

## **Appendix A**

### **Parent's and Child Health Questionnaire**

Parent's Questionnaire  
Air Pollution and Pediatric Health Impact Study

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### A Note from Dr. Crist

Thank you so much for helping us with this project. You are providing information that will help the Ohio Environmental Protection Agency and others make decisions about air pollution levels.

The answers that you provide in this questionnaire will not be connected to your child in any way. All information will be studied and reported as group information only, without identification. By completing this questionnaire, you are giving us permission to analyze your responses along with the responses of the parents of the other children at school.

Please answer every question carefully and accurately. If you have trouble answering any questions or need help completing the questionnaire, please contact the school principal, who will then contact me. I will arrange for one of my co-workers to get back to you to provide assistance.

Every child who turns in a completed questionnaire will receive a small gift as a sign of our appreciation.

## PARENT'S QUESTIONNAIRE

## INSTRUCTIONS:

1. This booklet asks about your child's health and well-being. Your individual answers will not be shared with anyone.
2. If choose not to participate it will not affect your child's grades.
3. Answer the questions by placing an X in the appropriate box or by filling in the appropriate blank.
4. Please answer each question. Certain questions may look alike but each one is different. Some questions ask about problems your child may not have. That's great, but it's important for us to know. Please answer each question.
5. There are no right or wrong answers. If you are unsure how to answer a question, please give the best answer you can and make a comment in the margin.
6. All comments will be read, so please feel free to make as many as you wish.

1. In general, would you say your child's health is:  
 Excellent          Very good          Good          Fair          Poor

2. Is your child:  
 Male                  -Female

3. What is your child's date of birth?

Month                          Day Year

The following questions pertain mainly to your child's chest. Please place a check next to *yes* or *no* if possible. If a question does not appear to be applicable to your child, check the *does not apply* box.

COUGH

4a. Does he/she usually have a cough with colds? Yes No Does not apply

4b. Does he/she usually have a cough apart from colds? Yes No Does not apply

*If you answered YES to 4a or 4b, please answer questions 4c and 4d.*

4c. For how many years has he/she had this cough?

Number of years

4d. Does he/she cough on most days (4 or more days per week) for as much as three months of the year?

Yes

No

WHEEZING

5a. Has your child ever had an attack of wheezing that has caused him/her to be short of breath? Yes No

*If you answered YES to 5a, please answer questions 5b through 5e.*

5b. Has he/she had 2 or more such episodes? Yes No

5c. Has he/she ever required medicine or treatment for any of the episodes? Yes No

5d. How old was this child when he/she had his/her first such attack?

5e. Is or was his/her breathing completely normal between attacks? Yes No

6. Does your child ever get attacks of wheezing after he/she has been playing hard or exercising? Yes No

CHEST ILLNESSES

7a. During the past 3 years has this child had any chest illness that has kept him/her from usual activities for as much as 3 days?

Yes

No

*If you answered YES to 7a, please answer questions 7b, 7c, and 7d.*

7b. Did he/she bring up more phlegm or seem more congested than usual with any of these illnesses? .

Yes

No

7c. How many illnesses like this has he/she had in the past 3 years?

Less than 1 illness per year

1 illness per year

2-5 illnesses per year

More than 5 illnesses per year

7d. How many of these illnesses have lasted for as long as 7 days?

8. Was he/she ever hospitalized for a severe chest illness or chest cold before the age of 2 years?

Yes, only once      Yes, 2 times      Yes, 3 or more times      NO

9. Did your child have any other severe chest illness or chest cold before the age of 2 years?

Yes

No

#### OTHER ILLNESSES

10. Has your child had any of the following illnesses, and if yes, give the age at which it first occurred.

a. Measles (not German)	Yes	No	At age
b. Sinus trouble	Yes	No	At age
c. Bronchiolitis	Yes	No	At age
d. Bronchitis	Yes	No	At age
e. Asthmatic bronchitis	Yes	No	At age
f. Pneumonia	Y e s	N o	At age
g. Whooping cough	Yes	No	At age
h. Croup	Yes	No	At age
i. Cystic fibrosis	Yes	No	At age

11. Did the doctor ever say that your child had eczema before the age of 2 years? Yes NO

12. Does or did your child have external ear (ear canal) infections (swimmer's ear)? Yes No

### ASTHMA

13a. Has a doctor ever said that your child had asthma? Yes No

*If you answered YES to 13a, please answer questions 13b, 13c, and 13d.*

13b. At what age did his/her asthma begin?

13c. Does he/she still have asthma?

Yes

No

13d. Does he/she currently take medicine or treatment for asthma? Yes No

*If you answered NO to 13c, please answer question 13e.*

13e. At what age did his/her asthma stop?

### ALLERGY

14. Has a doctor ever said that your child had an allergic reaction to pollen or dust? Yes No

### OTHER

15a. Does anyone in the family staying in this house with you smoke cigarettes, cigars, or pipes?

Yes

No

15b. If yes, how many people smoke including parents?

1          2          3          4          5 and more

15c. If people in the house smoke cigarettes, how many cigarettes do they smoke each day?

Less than 10

10-20

20-40

More than 40

15d. If people in the house smoke cigars or pipes, how many cigars or pipes do they smoke each day?

1-2

2-3

4-5

More than 5

16. Is there an air-conditioner in your house? Yes No

17. Are there any pets in your house?

Yes          No

COMMENTS: Is there anything else that you think is important for us to know about your child's health or other conditions to which your child is exposed?

Date \_\_\_\_\_

Thank you for completing the questionnaire.

Please fill out the card below with your child's name and the name of your child's teacher. At school, the card will be removed so that your child's name will not be on this form.

Your child should now return the entire questionnaire to his/her classroom teacher. -

Parents who do not return the questionnaire will be contacted at a later date.

## Child Health Questionnaire - Parent Report CHQ-PF28

### INSTRUCTIONS -

1. This booklet asks about your child's health and well-being. Your Individual answers will not be shared with anyone.
2. If you choose not to participate It will not affect the care you receive.
3. Answer the questions by marking the appropriate box 12L
4. Certain questions may look alike but each one Is different Some questions ask about problems your child may not have. That's great, but it's Important for us to know. Please answer each question.
5. There are no right or wrong answers. If you are unsure how to answer a question, please give the best answer you can and make a comment In the margin.
6. All comments will be read, so please feel free to make as many as you wish.

**SECTION 01: YOUR CHILD'S GLOBAL HEALTH**

1.1. In general, would you say your child's health is:

Excellent                  Very good                  Good                  Fair                  Poor

**SECTION #2: YOUR CHILD'S PHYSICAL ACTIVITIES**

The following questions ask about physical activities your child might do during a day

2.1. During the last 4 weeks, has your child been limited in any of the following activities due to health problems?

		Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
a.	Doing things that take a lot of energy, such as playing soccer or running?	0	0	0	0
b.	Doing things that take some energy such as riding a bike or skating?	0	0	0	0
c.	Bending, lifting, or stooping?	0	0	0	0

**SECTION 03: YOUR CHILD'S EVERYDAY ACTIVITIES**

3.1. During the past 4 weeks, has your child been limited in the AMOUNT of time he/she could spend on schoolwork or activities with friends due to EMOTIONAL difficulties or problems with his/her BEHAVIOR?

0	0	0	0
Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited

3.2. During the past 4 weeks has your child been limited in the KIND of schoolwork or activities he/she could do with friends due to problems with his/her PHYSICAL health?

0	0	0	0
Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited

SECTION #4: PAIN

4.1. During the past 4 weeks, how often has your child had bodily pain or discomfort?

0	0	0	0	0	0
None of the time		Once or twice	A few times	Fairly often	Very often Every/almost every day

SECTION #5: GETTING ALONG

Below is a list of items that describe children's behavior or problems they sometimes have.

5.1. How often during the past 4 weeks did each of the following statements describe your child?

	Very Often	Fairly Often	Sometimes	Almost Never	Never
a. argued a lot	0	0	0	0	0
b. had difficulty concentrating or paying attention	0	0	0	0	0
c. lied or cheated	0	0	0	0	0

5.2. Compared to other children your child's age, in general would you say -his/her behavior -is:

0	0	0	0	0
Excellent	Very good	Good	Fair	Poor

SECTION #6: GENERAL WELL-BEING

6.1. During the past 4 weeks, how much of the time do you think your child:

All of the time	Most of the time	Some of the time	A little of the time	None of the time
0	0	0		0
	0	0		0
	0	0		0

- a. felt lonely?
- b. acted nervous?
- c. acted bothered or upset?

SECTION X7: SELF-ESTEEM

The following ask about your child's satisfaction with self, school, and others. It may be helpful If you keep In mind how other children your child's age might feel about these areas.

7.1. During the past 4 weeks, how satisfied do you think your child has felt about:

	Very Satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
a. his/her school ability?					
b. his/her friendships?					
c. his/her life overall?					

SECTION #8: YOUR CHILD'S HEALTH

8.1. How true or false Is the statement for your child? **Options** (definitely true, mostly true, don't know, mostly false, definitely false)

- a. My child seems to be less healthy than other children I know.
- b. My child has never been seriously ill.
- c. I worry about my child's health more than other people worry about their children's health.

8.2. Compared to one year ago, how would you rate your child's health now:

0	0	0	0	0
Much better now than 1 year ago	Somewhat better now than 1 year ago	About the same now as 1 year ago	Somewhat worse now than 1 year ago	Much worse now than 1 year ago



**SECTION #9: YOU AND YOUR FAMILY**

**9.1. During the past 4 weeks, how MUCH emotional worry or concern did each of the following cause YOU?**

	None at all	A little bit	Some	Quite a bit	A lot
a. Your child's physical health					
b. Your child's emotional well-being or behavior					

**9.2. During the past 4 weeks, were you LIMITED In the amount of time YOU have for your own needs because of:**

	Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
a. Your child's physical health?				
b. Your child's emotional well-being or behavior?				

**9.3. During the past 4 weeks, how often has your child's health or behavior:**

	Very often	Fairly often	Sometimes	Almost never	Never
a. limited the type of activities you could do as a family?	0	0	0	0	0
b. interrupted various everyday family activities (eating meals, watching tv)?	0	0	0	0	0

**9.4. Sometimes families may have difficulty getting along with one another. They do not always agree and they may get angry. In general, how would you rate your family's ability to get along with one another?**

0 Excellent	0 Very good	0 Good	0 Fair	0 Poor
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## SECTION #10: FACTS ABOUT YOUR CHILD

10.1. Is your child: Male or Female

10.2. Was this your first child (natural, or adopted)?

Yes  No

10.3. What is your child's date of birth?

MONTH DAY YEAR

10.4. What is the highest grade of school your child has completed? (Circle one number only)

Preschool	6th grade
Kindergarten	7th grade
1 st grade	8th grade
2nd grade	9th grade
3rd grade	10th grade
4th grade A"	11 th grade
5th grade	12th grade

Ungraded  If ungraded, how many years attended? \_\_\_\_\_

11.5 Have you ever been told by a teacher, school official, doctor, nurse or other health professional that your child has any of the following conditions?

Yes

No

- a. anxiety problems
- b. asthma
- c. attentional problems
- d. behavioral problems
- e. chronic allergies or sinus trouble
- f. chronic orthopedic, bone or joint problems
- g. chronic respiratory, lung or breathing trouble (NOT ASTHMA)
- h. chronic rheumatic disease
- i. depression
- j. developmental delay or mental retardation
- k. diabetes
- l. epilepsy (seizure disorder)
- m. hearing impairment or deafness
- n. learning problems
- o. sleep disturbance
- p. speech problems
- q. vision problems
- r. does your child have any other chronic medical condition that is affecting what they do or how they feel? (Please describe below)

SECTION #11: FACTS ABOUT YOU

11.1. Are you:

Male

Female

11.2. What is your date of birth?

MONTH

DAY

YEAR

11.3. Which of the following best describes your current work status? (Check all that apply)

- |                                      |                                |                                   |   |                     |
|--------------------------------------|--------------------------------|-----------------------------------|---|---------------------|
| 0                                    | 0                              | 0                                 | 0   |                     |
| Not working due to my child's health | Not working for other" reasons | Looking for work outside the home | Working full or part time (either outside the home or at a home based business) | Full time homemaker |

11.4. Which of the following best describes your relationship to your child?

- |                   |             |               |                 |          |  |
|-------------------|-------------|---------------|-----------------|----------|--|
| 0                 | 0           | 0             | 0               | 0        | 0  |
| Biological parent | Step parent | Foster parent | Adoptive parent | Guardian | Other (please explain on the line below) |

11.5. What is the highest grade of school you have completed?

- |                          |                         |                                   |                |                                 |
|--------------------------|-------------------------|-----------------------------------|----------------|---------------------------------|
| 0                        | 0                       | 0                                 | 0              | 0                               |
| Some high school or less | High school diploma/GED | Vocational school or some college | College degree | Professional or graduate degree |

11.6. Which of the following best describes your current marital status?

Married      Widowed      Divorced      Separated      Remarried      Never married

11.7. Which of the following best describes your racial background?

Caucasian      Afro-American      Hispanic      Asian/Oriental or Pacific Islander      Other (please explain on the line below)

11.8. What is today's date?

MONTH      DAY      YEAR

PLEASE CONTINUE TO THE NEXT PAGE

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1. How many people share this child's bedroom?

1 person

2 persons

3 or more persons

2a. How many rooms (not counting bathrooms, closets, pantries) are there in your house/apartment?

2b. How many people live in your home?

3. How is your home heated?  Steam or hot water

Warm air furnace

Floor, wall, or pipeless furnace

Other means - with flue

Other means - without flue

Not heated

4. What fuel is used most for cooking in your home?  Coal or coke

Wood

Utility gas

Bottled, tank, or LP gas

Electricity

Fuel oil, kerosene

Other(specify)

5. Do you have any air conditioner(s), humidifier(s), or air filter(s) in your home? (5)

None

Air conditioner(s) and humidifier(s)

Air conditioner(s)

Air conditioner(s) and air filter(s)

Humidifier(s)

Humidifier(s) and air filter(s)

Air filter(s)

Air conditioner(s) and humidifier(s) and filter(s)

6. Do you have a cat, dog, or bird living in your home?

No

Cat

Dog

Bird

Cat and dog

Cat and bird

Dog and bird

Cat and dog and bird

The following questions pertain mainly to your child's chest. Please answer yes or *no* if possible. *If* a question does not appear to be applicable to your child, check the *does not* apply box.

COUGH

7a. Does he/she usually have a cough with colds? (7a)  
 Yes  
 No

7b. Does he/she usually have a cough apart from colds? (7b)  
 Yes  
 No

*If you answered YES to 7a or 7b, please answer questions 7c and 7d*

7c. For how many years has he/she had this cough? (7c)  
 Number of years                      Does not apply

7d. Does he/she cough on most days (4 or more days per week) for as much as 3 months of the year?  
 Yes                      no

WHEEZING

8a. Has this child ever had an attack of wheezing that has caused him/her to be short of breath? (8a)  
 0 Yes  
 0 NO

*If you answered YES to 8a please answer questions 8b through 8e*

8b. Has he/she had 2 or more such episodes? (8b)  
 Yes  
 No

8c. Has he/she ever required medicine or treatment for any of the episodes? (8c)  
 Yes  
 No

8d. How old was this child when he/she had his/her first such attack? (8d)

8e. Is or was his/her breathing completely normal between attacks? (8e)  
 Yes  
 No

9. Does this child ever get attacks of wheezing after he/she has been playing hard or exercising? (9)
- Yes  
NO

CHEST ILLNESSES

- 10a. During the past 3 years has this child had any chest illness that has kept him/her from usual activities for as much as 3 days? (10a)
- Yes  
No

*If you answered YES to 10a, please answer questions 10b, 10c, and 10d*

- 10b. Did he/she bring up more phlegm or seem more congested than usual with any of these illnesses? (10b)
- 0 Yes  
0 No  
0 Does not apply

- 10c. How many illnesses like this has he/she had in the past 3 years? (10c)
- 0 Less than 1 illness per year  
0 1 illness per year  
0 2-5 illnesses per year  
0 more than 5 illnesses per year  
0 Does not apply

- 10d. How many of these illnesses have lasted for as long as 7 days? (10d)

11. Was he/she ever hospitalized for a severe chest illness or chest cold before the age of 2 years?  
Yes, only once    Yes, 2 times    Yes, 3 or more times    NO

12. Did this child have any other severe chest illness or chest cold before the age of 2 years?  
Yes  
No

OTHER ILLNESSES

13. Has this child had any of the following illnesses, and if yes, give the age at which it first occurred.

a. Measles (not German)	Yes	No	At age	(13a)
b. Sinus trouble	Yes	No	At age	(13b)
c. Bronchiolitis	Yes	No	At age	(13c)
d. Bronchitis	Yes	No	At age	(13d)
e. Asthmatic bronchitis	Yes	No	At age	(13e)
f. Pneumonia	Yes	No	At age	(13f)
g. Whooping cough	Yes	No	At age	(13g)
h. Croup	Yes	No	At age	(13h)
i. Cystic fibrosis	Yes	No	At age	(13i)

14. Did the doctor ever say that this child had eczema before the age of 2 years?

Yes       NO

15. Does or did this child have external ear (ear canal) infections (swimmer's ear)?

Yes       NO

ASTHMA

- 16a. Has a doctor ever said that this child had asthma? (16a)  
0 Yes  
0 No

*If you answered YES to 16a, please answer questions 16b, 16c, and 16d.*

- 16b. At what age did his/her asthma begin? (16b)  
16c. Does he/she still have asthma? (16c)  
0 Yes  
0 No

- 16d. Does he/she currently take medicine or treatment for asthma? (16d)  
0 Yes  
0 No

*If you answered NO to 16c, please answer question 16e.*

- 16e. At what age did his/her asthma stop? (16e)

ALLERGY

- 17a. Has a doctor ever said that this child had an allergic reaction to food or medicine? (17a)  
0 Yes, food only  
0 -Yes, medicine only  
0 Yes, both food and medicine  
0 No

- 17b. Has a doctor ever said that this child had an allergic reaction to pollen or dust? (17b)  
0 Yes  
0 No

- 17c. Has a doctor ever said that this child had an allergic skin reaction to detergents or other chemicals? (Do not include poison oak or poison ivy.)  
0 Yes 0 No

FAMILY HISTORY

We would like to obtain some information about the parent(s) or guardian(s) living with this child. (In single-parent family, complete only A or B as appropriate.) Section C should be completed by all families.

## A. MALE PARENT OR GUARDIAN

18. Please indicate whether the male adult is (18)  
 natural father  
 Stepfather  
 Other

19. What is the highest grade of school he has completed? r (19)

20. Does he now smoke regularly (at least 1 cigarette per day or 1 oz. of tobacco per month)?  
 Yes NO

If yes: (20b)  
 cigarettes cigarettes and pipe  
 cigars cigars and cigarettes  
 pipe pipe and cigars  
 cigarettes, pipe and cigars  
 don't know

21. Has he ever smoked regularly (at least 20 packs of cigarettes or 12 oz. of tobacco in a lifetime) while living in the home with this child? (21a)

Yes No  
 if yes: (21b)  
 cigarettes cigarettes and pipe  
 cigars cigars and cigarettes  
 pipe pipe and cigars  
 cigarettes, pipe and cigars  
 don't know

## B. FEMALE PARENT OR GUARDIAN

22. Please indicate whether the female adult is: (22)  
 natural mother  
 Stepmother  
 Other

23. What is the highest grade of school she has completed? (23)

FAMILY HISTORY CONTINUED

24. Does she now smoke regularly (at least 1 cigarette per day or 1 oz. of tobacco per month)?

Yes      No

If yes:

cigarettes  
cigars  
pipe

cigarettes and pipe  
cigars and cigarettes  
pipe and cigars  
cigarettes, pipe and cigars  
don't know

(24b)

25. Has she ever smoked regularly (at least 20 packs of cigarettes or 12 oz. of tobacco in a lifetime) while living in the home with this child?

Yes      No

If yes:

cigarettes  
cigars  
pipe

cigarettes and pipe  
cigars and cigarettes  
pipe and cigars  
cigarettes, pipe and cigars  
don't know

(25b)

## C. OTHER HOUSEHOLD MEMBERS

26. Are there other members of the household who currently smoke regularly (not counting persons mentioned above)?

0 Yes    0 NO

(26)

*If yes, specify number of persons*