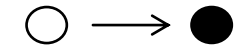
Study No:

Using a **PENCIL** fill in the circles like this



DO NOT tick or cross the circles

An eraser can be used to rectify mistakes

RHINO Health questionnaire for school age children

Today's date: _____

Person completing the questionnaire:

Mother (M)

Father (F)

Other (O) Who? _____

1. Has your child ever had wheezing or whistling in the chest at <u>any time</u> in the past?

Yes (Y) No (N) Unsure (U)

IF YOU HAVE ANSWERED "NO" PLEASE GO TO <u>QUESTION 10</u>.

2. Has your child had wheezing or whistling in the chest <u>in the last 12 months</u>?

Yes (Y) No (N) Unsure (U)

IF YOU HAVE ANSWERED "NO" PLEASE GO TO <u>QUESTION 10</u>.

3. How many attacks of wheezing has your child had <u>in the last 12 months</u>?

None (N) 1 to 3 (1) 4 to 12 (4) More than 12 (>)

4. <u>In the last 12 months</u>, how often, on average, has your child's sleep been disturbed due to wheezing?

a. Never woken with wheezing (Y)

b. Less than one night per week (Y)

c. One or more nights per week (Y)

5. <u>In the last 12 months</u>, has wheezing ever been severe enough to limit your child's speech to only one or two words at a time between breaths?

Yes (Y) No (N) Unsure (U)

6. Has a doctor ever told you that your child has asthma?

Yes (Y) No (N) Unsure (U)

7. <u>In the last 12 months</u>, has your child's chest sounded wheezy during or after exercise?

Yes (Y) No (N) Unsure (U)

8. <u>In the last 12 months</u>, has your child had a dry cough at night, apart from a cough associated with a cold or a chest infection?

Yes (Y) No (N) Unsure (U)

9. <u>In the last 12 months</u>, has your child ever used any regular asthma inhalers (pumps) or medicines?

Yes (Y) No (N) Unsure (U)

If yes, please provide the name (or colour of the pump) with details of how often used:

_____

_____

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10. Is there a family history of:

	Yes	No
a. Asthma	Ⓨ	Ⓝ
b. Eczema	Ⓨ	Ⓝ
c. Hayfever	Ⓨ	Ⓝ
d. Allergies	Ⓨ	Ⓝ

11. In the last 12 months, has your child had any chest infections?

Yes Ⓨ No Ⓝ Unsure Ⓤ

12. In the last 12 months, how many chest infections has your child had?

None Ⓝ 1 to 3 ① 4 to 10 ④ More than 10 ⑤

13. In the last 12 months, how many courses of antibiotics has your child had?

None Ⓝ 1 to 3 ① 4 to 10 ④ More than 10 ⑤

14. In the last 12 months, how many admissions (overnight or longer) has your child had to hospital for breathing problems?

None Ⓝ 1 to 3 ① 4 to 10 ④ More than 10 ⑤

15. Does the child's mother smoke cigarettes?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, how many per day?

1 to 10 ① 11 to 20 ② More than 20 ⑤

Did the child's mother smoke during the pregnancy?

Yes Ⓨ No Ⓝ Unsure Ⓤ

16. Does the child's father smoke cigarettes?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, how many per day?

1 to 10 ① 11 to 20 ② More than 20 ⑤

17. Do any other house members smoke cigarettes?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, how many per day for the whole household?
(Please add up all the cigarettes which are smoked by everyone living in the same household including the mother).

1 to 10 ① 11 to 20 ② More than 20 ⑤

18. Who else lives in the same house as the child?

Mother Ⓜ Father Ⓕ Brother/s Ⓑ Sister/s Ⓢ Other Ⓞ

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19. Has your child ever been diagnosed with any breathing problems (e.g. asthma, cystic fibrosis, BPD/CLD etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

20. Has your child ever been diagnosed with any other conditions (e.g. diabetes, epilepsy etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

21. Is your child on any medication?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

22. Does your child take part in any physical activity such as cycling, swimming or dancing?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details of how often and for how long:

_____

_____

23. Does your child have any learning problems?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

24. Does your child have any problems with their behaviour (hyperactive, disruptive, aggressive etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

25. Does your child have an educational statement?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

26. Does your child have any problems with moving (difficulty walking, use of a wheelchair etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

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27. Does your child have any problems with using their hands (difficulty writing, difficulty feeding etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

28. Does your child have any problems with their speech (delayed, limited, impediment etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

29. Does your child have any problems with their vision (wears glasses, registered blind etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

30. Does your child have any problems with hearing (partially hearing, wears hearing aids etc.)?

Yes Ⓨ No Ⓝ Unsure Ⓤ

If yes, please provide some details:

_____

_____

Thank you very much for filling in the form.

The following section asks how you are happy for us to use the data or to contact you:

A. Would you and your child be interested in participating in the next part of the RHINO study (home visit)? Is it OK for a member of the RHINO team to contact you to discuss this (if yes please include contact details below)?

Yes Ⓨ No Ⓝ **Please initial the box here** ☐

B. Most healthcare information in Wales is stored on computer databases, As part of this study, we would also like to study how children in Wales have used services such as their GP or hospital. Would you be happy for us to use your son's or daughter's records on these databases?

Yes Ⓨ No Ⓝ **Please initial the box here** ☐

C. If we need to clarify some of your answers, may we contact you (if yes please leave contact details below)?

Yes Ⓨ No Ⓝ **Please initial the box here** ☐

Name, Address, Telephone number &/or email (preferred method of being contacted):

_____

_____

_____

_____ _____ _____ _____

Name of Child Name of Parent/Guardian Date Signature

Thank you very much *for taking the time to fill in the form and for contributing to our research. Could you please send the form in the enclosed self-addressed envelope to:* RHINO Study Team, UGT 155, Department of Child Health, Upper Ground Floor, Cardiff University, School of Medicine, Heath Park, Cardiff, CF14 4XN