

APPENDIX/SUPPLEMENTAL MATERIAL

Table 1: Household Questionnaire

A. BASELINE HOUSEHOLD VISIT	
How many pregnancies have you had?	
How many live births?	
How many of these children are still living?	
How many people live in your household? For each member:	
<ul style="list-style-type: none"> - Relationship to mother - Age - Sex - Head of household? - Country of birth - Race (White/Asian/Black/Native American/other) - Ethnicity (Hispanic/non-Hispanic) - Years of schooling 	
Does your work outside the home include the frequent use of cleaning products or chemicals?	
How often do you bathe, shower or otherwise wash your body? (More than once per day/Daily/Every other day/Every 3-6 days/Once per week or less)	
Are there any pets or domesticated animals that you care for in your house or your yard? (If yes, provide type and number of each.)	
In the past 4 months, has your household had problems with vermin? (If yes, provide type.)	
How would you rate the cleanliness of your household? (Very clean/Acceptably clean/Mildly dirty/Very dirty)	
Description of home	
<ul style="list-style-type: none"> - Number of rooms, sinks, toilets - Residence size (Small / Medium / Large) and type (Home or apartment/ Room with kitchen access/ Room without kitchen access / Shelter or temporary accommodation). 	
Interviewer administered household cleanliness score:	
<ul style="list-style-type: none"> - Floors and carpets - Walls and visible furniture and window-sills - Bathroom and toilet - Kitchen and food 	
Weight of father [once consented]	
B. HOUSHOLD VISIT #1 WITH BABY	
Have you moved home, or changed address, since our last visit? (If yes, describe changes to household composition and residence characteristics)	
Are there any changes in pets or domesticated animals that you care for since our last visit (4 months ago)? (If yes, describe changes)	
Did you have any concerns with vermin since our last visit? (If yes, describe concerns.)	
Baby's sex, race, ethnicity	
How was your baby delivered? (Vaginal/Cesarean)	

Table 1: Household Questionnaire

How much weight did you gain during pregnancy?
Did you ever breastfeed or try to breastfeed your baby, either in the hospital or birth center or after you went home?
In the last seven days, was your baby fed any of the foods listed below? <ul style="list-style-type: none">- Breast milk- Formula- Water- Sugar water- Cow's milk- Other
Does your baby have a regular pediatrician or pediatrician group?
Since the time your baby was discharged from the hospital after birth, has he or she been hospitalized for any reason, or has your baby been taken to a hospital for any outpatient procedure or surgery?
Baby's weight
Interviewer administered household cleanliness score: <ul style="list-style-type: none">- Floors and carpets- Walls and visible furniture and window-sills- Bathroom and toilet- Kitchen and food
C. HOUSEHOLD VISITS #2-9 WITH BABY
Have you moved home, or changed address, since our last visit? (If yes, describe changes to household composition and residence characteristics)
Are there any changes in pets or domesticated animals that you care for since our last visit (4 months ago)? (If yes, describe changes.)
Did you have any concerns with vermin since our last visit? (If yes, describe concerns.)
In the last seven days, was your baby fed any of the foods listed below: <ul style="list-style-type: none">- Breast milk- Formula- Cow's milk- Other milk (soy milk, rice milk, goat milk, etc.)
Does your baby usually sleep or co-sleep in a bed with you or anyone else? If yes, who does he/she co-sleep with? <ul style="list-style-type: none">- Mother- Father- Sibling- Grandparents- Uncle/Aunt- Cousin- Child
How many teeth does your baby have now?
Has your baby had a diagnosis of the following problems since our last visit? <ul style="list-style-type: none">- Reflux

Table 1: Household Questionnaire

<ul style="list-style-type: none">- Asthma- Food allergies- Eczema (atopic dermatitis)- Other
In the last 4 months, has your child visited his/her regular pediatrician's office? <ul style="list-style-type: none">- How many times did he/she visit the pediatrician's office?
In the last 4 months, has your child been seen by any other health care providers (including ERs, urgent care, etc.?) <ul style="list-style-type: none">- How many times did he/she visit another healthcare provider?
In the last 4 months, was your baby cared for by someone other than you on a regular schedule? That is, did someone else regularly keep your baby at least once a week for 3 hours or more at a time? (Include arrangements in which the exact day or time may change if child care usually occurred at least once a week.) If yes, Where did the child care usually occur? <ul style="list-style-type: none">- Baby's home with no other children- Baby's home with other children or baby's brothers or sisters- Other private home with no other children- Other private home with other children or baby's brothers or sisters- Day care or child care center - Other
In the last 4 months, has your child missed attending any days of day care due to illness? How many days did your child miss?
Baby's weight
Interviewer administered household cleanliness score: <ul style="list-style-type: none">- Floors and carpets- Walls and visible furniture and window-sills- Bathroom and toilet- Kitchen and food

Table 2: Weekly Survey

A. MOTHER	
In the past 7 days, have you felt sick or unwell at any time?	
If yes,	How many hours of sleep did you have in the last 24 hours? On a scale from 0 to 4, where 0 is "not physically active at all" and 4 is "extremely active", how do you rate your physical activity level for yesterday? On a scale from 0 to 4, where 0 is "not stressed at all" and 4 is "extremely stressed" how do you rate your stress level today?
If no,	How many days in the past 7 days have you been sick? Did you visit a health care provider for any health concern in the past 7 days (not including routine, scheduled appointments)? How many days in the past 7 have you had a cold or a runny nose? How many days in the past 7 have you had a cough? How many days in the past 7 have you had a fever? How many days in the past 7 have you had diarrhea? How many days in the past 7 have you had vomiting not including morning sickness? How many days in the past 7 did you take antibiotics?
B. BABY	
In the last 24 hours did your baby cry for more than 3 hours straight, unable to be comforted?	
Has your child used a diaper this past week?	
If yes,	Has your baby had diaper rash in the past 7 days?
In the past week, has your child been sick or unwell at any time?	
If no,	Did your baby drink any of the following in the last 24 hours? - Breast milk - Formula - Cow milk or other type of milk? Did you introduce any new foods to your baby in the past 7 days? In the last 24 hours, how many hours in a row was the longest stretch of time that your baby slept?
If yes,	How many days in the past 7 days has your child been sick? Did your child visit a health care provider for any health concern in the past 7 days (not including routine, scheduled appointments)? How many days in the past 7 did your child have a cold or runny nose? How many days in the past 7 did your child have a cough? How many days in the past 7 did your child have a fever? How many days in the past 7 did your child have ear tugging / pulling? How many days in the past 7 did your child have diarrhea? How many days in the past 7 did your child have vomiting? Did your child take antibiotics in the past 7 days? If yes, How many days in the past 7 did your child take antibiotics?