Ccontrol

Date of visit	__________________ (mm-dd-yyyy)
1. What is the participant's date of birth?	__________________ (mm-dd-yyyy)
2. Does your child have sickle cell disease or trait?	○ Yes ○ No ((if yes, stop-ineligible))
3. What is the participant's gender?	○ male ○ female
4. Is your child African American (Black)?	○ Yes ○ No
5. Was your child born before 35 weeks gestational age?	○ Yes ○ No ((if yes, stop-ineligible))
6. Was your child hospitalized in an intensive care nursery in the first month of life?	○ Yes ○ No ((if yes, stop-ineligible))
7. Does your child have any cogenital problems of the lungs or chest?	○ Yes ○ No ((if yes, stop-ineligible))
8. Has a doctor ever told you that your child has asthma?	○ Yes ○ No ((if yes, stop-ineligible))
9. Does your child have any active or chronic lung disease (ie: asthma, sarcoidosis)?	○ Yes ○ No ((if yes, stop-ineligible))

10. Has your child been hospitalized for respiratory disease (ie: Pneumonia, RSV) in the last two years? ((if yes, stop-ineligible))

○ Yes ○ No

11. Has your child has any wheezing (whistling sounds)during any of these in the last year? (Check all that apply):

☐ With a cold ☐ Without a cold ☐ At any time of day

12. Has your child smoked cigarettes in the past year?	○ Yes ○ No ((if yes, stop-ineligible))
13. Are there any family members in the home who smoke now?	○ Yes ○ No ((if yes, stop-ineligible))

14. Has your child used smokeless tobacco products (chew, snuff) in the past year?

◯ Yes
◯ No
((if yes, stop-ineligible))

15. Does your child have a history of gastroesophageal reflux that is not controlled by standard medical therapy? ((if yes, stop-ineligible))

◯ Yes ◯ No

16. Has your child had any acute respiratory infection (colds) in the past 3 weeks? (If so, then postpone the visit for at least 3 weeks)

◯ Yes ◯ No

17. Comments

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