**PERINATAL FACTORS & DEVELOPMENT QUESTIONNAIRE (Singleton Version)**

Person completing questionnaire:________________________________________________Today's date:___________________
Mailing Address______________________________________________________________________________________
E-mail:______________________________________________________Phone Number: ______________________________

DIRECTIONS**:** Please answer the following questions as best you can. If you think you know the answer to a question but are unsure, mark your answer with a "?" If you have no idea, please write "**unknown**". If you prefer not to answer a particular question, please write "**skip**". If you need any help completing this questionnaire, please contact Ellyn Sheffield by phone (732-445-5231) or email (sheffield@ruccs.rutgers.edu).

Child's Name:_______________________________________________________________________ Sex:_ Male _ Female
Date of Birth_________Due Date:__________Gestational age (at birth in weeks): ___________ Birth weight:______________

**I. DESCRIPTION OF YOUR FAMILY**. Please fill this section out whether you are the biological or adoptive parent/legal guardian of this child. You will be asked to give biological family information only in specifically worded questions. If you would like to tell us something that isn't covered about you, your child's biological parents, your household arrangements, etc., please use the back of this questionnaire to inform us.

**Ethnicity**: _ Hispanic or Latino _ Not Hispanic or Latino

**Race (you may check multiple categories)**: _ American Indian/Alaska Native _ Asian _ Black/African American

_ Native Hawaiian/Other Pacific Islander _ White

Was this child a _ Singleton conception _ Twin conception _ Higher order conception _ Don't Know

If your child's twin (or high order multiple) died, please give date of death, cause of death, and weight of death:
Date of death:__________________Cause of death:________________________________Weight at death:________________
Date of death:__________________Cause of death:________________________________Weight at death:________________

**Mother's** date of birth __________ Does she work outside the home? _ Yes _ No If 'Yes', _ Full-time _ Part-time
How would you classify this work: _ Manual labor _ Semi-skilled labor _ Craftsman _ Service Oriented _ Clerical/Sales
_ Managerial (all levels) _ Professional _ Student _ Other_________________________________________________

**Father's** date of birth ___________ Does he work outside the home? _ Yes _ No If 'Yes', _ Full-time _ Part-time
How would you classify this work: _ Manual labor _ Semi-skilled labor _ Craftsman _ Service Oriented _ Clerical/Sales
_ Managerial (all levels) _ Professional _ Student _ Other_________________________________________________

Does the child live with both of the above parents? _ Yes _ No. If 'No', who does the child live with? (Check all that apply.)

_ Mother _ Father _ Step-Mother _ Step-Father _ Grandparent _ Other relative _ Partner _ Other caretaker

Is the child biologically related to both parents? _ Yes _ No. If 'No', please give the biological mother's age when the child was born _________________________ Biological father's age when the child was born __________________________________________

**Total household income:**

_ < $15,000 _ $15,000-$24,999 _ $25,000-$34,999 _ $35,000-$49,999 _ $50,000-$74,999 _ $75,000- $99,999 _ >$100,000

**Check the highest grade of education completed by mother and father:**

| | Less than 9th grade | 9th through 11th grade | High school graduate | Some college or technical training | College grad (BA/BS) | Advanced degree (Masters/PhD/MD) |
|---|---|---|---|---|---|---|
| Mother | | | | | | |
| Father | | | | | | |

**Brothers and sisters**

| Sibling's name | Sex | Date of birth | Gestational age | Birth weight | Adopted | Step-child | Deceased |
|---|---|---|---|---|---|---|---|
| | | | | | _ | _ | _ |
| | | | | | _ | _ | _ |
| | | | | | _ | _ | _ |
| | | | | | _ | _ | _ |
| | | | | | _ | _ | _ |
| | | | | | _ | _ | _ |

If you suffered any pregnancy losses (e.g., miscarriages, stillbirths) not listed above, please indicate the gestational age at the time of the loss and the cause of the loss. ____________________

____________________

**II. INFORMATION ABOUT THE BIOLOGICAL MOTHER'S OVERALL HEALTH** (If you are not the biological mother, please fill out information about the biological mother as best as you can. If you do not know a particular fact, please write "**unknown"**)

1. Do you have any chronic physical or psychological conditions when you are not pregnant? _ Yes _ No. If 'Yes', please describe:____________________

____________________

____________________

2. Do you regularly take any medications (prescription or nonprescription) when you are not pregnant? _ Yes _ No. If 'Yes', please list: ____________________

____________________

**III. INFORMATION ABOUT THIS PREGNANCY** (If you are not the biological mother, please fill out information about the biological mother as best as you can. If you do not know a particular fact, please write **'unknown'**.)

1. What did you weigh when you became pregnant? __________What did you weigh when you delivered?________
2. How many cigarettes/day did you smoke while pregnant? _______________
3. How many alcoholic drinks/day did you have while pregnant? ________________
4. List any vitamins or supplements you took while pregnant________________________________________
5. List any nonprescription drugs you took while pregnant (e.g., over-the-counter drugs, herbal remedies, marijuana etc.)

____________________

____________________

____________________

6. How many weeks pregnant were you when you first received prenatal care? ________________________________________
7. Was this pregnancy the result of infertility treatment? _ Yes _ No If 'Yes', check all methods that were used to achieve this pregnancy: _ Ovulation induction _ Intrauterine insemination _ IVF _ GIFT/ZIFT _ ICSI _ Donor Egg _ Donor Sperm

**8. Pregnancy complications/pregnancy health problems.** If you suffered any of the following problems, please indicate when in the pregnancy the problem was **first** diagnosed and any treatments that were given (check all that apply).

| **Preterm Labor** | **Premature Rupture of Membranes** |
|---|---|
| Week diagnosed_______________ | Week diagnosed _______________________ |
| _ Bedrest | _ Bedrest |
| _ Hospitalization | _ Hospitalization |
| _ Contraction monitor | _ Fetal heart monitor |
| _ IV hydration | _ Fetal ultrasounds |
| _ Anti-contraction drugs (oral or patch) | _ IV hydration |
| _ Anti-contraction drugs (injection or pump) | _ Antibiotics |
| _ IV Magnesium sulfate | _ Steroids |
| _ Steroids | _ Trandelenburg position (legs higher than head) |
| _ Antibiotics | _ Delivery |
| _ Delivery | _ Other___________________________________ |
| _ Other _________________________________ | |

**Preeclampsia (Pregnancy-induced hypertension)**
Week diagnosed________________________________
_ Bedrest
_ Aspirin
_ Hospitalization
_ Oral blood pressure medications
_ IV Magnesium sulfate
_ Steroids
_ Delivery
_ Other______________________________________

**HELLP syndrome**
Week diagnosed____________________________
_ Hospitalization
_ Oral blood pressure medication
_ IV Magnesium sulfate
_ Steroids
_ Platelets
_ Blood transfusion
_ Delivery
_ Other__________________________________

**Eclampsia (seizures due to high blood pressure)**
Week diagnosed________________________________
_ Oral blood pressure medications
_ IV Magnesium Sulfate
_ Steroids
_ Delivery
_ Other______________________________________

**Incompetent cervix**
Week diagnosed____________________________
_ Bedrest
_ Hospitalization
_ Cerclage
_ Trandelenburg position (legs higher than head)
_ Other______________________________________

**Intrauterine Growth Restriction (IUGR)**
Week diagnosed____________________________
_ Bedrest
_ Hospitalization
_ Aspirin
_ Steroids
_ Fetal ultrasound
_ Fetal heart monitor
_ Delivery
_ Other______________________________________

**Fetal distress (decreased movement, heart rate)**
Week diagnosed____________________
_ Bedrest
_ Hospitalization
_ Fetal heart monitor
_ Fetal ultrasound
_ Delivery
_ Other______________________________________

**Vaginal bleeding (other than 1st trimester spotting)**
Week diagnosed____________________
_ Bedrest
_ Hospitalization
_ IV hydration
_ Blood transfusion
_ Delivery
_ Other______________________________________

**Placental abruption**
Week diagnosed______________________________
_ Bedrest
_ Hospitalization
_ IV hydration
_ Blood transfusion
_ Delivery
_ Other__________________________________

**Placental previa**
Week diagnosed______________________________
_ Self correcting
_ Blood transfusion
_ Cesarean-section delivery
_ Other______________________________________

**Loss of twin (or higher order multiple)**
Week diagnosed______________________________
_ Hospitalization
_ Steroids
_ Fetal heart monitor
_ Fetal ultrasound
_ Delivery of twin
_ Other______________________________________

| **Uterine infection**<br>Week diagnosed____________________<br>_ Hospitalization<br>_ Antibiotics (oral)<br>_ Antibiotics (IV)<br>_ Delivery<br>_ Other____________________ | **Urinary tract infection**<br>Week diagnosed____________________<br>_ Antibiotics (oral)<br>_ Antibiotics (IV)<br>_ Diet (for example: cranberry juice)<br>_ Hospitalization<br>_ Other____________________ |
|---|---|
| **Too little amniotic fluid**<br>Week diagnosed____________________<br>_ Bedrest<br>_ Hospitalization<br>_ Frequent ultrasounds<br>_ IV Hydration<br>_ Steroids<br>_ Delivery<br>_ Other____________________ | **Too much amniotic fluid**<br>Week diagnosed____________________<br>_ Frequent ultrasounds<br>_ Medication (to reduce fetal urine production)<br>_ Extraction of amniotic fluid<br>_ Hospitalization<br>_ Steroids<br>_ Delivery<br>_ Other____________________ |
| **Blood clots**.<br>Week diagnosed____________________<br>_ Compression stockings<br>_ Oral anticoagulants<br>_ Heparin<br>_ Other____________________ | **Gestational diabetes**<br>Week diagnosed____________________<br>_ Diet control<br>_ Oral anti-diabetic medication<br>_ Insulin<br>_ Other____________________ |
| **Other** ____________________<br>Week diagnosed____________________<br>Treatment____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________ | **Other** ____________________<br>Week diagnosed____________________<br>Treatment____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________ |
| **Other** ____________________<br>Week diagnosed____________________<br>Treatment____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________ | **Other** ____________________<br>Week diagnosed____________________<br>Treatment____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________ |

**9. Prenatal drugs. If you took any drugs while pregnant, please indicate when you took them and why. If you were given more than one course of the drug, list the courses separately.** A "course" refers to a treatment course, not the number of doses received. For example, if a doctor prescribes once-a-day antibiotics for 10 days, this is a single "course" (and 10 doses). Betamethasone is usually given as 2 shots in a 24-hour period, so 2 shots in 24 hours means **one** course. Dexamethasone is usually given as a series of 4 shots in a 24-hour period, so 4 shots in 24 hours means **one** course.
**Example**: A mother received 1 course of magnesium sulfate at 30 weeks for preterm labor and 1 course at 36 weeks for preeclampsia. Because the mother threatened to deliver prematurely, the mother also got weekly betamethasone shots from weeks 28 through 31 to speed up fetal lung maturation. This mother should fill out the chart this way:

| **Drug** | **How Administered** | **# courses** | **Week given** | **Reason** |
|---|---|---|---|---|
| Magnesium sulfate | | 2 | 30, 36 | P Preterm Labor P Preeclampsia _ Eclampsia<br>_ Other________________________ |
| Steroid:<br>Betamethasone (Celestone) | P Injection | 4 | 28, 29, 30, 31 | P Fetal Lung Maturation<br>_ Other_______________________ |

| **Drug** | **How Administered** | **# courses** | **Week given** | **Reason** |
|---|---|---|---|---|
| Magnesium sulfate | _ IV | | | _ Preterm Labor _ Preeclampsia _ Eclampsia<br>_ Other________________________________ |
| Anti-hypertension drugs other than Magnesium sulfate | _ Oral _ IV<br>_ Injection | | | _ Hypertension _ Other_________________ |
| Terbutaline (Brethine) | _ Oral _ IV<br>_ Injection _ Pump | | | _ Preterm Labor _ Other_________________ |
| Indomethacin (Indocin) | _ Oral<br>_ Suppository | | | _ Preterm Labor _ Decrease Amniotic Fluid<br>_ Other________________________________ |
| Nifedipine (Procardia, Adalat) | _ Oral | | | _ Preterm Labor _ Other_________________ |
| Nitroglycerin | _ Oral _ Patch | | | _ Preterm Labor _ Other_________________ |
| Ritodrine (Yutopar) | _ IV | | | _ Preterm Labor _ Other_________________ |
| Other Anticontraction Drug (don't know name) | _ Oral _ Injection<br>_ IV _ Patch<br>_ Suppository | | | _ Preterm Labor<br>_ Other________________________________ |
| Steroid:<br>Betamethasone (Celestone) | _ Injection | | | _ Fetal Lung Maturation<br>_ Other________________________________ |
| Steroid:<br>Dexamethasone (Decadron) | _ IV<br>_ Injection | | | _ Fetal Lung Maturation<br>_ Other________________________________ |
| Steroid: Hydrocortisone (Hydrocortone) | _ IV<br>_ Injection | | | _ Fetal Lung Maturation<br>_ Other________________________________ |
| IV/Injected Steroid (Don't know name) | _ IV<br>_ Injection | | | _ Fetal Lung Maturation<br>_ Other________________________________ |
| Steroids (oral or inhaled) | _ Oral _ Inhaled | | | _ Asthma _ Other_________________ |
| Oral anti-diabetes drugs | _ Oral | | | _ Diabetes _ Other_________________ |
| Insulin | _ Injection | | | _ Diabetes _ Other_________________ |
| Antibiotics | _ Oral _ Injection<br>_ IV | | | _ Uterine Infection _ Group B Strep<br>_ Other infection _ Other_________________ |
| Heparin | _ Injection _ IV | | | _ Blood clot _ Clotting disorder _ Autoimmune disorder _ Other___________________________ |
| Aspirin | _ Oral | | | _ Blood clot _ Clotting disorder _ Autoimmune disorder _ Other___________________________ |
| Other (give name) | | | | |
| Other (give name) | | | | |

## IV. INFORMATION ABOUT YOUR CHILD'S BIRTH & NEONATAL PERIOD

1. My child was delivered: _ vaginally _ by cesarean-section

**If you went into labor (even if you ended up having a c-section), please answer questions 2a through 2d:**

2a. Was labor induced? _ Yes _ No. If yes, what method(s) were used? _ Pitocin _ Doctor/midwife ruptured membranes _ Other______________________________

2b. How long were you in active labor? ______________________________

2c. Was your child breech? _ Yes _ No

2d. Were forceps used in the delivery? _ Yes _ No

**If your child was delivered by cesarean-section, please answer questions 3a and 3b:**

3a. Was it a planned (scheduled) c-section? _ Yes _ No. If yes, indicate why (check all that apply) _ Previous c-section _ Breech _ Large baby _ Carrying twins _ Placental previa _ Other ______________________________

3b. If it wasn't planned, why did you have a c-section? (check all that apply) _ Failure of labor to progress _ Fetal distress _ Maternal distress _ Other ______________________________

4. Did your child breathe or cry spontaneously? _ Yes _ No

5. If you know them, give your child's 1 & 5 minute Apgar scores:
   1 minute Apgar ____________ 5 minute Apgar ____________

6. How long did your child stay in the hospital? ______________________________
7. How long did your child stay in a neonatal intensive care unit (NICU)? ______________________________
8. Was your child ever on a ventilator? _ Yes _ No If yes for how long? ______________________________

9. Was your child ever on CPAP? _ Yes _ No If yes, for how long? ______________________________

10. How noisy was your child's NICU?
   _ Quiet enough to hear and converse in whispers
   _ Quiet enough to carry on a normal conversation, as if you were at home with your spouse or significant other
   _ Quiet enough to carry on a normal conversation, but with a TV or appliance going, or kids yelling in the background.
   _ Too noisy to carry on a normal conversation, so that you had to raise your voice somewhat or repeat yourself to be heard.
   _ So noisy that you found yourself raising your voice a lot, and even shouting to be heard.

11. Was music pumped through speakers into the NICU? _ Yes _ No _ Sometimes _ Don't Remember
   If yes, how loud: _ Barely audible _ Soft _ Normal listening level _ Loud _ Very loud

12. The NICU generally was: _ Quieter at night _ Quieter during the day _ No difference _ Don't Remember

13. How often did you notice noises (bells, beeps, alarms, etc.) in the NICU?
   _ Less than once an hour _ Once or twice an hour _ Every 5 to 10 minutes _ Every few minutes _ Constantly

14. How well-lit was your child's NICU? _ Very dim _ Somewhat dim _ Average _ Somewhat bright _ Very bright

15. Were the lights dimmed at night? _ Always _ Sometimes _ Never _ Don't Remember.

16. Was your child's incubator covered to block out light? _ Always _ Sometimes _ Never _ Don't Remember.

17. Did you touch and hold your child in the NICU? _ Always _ Sometimes _ Never _ Don't Remember.

18. Did you use "kangaroo care" (skin-to-skin contact)? _ Always _ Sometimes _ Never _ Don't Remember.

19. Did you help diaper, feed, etc. your child? _ Always _ Sometimes _ Never _ Don't Remember.

20. Did the NICU staff cluster procedures? _ Always _ Sometimes _ Never _ Don't Know _ Don't Remember.

21. Did the NICU staff practice "developmental care" (services and education based on medical developmental needs, interventions

that families can integrate into daily routines, etc.) _ Yes _ No _ Don't Know _ Don't Remember.

22. Check any drugs that your child was given in the hospital or during the first 3 months of life:

| **Medications** | **Medications** | **Nutritional Supplements** |
| --- | --- | --- |
| _ Antibiotics | _ Aminophylline | _ Sodium |
| _ Antifungals | _ Caffeine | _ Potassium |
| _ Antivirals | _ Indocin | _ Magnesium |
| _ Surfactant | _ Prostaglandin E | _ Calcium |
| _ Synagis | _ Aspirin | _ Iron |
| _ RSV Immunoglobin | _ Heparin | _ Vitamin E |
| _ IV steroid | _ Phenobarbital | _ Vitamin K |
| _ Inhaled steroid | _ Dilantin | _ Multivitamin |
| _ Bronchodialator | _ Valium | _ 20 calorie/oz formula |
| _ Diuretics | _ Narcotic Analgesics | _ 24 calorie/oz formula |
| _ Anti-hypertensives | _ Narcotic Sedatives | _ Elemental formula |
| _ Vasopressor | _ Tagamet | _ Human Milk Fortifier |
| _ Albumin | _ Zantac | _ Medium Chain Oils |
| _ Anti-arhythmia drugs | _ Prilosec | _ Polycose |
| _ Thyroid hormone | _ Reglan | _ Total Parental Nutrition (IV hyperalimentation) |
| _ Other ____________ | _ Propulsid | _ |
| _ Other ____________ | _ Other ____________ | _ Other ____________ |

23a. How much breast milk did your child receive during his/her first 3 months of life? _ None _ Received some supplemental formula _ Exclusively received breastmilk

23b. If s/he received breastmilk, how many months did s/he get it? _ < 1month _ 1-3 months _ 4-6 months _ 7-9 months _ 10-12 months _ > 12 months

**24. Child's Neonatal Complications/Health Problems.** If your child had any of the following problems, indicate when the problem was **first** diagnosed and treatments that were given (Give your child's **chronological age**. For example, if your child had BPD at birth, and s/he was born at 24 weeks, indicate age as **0 weeks**, or if your child had pneumonia 20 weeks after birth indicate age as **20 weeks**.)

| Complication | Chron Age | Treatment |
|---|---|---|
| Anemia | ________weeks | _ Iron _ Blood Transfusion _ Other________________ |
| Apnea | ________weeks | _ Medication _ Apnea monitor _ CPAP _Other___________ |
| Bradycardia | ________weeks | _ Medication _ Other______________________________ |
| Bronchopulmonary Dysplasia (BPD) | ________weeks | _ Surfactant _ Oxygen _ Vent _ CPAP _ Bronchodialator<br>_ IV Steroids _ Inhaled Steroids _ Diuretics _ Other_________ |
| Cardiac arythmias | ________weeks | _ Medication _ Other______________________________ |
| Congestive Heart Failure | ________weeks | _ Diuretics _ Bronchodialator _ Digitalis _ Other___________ |
| Gastroesophogeal Reflux | ________weeks | _ Thickened feed _ Keep head up _ Medication _ Surgery<br>_ Other__________________________________________ |
| Feeding Disorder | ________weeks | _ Caloric supplementation _ Feeding therapy _ Tube Feed<br>_ Other______________________________________________ |
| Genetic disorder (describe) | ________weeks | |
| Failed hearing screening (e.g. BAER test) | ________weeks | |
| Hernia/Hydrocele | ________weeks | _ Surgery _ Other______________________________ |
| High Blood Potassium | ________weeks | _ Calcium Supplement _ Other___________________________ |
| High Blood Pressure | ________weeks | _ Medication _ Other__________________________________ |
| High Blood Sodium | ________weeks | _ Medication _ Other_________________________________ |
| High Blood Sugar | ________weeks | _ Insulin _ Other___________________________________ |
| Hydrocephalus | ________weeks | _ Medication _ Surgical drainage _ Shunt _ Other__________ |
| Hypothyroidism | ________weeks | _ Medication _ Other______________________________ |
| Intraventricular Hemorrhage (IVH)<br>(Indicate grade for each side) | ________weeks | _ Left side _ Grade 1 _ Grade 2 _ Grade 3 _ Grade 4<br>_ Right side _ Grade 1 _ Grade 2 _ Grade 3 _ Grade 4 |
| Jaundice | ________weeks | _ Phototherapy _ Blood transfusion _ Other_________________ |
| Low Blood Calcium | ________weeks | _ Calcium supplement _ Other________________________ |
| Low Blood Pressure | ________weeks | _ Medication _ IV Fluids _ Other______________________ |
| Low Blood Sugar | ________weeks | _ Glucose _ Other___________________________________ |
| Meconium aspiration | ________weeks | _ Antibiotics _ Respiratory support _ Other_______________ |
| Meningitis | ________weeks | _ Antibiotics _ Other__________________________________ |
| Necrotizing Enterocolitis (NEC) | ________weeks | _ Stop feeding _ Antibiotics _ Surgery _ Other____________ |
| Patent Ductus Arteriosus (PDA) | ________weeks | _ Indocin _ Other medication _ Surgery _ Other____________ |
| Periventricular Leukomalacia (PVL) | ________weeks | _ Left side _ Right side |
| Polycythemia (too many red blood cells) | ________weeks | _ IV fluids _ Other_________________________________ |
| Respiratory Distress Syndrome (RDS) | ________weeks | _ Surfactant _ Oxygen _ Vent _ CPAP _ Bronchodialator<br>_ IV Steroids _ Inhaled Steroids _ Diuretics _ Other________ |
| Pneumonia | ________weeks | _ Antibiotics _ Vent _ CPAP _ Oxygen _ Other___________ |
| Retinopathy of Prematurity (ROP)<br>(indicate grade for each side) | ________weeks | _ Left side Grade _____________ _ Cryotherapy<br>_ Right side Grade ____________ _ Cryotherapy |
| Seizures | ________weeks | _ Medication _ Surgery _ Other_________________________ |
| Sepsis (blood infection) | ________weeks | _ Antibiotics _ Other_________________________________ |
| Urinary Tract Infection | ________weeks | _ Antibiotics _ Other______________________________ |

| Complication | Chron Age | Treatment |
|---|---|---|
| Other problem (describe) | ________weeks | |
| Other problem (describe) | ________weeks | |
| Other problem (describe) | ________weeks | |

**V. Neurological/Psychiatric Disorders:** Use an 'X' to indicate if your child has ever been diagnosed with the following:

| | | | |
|---|---|---|---|
| Cerebral Palsy | | Articulation Disorder | |
| Mental Retardation | | Apraxia/Dyspraxia | |
| Attention Deficit Disorder | | Central Auditory Processing Disorder | |
| Hyperactivity | | Specific Language Impairment | |
| Asperger's syndrome | | Stuttering | |
| Autism | | Semantic/pragmatic language disorder | |
| Pervasive Developmental Disorder | | Other spoken language impairment | |
| Schizophrenia | | Dyslexia | |
| Obsessive Compulsive Disorder | | Other written language disorder | |
| Depression | | Nonverbal Learning Disorder | |
| Suicidal tendencies | | Social problems/behavioral immaturity | |
| Anxiety | | Sensory Integration Disorder | |
| Phobias/unusual fears | | Self-mutilating behavior (e.g., head banging, biting self, cutting self) | |
| Feeding disorder | | Tics (verbal, facial, or body) | |
| Eating disorder (bulimia/anorexia) | | Hearing loss _ Left ear _ Right ear _ Both ears | |
| Visual impairment/need for glasses | | Hydrocephalus | |
| Genetic disorder | | Intraventricular Hemorrhage (IVH) _ Grade 1 _ Grade 2 _ Grade 3 _ Grade 4 | |
| Meningitis | | Periventricular Leukomalacia (PVL) | |
| Seizures | | Other neurological/psychological disorder: (describe) | |
| Other neurological/psychological disorder(s): (describe) | | Other neurological/psychological disorder: (describe) | |

My child's IQ is __ < 25 __ 25-39__ 40-54__ 55-69 __ 70-84 __ 85-99 __ 100-114 __ 115-129 __ >129 __ don't know
If your child has any special skills or abilities, please list them: ____________________________________________

________________________________________________________________________________

________________________________________________________________________________

**VI. THERAPY & SPECIAL EDUCATIONAL SERVICES.** If your child has ever received any therapy or special educational services, please fill out the following chart. Use an **"X"** to indicate the services your child received at each age (Use your child's chronological age, **not** your child's age adjusted for prematurity.)

| Therapy or Educational Service | AGE (in chronological years) | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| Speech/language therapy | | | | | | | | | | | | | | | | | | | |
| Feeding therapy | | | | | | | | | | | | | | | | | | | |
| Occupational therapy | | | | | | | | | | | | | | | | | | | |
| Physical therapy | | | | | | | | | | | | | | | | | | | |
| Behavior therapy | | | | | | | | | | | | | | | | | | | |
| Psychological therapy/counseling | | | | | | | | | | | | | | | | | | | |
| Reading specialist | | | | | | | | | | | | | | | | | | | |
| Math specialist | | | | | | | | | | | | | | | | | | | |
| Classroom aide (part-time) | | | | | | | | | | | | | | | | | | | |
| Classroom aide (full-time) | | | | | | | | | | | | | | | | | | | |
| Repeated grade in school | | | | | | | | | | | | | | | | | | | |
| Special classroom (part-time) | | | | | | | | | | | | | | | | | | | |
| Special classroom (full-time) | | | | | | | | | | | | | | | | | | | |
| Other (describe) | | | | | | | | | | | | | | | | | | | |
| Other (describe) | | | | | | | | | | | | | | | | | | | |

| Other (describe) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**VII. DEVELOPMENTAL MILESTONES.** How old (in months) was your child when s/he achieved the following milestones? If you are unsure of when a milestone was achieved, give your best guess and put a '?' next to your answer. If you can't remember when a milestone was achieved at all, check "Don't remember". If your child has not achieved the milestone yet, check "Not Yet". (Use your child's chronological age, **not** his/her age adjusted for prematurity.)

1. Socially smiled at parents (no gas smiles please!): ________________ months _ Don't remember _ Not yet
2. Sat alone (without support): ________________ months _ Don't remember _ Not yet
3. Crawled (not crept) ________________ months _ Don't remember _ Not yet
4. Walked alone (took 5+ independent steps without support): ________________ months _ Don't remember _ Not yet
5. Walked up stairs (holding onto railing is ok): ________________ months _ Don't remember _ Not yet
6. Ran: ________________ months _ Don't remember _ Not yet
7. Scribbled: ________________ months _ Don't remember _ Not yet
8. Cut with scissors: ________________ months _ Don't remember _ Not yet
9. Fed self with fingers: ________________ months _ Don't remember _ Not yet
10. Fed self with fork or spoon: ________________ months _ Don't remember _ Not yet
11. Drank from an open cup: ________________ months _ Don't remember _ Not yet
12. Babbled (said repeated syllables such as "babababa", "dadada" and "gaga"): ________ months _ Don't remember _ Not yet
13. Said single words other than "Mama" & "Dada": ________________ months _ Don't remember _ Not yet
14. Said 2 word sentences (e.g., "Daddy go", "more cookie"): ________________ months _ Don't remember _ Not yet
15. Pronounced words so that most people understood the words: ________________ months _ Don't remember _ Not yet

**VIIIa. Compared to other children who are the same age as my child, my child's development is**

| | Very Delayed | Delayed | Similar | Advanced | Very Advanced |
|---|---|---|---|---|---|
| Cognitive Development | | | | | |
| Fine Motor Development | | | | | |
| Gross Motor Development | | | | | |
| Language Development | | | | | |
| Social Development | | | | | |
| Overall Development | | | | | |

**VIIIb. Compared to my child's biological brothers and sisters, my child's development is**

| | Very Delayed | Delayed | Similar | Advanced | Very Advanced | N/A (no siblings) |
|---|---|---|---|---|---|---|
| Cognitive Development | | | | | | |
| Fine Motor Development | | | | | | |
| Gross Motor Development | | | | | | |
| Language Development | | | | | | |
| Social Development | | | | | | |
| Overall Development | | | | | | |

**VIIIc. Compared to my child's biological brothers and sisters who were FULL TERM, my child's development is**

| | Very Delayed | Delayed | Similar | Advanced | Very Advanced | N/A (no FT siblings) |
|---|---|---|---|---|---|---|
| Cognitive Development | | | | | | |
| Fine Motor Development | | | | | | |
| Gross Motor Development | | | | | | |
| Language Development | | | | | | |
| Social Development | | | | | | |
| Overall Development | | | | | | |

**IX. LANGUAGE BACKGROUND OF CAREGIVERS**

First (primary) language of mother: ________________________________
First (primary) language of father: ________________________________

If your child has regularly been exposed to languages other than English, indicate the language(s), the amount of exposure (in hrs/week), and how old your child was when the exposure occurred (e.g., Spanish, 15 hrs/wk, from age 6 mos-3.5 years)

________________________________________________________________

________________________________________________________________

Thank you for completing this questionnaire. Please use the enclosed pre-addressed, pre-paid envelope to return all completed questionnaires. If you have misplaced the pre-paid envelope, mail your questionnaires to.:

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Perinatal Factors & Language Development Study
Psychology Department & Center for Cognitive Science
152 Frelinghuysen Road
Rutgers University
Piscataway, New Jersey 08854

**X. PAYMENT FOR PARTICIPATION**

_ I would prefer to donate my contribution to The Perinatal Factors & Language Development Study
_ I would prefer to receive a gift certificate from www.amazon.com