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.

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?

_____

WHAT HAPPENED TO THE BABY AFTER IT WAS BORN?

_____

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

_____

WHAT WAS IT LIKE WHEN YOU FIRST HELD THE BABY?

_____

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. _____
1.
2. _____
2.
3. _____
3.
4. _____
4.
5. _____
5.
6. _____
6.
7. _____

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?

_____

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

_____

ANY OTHER THOUGHTS ABOUT YOUR CHILD'S CONDITION?

_____

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? _____
_____
_____
_____
_____

Course of asthma:
_____
_____
_____
_____
_____
_____

What are your child's triggers? _____
_____
_____

Child's symptoms? _____
_____
_____
_____
_____

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

(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

2. 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

3. 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

4. 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

5. 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