

Infant Follow-Up

FGLS Number

 -

Date of birth of infant

 - -

Paediatric Outpatient Record Number

Date of this visit

 - -

Paediatric Hospital Record Number

Was the child part of the Preterm Postnatal Follow-up Study?

 yes no

Please answer all yes/no questions by placing an 'x' in the corresponding box

Section 1: Status of the infant

1. Status of the infant? Alive and healthy Alive with long-term health issues Alive with evidence of chromosomal or congenital abnormalities (e.g. Down's syndrome, hydrocephalus...). If yes, complete an Abnormality form
 Deceased

If yes, please indicate date of death - - and cause of death

Section 2: Medical history - Morbidities

During the 1st year of life, has the infant either **been diagnosed** with or been **admitted to hospital** or **started treatment indicated by a health care provider** for any of the following conditions? (Cross as many as necessary)

- | | | |
|---|---|--|
| 2. Exanthema or skin diseases <input type="checkbox"/> yes <input type="checkbox"/> no | 13. Gastrointestinal parasitosis <input type="checkbox"/> yes <input type="checkbox"/> no | 25. Any haemolytic condition including sickle-cell anaemia or leukaemia <input type="checkbox"/> yes <input type="checkbox"/> no |
| 3. Repeated otitis media (≥3 separate episodes) <input type="checkbox"/> yes <input type="checkbox"/> no | 14. Repeated diarrhoea (≥3 days on ≥3 separate episodes) <input type="checkbox"/> yes <input type="checkbox"/> no | 26. Any malignancy <input type="checkbox"/> yes <input type="checkbox"/> no |
| 4. Repeated pneumonia / acute respiratory infection / bronchiolitis (≥3 separate episodes) <input type="checkbox"/> yes <input type="checkbox"/> no | 15. Persistent vomiting (≥3 episodes) <input type="checkbox"/> yes <input type="checkbox"/> no | 27. Malnutrition / growth problems <input type="checkbox"/> yes <input type="checkbox"/> no |
| 5. Urinary tract infections / pyelonephritis / reflux (≥ 3 separate episodes) <input type="checkbox"/> yes <input type="checkbox"/> no | 16. Hearing problems <input type="checkbox"/> yes <input type="checkbox"/> no | 28. Coeliac disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| 6. Fever (≥3 days on ≥3 separate episodes) <input type="checkbox"/> yes <input type="checkbox"/> no | 17. Asthma <input type="checkbox"/> yes <input type="checkbox"/> no | 29. Metabolic disorders (e.g. PKU, maple syrup disease) <input type="checkbox"/> yes <input type="checkbox"/> no |
| 7. Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no | 18. Neurological disorders <input type="checkbox"/> yes <input type="checkbox"/> no | 30. Any immune disorders <input type="checkbox"/> yes <input type="checkbox"/> no |
| 8. Hepatitis <input type="checkbox"/> yes <input type="checkbox"/> no | 19. Seizures <input type="checkbox"/> yes <input type="checkbox"/> no | 31. Injury / trauma <input type="checkbox"/> yes <input type="checkbox"/> no |
| 9. Meningitis <input type="checkbox"/> yes <input type="checkbox"/> no | 20. Cerebral palsy <input type="checkbox"/> yes <input type="checkbox"/> no | 32. Any condition requiring surgery. Indicate diagnosis: <input type="text"/> |
| 10. HIV / AIDS <input type="checkbox"/> yes <input type="checkbox"/> no | 21. Cardiovascular problems <input type="checkbox"/> yes <input type="checkbox"/> no | 33. Any other conditions. Indicate diagnosis: <input type="text"/> |
| 11. Malaria <input type="checkbox"/> yes <input type="checkbox"/> no | 22. Cystic fibrosis <input type="checkbox"/> yes <input type="checkbox"/> no | |
| 12. Any other infection requiring antibiotic /antiviral treatment (≥3 separate episodes) <input type="checkbox"/> yes <input type="checkbox"/> no | 23. Blindness / major visual problems <input type="checkbox"/> yes <input type="checkbox"/> no | |
| | 24. Gastroesophago-pharyngeal reflux <input type="checkbox"/> yes <input type="checkbox"/> no | |

34. Was the infant admitted to hospital? yes no
35. Number of separate admissions
36. Total number of days in hospital (all admissions)
37. Diagnosis for 1st admission
38. Diagnosis for 2nd admission
39. Diagnosis for 3rd admission

Section 3: Infant anthropometry

- | | | |
|--|---|---|
| 1 st set of anthropometric measurements | Repeat measurements, if required | Repeat measurements, if required |
| 40. Weight <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> kg | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> kg | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> kg |
| 41. Length <input type="text"/> <input type="text"/> . <input type="text"/> cm | <input type="text"/> <input type="text"/> . <input type="text"/> cm | <input type="text"/> <input type="text"/> . <input type="text"/> cm |
| 42. Head circumference <input type="text"/> <input type="text"/> . <input type="text"/> cm | <input type="text"/> <input type="text"/> . <input type="text"/> cm | <input type="text"/> <input type="text"/> . <input type="text"/> cm |

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Section 3: Infant anthropometry (continued)

2nd set of anthropometric measurements

43. Weight . kg

44. Length . cm

45. Head circumference . cm

Repeat measurements, if required

. kg

. cm

. cm

Repeat measurements, if required

. kg

. cm

. cm

Section 4: Medical history - Treatments

During the 1st year of life, which of the following treatments have been prescribed by a health care provider?

46. Iron, B12, Folic acid or other vitamins yes no 52. Anticonvulsants yes no 58. Antivirals yes no

47. Antibiotics (≥3 regimens on separate episodes) yes no 53. Non-steroidal anti-inflammatory agents yes no 59. Gastrointestinal agents yes no

48. Antitussives or expectorants (≥3 regimens) yes no 54. Antipyretics yes no 60. Any other treatment. yes no

49. Bronchodilators yes no 55. Blood transfusion yes no Indicate treatment:

50. Glucocorticoids yes no 56. Diuretics yes no 61. Is the child up-to-date with local vaccination policy? yes no

51. Antacids yes no 57. Oxygen yes no (country-specific)

Section 5: Maternal status

62. Is the mother alive? or deceased? If deceased, skip to Q67

63. Is she pregnant? yes no 64. Is she working outside the home? yes no If no, skip to Q66

65. How old was the baby when she returned to work? mths wks

66. Does the mother smoke? yes no if yes, indicate number of cigarettes/day

67. Does the father/partner smoke? yes no if yes, indicate number of cigarettes/day

68. Is the child attending a nursery or a day care centre? yes no

69. If yes, how old was the child when (s)he first went to nursery or a day care centre? mths wks

Section 6: Next examination

Please now arrange the next follow-up examination (1 year from 1st birthday / 2 years from birth)

70. Date of the next study examination - -

Name of Researcher	<input type="text"/>				
Signature	<input type="text"/>				
Researcher Code	<input type="text"/> <input type="text"/>	Code of 1 st anthropometrist	<input type="text"/> <input type="text"/>	Code of 2 nd anthropometrist	<input type="text"/> <input type="text"/>