APPENDIX A

MATERNAL-INFANT BONDING SURVEY

Brown, G., Pennington, D., and Madrid, A.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child\_\_\_\_\_\_\_\_\_\_\_\_\_

The following questions are to see if there are any of factors

that may have had some impact on your child’s birth.

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| POSSIBLE PREGNANCY PROBLEMS | Y | N | **?** |
| Had worrisome bleeding during pregnancy |  |  |  |
| Had toxemia |  |  |  |
| Vomited a lot |  |  |  |
| Had to be medicated |  |  |  |
| Gained too much weight |  |  |  |
| Took a lot of illegal drugs |  |  |  |
| Drank excessively |  |  |  |
| Was sick through much of pregnancy |  |  |  |
| Labor lasted longer than 15 hours |  |  |  |
| Had a difficult delivery |  |  |  |
| Had a Caesarean Section |  |  |  |
| Was put to sleep for delivery |  |  |  |
| Got hurt during pregnancy |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **POSSIBLE OTHER PREGNANCY PROBLEMS** | Y | N | **?** |
| Had a previous miscarriage |  |  |  |
| Was overly depressed during pregnancy |  |  |  |
| Was very scared during pregnancy |  |  |  |
| Lost someone close during pregnancy |  |  |  |
| Had marital problems during pregnancy |  |  |  |
| Had serious financial problems during pregnancy |  |  |  |
| Had a serious loss after the child was born |  |  |  |
| Was overly depressed after the child was born |  |  |  |
| Had emotional problems after the child was born |  |  |  |
| Was very sick during delivery |  |  |  |
| Was very sick after the baby was born |  |  |  |
| Child was a twin or triplet |  |  |  |
| Moved during pregnancy or first year |  |  |  |

HOW WAS YOUR RELATIONSHIP TO THE BABY’S FATHER DURING PREGNANCY?

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WHAT HAPPENED TO THE BABY AFTER IT WAS BORN?

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HOW LONG AFTER THE BABY WAS BORN DID YOU HOLD IT?

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WHAT WAS IT LIKE WHEN YOU FIRST HELD THE BABY?

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| --- | --- | --- | --- |
| BABY’S CONDITION | Y | N | **?** |
| Injured during birth |  |  |  |
| Was born jaundiced |  |  |  |
| Had trouble breathing |  |  |  |
| Born with cord around neck |  |  |  |
| Was sick after birth |  |  |  |
| Spent time in an incubator |  |  |  |
| Spent time in an Intensive Care Nursery |  |  |  |
| Was born premature |  |  |  |
| Had an infection |  |  |  |
| Needed oxygen |  |  |  |
| Vomited often |  |  |  |
| Gagged often |  |  |  |
| Was kept in hospital after mother went home |  |  |  |
| Was born breach |  |  |  |

LIST OTHER PROBLEMS THAT OCCURRED DURING PREGANCY, DELIVERY,

OR THE FIRST COUPLE OF MONTHS OF THE BABY’S LIFE.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **BABY’S PROBLEMS IN THE BEGINNING** | **Y** | **N** | **?** |
| Colic |  |  |  |
| Coughed a lot |  |  |  |
| Wheezed |  |  |  |
| Was sickly |  |  |  |
| Difficult to calm or comfort |  |  |  |
| Cried often |  |  |  |
| Was demanding |  |  |  |
| Could not be alone |  |  |  |
| Did not like to be held |  |  |  |
| Irritable |  |  |  |
| Was easily upset |  |  |  |
| Had lots of mucous |  |  |  |
| Was frightened easily |  |  |  |
| Seemed in pain a lot |  |  |  |
| Difficult to console |  |  |  |
| Feeding difficulties |  |  |  |
| Was not affectionate |  |  |  |

ANY OTHER THOUGHTS ABOUT YOUR BABY IN THE FIRST YEAR OF LIFE?

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ANY OTHER THOUGHTS ABOUT YOU OR YOUR FAMILY DURING PREGNANCY, BIRTH, OR THE FIRST YEARS OF YOUR CHILD’S LIFE?

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ANY OTHER THOUGHTS ABOUT YOUR CHILD’S CONDITION?

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Thank you!

APPENDIX B

# CHILD INFORMATION

CHILD'S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_\_\_

Parent's name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This questionnaire asks lots of questions about your child’s condition. Please answer the best you can, even though you may contradict yourself in places. It’s all right. We’ll get the idea of your child’s health through all of this.

Age when child was diagnosed with asthma \_\_\_\_\_\_\_\_

Age when symptoms began:\_\_\_\_\_

Who made the diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did this occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Course of asthma:

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What are your child's triggers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Child's symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What medications is your child taking, how much and how often?

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## (Step)

Your child's daytime symptoms are:

None 2 days a week or less

greater than twice a week

daily continual

Your child's night time symptoms are:

none 2 nights or less a month

more than 2 nights a month

more than once a week frequent

How many doctor visits for asthma in the last 6 months? \_\_\_\_

How many Emergency Room visits in the last 6 months? \_\_\_\_\_

How many hospitalizations in the last 6 months?\_\_\_

Total days? \_\_\_\_

How many times did your child use oral steroids in the last 6 months?\_\_\_ Total days\_\_\_

Days absent from school or housebound last 6 months? \_\_\_\_\_

Wheezes with exercise? never sometimes frequently

almost always always \_\_\_\_\_

Child's overall health (A-F): \_\_\_\_\_\_

Child's overall energy level (A-F): \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Monitor)**

Please check ONE answer for each the the questions.

1. In the past 4 weeks, how much of the time did your child's asthma keep him/her from getting much done at school or at home?

* none of the time \_\_\_
* a little of the time
* some of the time
* most of the time
* all of the time

1. During the past 4 weeks, how often has your child had shortness of breath?

not at all \_\_\_

* once or twice a week
* 3-6 times a week
* once a day
* more than once a day

1. During the past 4 weeks, how often did your child's asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

* not at all \_\_\_
* once or twice
* once a week
* 2 to 3 times a week
* 4 or more nights a week

1. During the past 4 weeks, how often has your child used the rescue inhaler or nebulizer medication (such as albuterol)?

* not at all \_\_\_
* once a week or less
* a few times a week
* 1 or 2 times a week
* 3 or more times a week

1. How would you rate your child's asthma control during the past 4 weeks?

* completely controlled \_\_\_
* well controlled
* somewhat controlled
* poorly controlled
* not controlled at all

**\_\_\_**