RE8.3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.3	<input type="checkbox"/>	RE10.3	<input type="checkbox"/>
4	RE1.4	<input type="checkbox"/>	RE2.4	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.4	<input type="checkbox"/>	RE4.4	<input type="checkbox"/> <input type="checkbox"/>	RE5.4	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.4	<input type="checkbox"/>	RE7.4	<input type="checkbox"/>	RE8.4	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.4	<input type="checkbox"/>	RE10.4	<input type="checkbox"/>
5	RE1.5	<input type="checkbox"/>	RE2.5	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.5	<input type="checkbox"/>	RE4.5	<input type="checkbox"/> <input type="checkbox"/>	RE5.5	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.5	<input type="checkbox"/>	RE7.5	<input type="checkbox"/>	RE8.5	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.5	<input type="checkbox"/>	RE10.5	<input type="checkbox"/>
6	RE1.6	<input type="checkbox"/>	RE2.6	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.6	<input type="checkbox"/>	RE4.6	<input type="checkbox"/> <input type="checkbox"/>	RE5.6	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.6	<input type="checkbox"/>	RE7.6	<input type="checkbox"/>	RE8.6	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.6	<input type="checkbox"/>	RE10.6	<input type="checkbox"/>
7	RE1.7	<input type="checkbox"/>	RE2.7	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.7	<input type="checkbox"/>	RE4.7	<input type="checkbox"/> <input type="checkbox"/>	RE5.7	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.7	<input type="checkbox"/>	RE7.7	<input type="checkbox"/>	RE8.7	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.7	<input type="checkbox"/>	RE10.7	<input type="checkbox"/>
8	RE1.8	<input type="checkbox"/>	RE2.8	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.8	<input type="checkbox"/>	RE4.8	<input type="checkbox"/> <input type="checkbox"/>	RE5.8	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.8	<input type="checkbox"/>	RE7.8	<input type="checkbox"/>	RE8.8	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.8	<input type="checkbox"/>	RE10.8	<input type="checkbox"/>
9	RE1.9	<input type="checkbox"/>	RE2.9	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.9	<input type="checkbox"/>	RE4.9	<input type="checkbox"/> <input type="checkbox"/>	RE5.9	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.9	<input type="checkbox"/>	RE7.9	<input type="checkbox"/>	RE8.9	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.9	<input type="checkbox"/>	RE10.9	<input type="checkbox"/>
10	RE1.0	<input type="checkbox"/>	RE2.0	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE3.0	<input type="checkbox"/>	RE4.0	<input type="checkbox"/> <input type="checkbox"/>	RE5.0	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE6.0	<input type="checkbox"/>	RE7.0	<input type="checkbox"/>	RE8.0	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RE9.0	<input type="checkbox"/>	RE10.0	<input type="checkbox"/>

RE1 . If the answer is “Yes” in a child’s malformation, please specify the type of malformation (in case of more than one child, tick no. of pregnancy and specify)

Type of Malformation/s _____

RE12. If the answer is “No” to is the child alive?, specify (in case of more than one child, tick no. of pregnancy and specify)

Age (days, months or years) _____, cause of the death _____

RAC. CONTRACEPTIVES

RAC1. Have you ever used an IUD as a contraceptive?

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

RAC1a. If it was a hormone IUD, please say how long for. (calculate the time corresponding to every period you used it, if there have been interruptions, and then add up the total number of months and/or years):

- 1 < 1 year
- 2 1-2 years
- 3 2-5 years
- 4 > 5 years
- 9 Doesn't know / No answer

RAC1

RAC1a

RAC 2

RAC2a

RAC3

RAC3a1

RAC3a2

RAC3a3

RAC3a4

RAC3a5

RAC3a6

RAC3a7

RAC3a8

RAC3a9

RAC3b

RAC3c

RAC2. Have you ever used oral, injection or implant contraceptives?

- 1 Yes
- 2 No
- 9 N.A.

RAC2a. How long have you used them for? (calculate the time corresponding to every period you used them, if there have been interruptions, and then add up the total number of months and/or years)

- 1 < 1 year
- 2 1-2 years
- 3 3-5 years
- 4 6-10 years
- 5 11-15 years
- 6 >15 years
- 9 Doesn't know / No answer

RAC3. Have you used a contraceptive method before this pregnancy?

- 1 Yes
- 2 No

IF THE ANSWER IS **NO** GO TO QUESTION RA1

RAC3a. Could you tell me which one? (the last one you used)

	Yes	NO	N.A.
1. Device, IUD	1	2	9
2. Injections	1	2	9
3. Contraceptive pills	1	2	9
4. Ovules	1	2	9
5. Sponge with spermicidal	1	2	9
6. Diaphragm	1	2	9
7. Sheath or condom	1	2	9
8. Coitus interruptus	1	2	9
9. Others, specify:	1	2	9

RAC3b. When did you stop using this contraceptive method?

Date:

Day Month Year

RAC3c. Did you stop using it to get pregnant?

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

IF THE ANSWER IS **YES** GO TO QUESTION RA3

RA. PRESENT PREGNANCY

RA1. Did you get pregnant on purpose?.....

- 1 Yes
- 2 No
- 3 Had not planned it
- 9 Doesn't know / No answer

RA1

RA2. When did you start trying to get pregnant?

(month, year):

RA2

RA3. How many prenatal visits have you had in the Primary Care Centre (CAP) before this first visit in the hospital? N°

RA3

RA4. How many prenatal visits have you had in a private gynaecologist's surgery before this first visit in the hospital? N°

RA4

RA5. Date of the 1st prenatal visit (CAP or private gynaecologist):

RA5

RA6. How much did you weigh before this pregnancy approximately?

Kg

RA6

RA7. Height in cm (check): cm

RA7

RA8. Have you been sick during this pregnancy?

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

RA8

RA8a. When did it start? Month of pregnancy

RA8a

RA8b. How long for? (weeks)

RA8b

RA8c. Have you gone into hospital for this reason?

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

RA8c

RA9. Have you had a high temperature since the beginning of the pregnancy?

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

RA9

RA9a. What week of your pregnancy?

RA9a

RA9b. Date (month, year)

RA9b

RA10. Have you noticed any increase of hair on your face, breast or other parts of the body during this pregnancy?

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

RA10

RA10a. What was the doctor's diagnosis?.....

RA10a

RA1

RA2

RA3

RA4

RA5

RA6

RA7

RA8

RA8a

RA8b

RA8c

RA9

RA9a

RA9b

RA10

RA10a

M. MEDICAL ANTECEDENTS				
MF. FAMILY ILLNESSES				
MF1. Has anyone living with you been diagnosed any infectious illness during the last <u>six months</u> ? (tuberculosis, HIV, viral exanthematic illnesses such as German measles, chickenpox, etc.):				
MF1a. Type of problem		MF1b. Person affected		
	MF1a.1 <input type="checkbox"/>		MF1b.1 <input type="checkbox"/>	
	MF1a.2 <input type="checkbox"/>		MF1b.2 <input type="checkbox"/>	
	MF1a.3 <input type="checkbox"/>		MF1b.3 <input type="checkbox"/>	
	MF1a.4 <input type="checkbox"/>		MF1b.4 <input type="checkbox"/>	
	MF1a.5 <input type="checkbox"/>		MF1b.5 <input type="checkbox"/>	
Among your close relatives and the child's father's				
MF2. Have there been any problems...? :		Yes	No	N.A.
a) To have children		1	2	9
b) Regarding repeated abortions		1	2	9
c) Sterility (no children)		1	2	9
If all the answers are No , go to MF5				
MF3. Type of problem		MF4. Relative affected		
	MF3.1 <input type="checkbox"/>		MF4.1 <input type="checkbox"/>	
	MF3.2 <input type="checkbox"/>		MF4.2 <input type="checkbox"/>	
	MF3.3 <input type="checkbox"/>		MF4.3 <input type="checkbox"/>	
	MF3.4 <input type="checkbox"/>		MF4.4 <input type="checkbox"/>	
	MF3.5 <input type="checkbox"/>		MF4.5 <input type="checkbox"/>	
MF5. Do you know if anyone in your family, yourself, the child's father or the latter's family, were born with?:		Yes	No	N.A.
a) Hereditary or chromosomal diseases		1	2	9
b) Congenital malformations		1	2	9
c) Serious diseases		1	2	9
If all the answers are No , go to MC1				
MF6. Specify the type of problem		MF7. Relative affected		
	MF6.1 <input type="checkbox"/>		MF7.1 <input type="checkbox"/>	
	MF6.2 <input type="checkbox"/>		MF7.2 <input type="checkbox"/>	
	MF6.3 <input type="checkbox"/>		MF7.3 <input type="checkbox"/>	
	MF6.4 <input type="checkbox"/>		MF7.4 <input type="checkbox"/>	

MC. MOTHER'S CHRONIC ILLNESSES

MC1. Has a doctor ever diagnosed you any of the illnesses below?

Illnesses	Yes	No	Age when diagnosed
a. Diabetes (not related to pregnancies)	1	2	
b. Heart conditions	1	2	
c. Alterations of blood coagulation	1	2	
d. Renal and suprarenal diseases	1	2	
e. Alterations of the thyroid gland	1	2	
f. Tuberculosis	1	2	
g. HIV infection	1	2	
h. Anxiety	1	2	
i. Depression	1	2	
j. Urinary tract affection	1	2	
k. Chronic intestinal inflammatory disease	1	2	
l. Reproductive apparatus tumours	1	2	
m. Others, specify:	1	2	

MC1a
 MC1b
 MC1c
 MC1d
 MC1e
 MC1f
 MC1g
 MC1h
 MC1i
 MC1j
 MC1k
 MC1l
 MC1m

MM. MEDICAL HISTORY

MM1. Have you had x-rays taken in the last 10 years?

- 1 Yes
- 2 No
- 9 N.A.

IF THE ANSWER IS **No** or **N.A.** GO TO QUESTION **MM1b**

MM1 1a

MM1a. How many radiographs have you been taken, when, what part of your body and why in the last 10 years?

Nº radiographs	Year	Part of the body	Cause

MM1b. Did you have any x-ray taken before 18 years of age?

- 1 Yes
- 2 No
- 9 Doesn't know / No answer

MM1b

IDNUM

C. COMPLICATIONS APPEARED SINCE THE BEGINNING OF THE PREGNANCY

Note: Add extra pages if necessary.

C1. Have you had any problems?	C1.1 Were you examined in a Primary Care Centre for this problem?	C1.2. Have you been examined in Accident & Emergency or in a Specialised Centre or by a Private Specialist for this problem?
1 High temperature 2 Urinary infection 3 High blood pressure 4 Liquid or blood leakage through the vagina 5 Contractions 6 Others, specify	1 Yes 2 No C1.1a Where and who saw you?..... C1.1b Date: C1.1c What was the diagnosis? C1.1d Treatment received? C1.1e Information obtained from the mother's card? 1 Yes 2 No	1 Yes 2 No C1.2a. Specify place and name of the doctor C1.2b. Date: C1.2c What was the diagnosis? C1.2d Treatment received? C1.2e. Information obtained from a medical report? 1 Yes 2 No
C2. Have you had any problems?	C2.1 Were you examined in a Primary Care Centre for this problem?	C2.2. Have you been examined in Accident & Emergency or in a Specialised Centre or by a Private Specialist for this problem?
1 High temperature 2 Urinary infection 3 High blood pressure 4 Liquid or blood leakage through the vagina 5 Contractions 6 Others, specify	1 Yes 2 No C2.1a Where and who saw you?..... C2.1b Date: C2.1c What was the diagnosis? C2.1d Treatment received? C2.1e Information obtained from the mother's card? 1 Yes 2 No	1 Yes 2 No C2.2a. Specify place and name of the doctor C2.2b. Date: C2.2c What was the diagnosis? C2.2d Treatment received? C2.2e. Information obtained from a medical report? 1 Yes 2 No
C3. Have you had any problems?	C3.1 Were you examined in a Primary Care Centre for this problem?	C3.2 Have you been examined in Accident & Emergency or in a Specialised Centre or by a Private Specialist for this problem?
1 High temperature 2 Urinary infection 3 High blood pressure 4 Liquid or blood leakage through the vagina 5 Contractions 6 Others, specify	1 Yes 2 No C3.1a Where and who saw you?..... C3.1b Date: C3.1c What was the diagnosis? C3.1d Treatment received? C3.1e Information obtained from the mother's card? 1 Yes 2 No	1 Yes 2 No C3.2a. Specify place and name of the doctor C3.2b. Date: C3.2c What was the diagnosis? C3.2d Treatment received? C3.2e. Information obtained from a medical report? 1 Yes 2 No

END OF THE INCLUSION VISIT (V1)

COLLECTION OF SAMPLES FOR INMA	
Time of the end of the General Questionnaire and FFQ	□□: □□
FFQ Nº 1 Done	YES NO
If FFQ Nº 1 has NOT been taken → Date Arranged	□□□□ □□□□
“La Fe” SCREENING taken	Blood Sample YES NO
	Ultrasound Scan YES NO
If not, date arranged for SCREENING	Blood Sample □□□□ □□□□
	Ultrasound Scan □□□□ □□□□
Date of the next visit in the “LA FE” hospital (20th week)	□□□□ □□□□
12th week urine sample	YES NO
12th week fingernail sample	YES NO
COMPREHENSION:	
1. Estimated level of comprehension of the questionnaire:	1. Excellent 2. Good 3. Medium 4. Poor
2. Who answers the questions regarding the husband or partner?	1. He himself 2. Woman 3. Others
INTERVIEWER'S REMARKS	