Estimated time to complete diary: 15-20 min

Subject ID: _____

Date: _____

Monthly Diary

for

Babies & Breastfeeding Mothers

Markers of Autism Risk in Babies – Learning Early Signs

MARBLES

UC Davis IRB Number: 225645

Version 01/23/2015

Monthly diary for month beginning on __/__/____(MM/DD/YYYY) and ending on __/__/____(MM/DD/YYYY)
Date completed: _____ Your baby's current age? ____months + ____weeks

1. Please write down whether you experienced any of the following symptoms during the last month.

					Severity (Mild 1 2 3 4 Severe)	Frequency	Date Started	Date Stopped	Medication Used (Details on next page)			
a. Abdominal pain	No		Yes		1 2 3 4				No		Yes	
b. Anxiousness	No		Yes		1 2 3 4				No		Yes	
c. Prolonged crying (>2hrs)	No		Yes		1 2 3 4				No		Yes	
d. Bloating or Gaseous Sensation	No		Yes		1 2 3 4				No		Yes	
e. Congestion	No		Yes		1 2 3 4				No		Yes	
f. Constipation	No		Yes		1 2 3 4				No		Yes	
g. Cough – dry	No		Yes		1 2 3 4				No		Yes	
h. Cough – wet	No		Yes		1 2 3 4				No		Yes	
i. Diarrhea (frequent watery stools)	No		Yes		1 2 3 4				No		Yes	
k. Blood in stools	No		Yes		1 2 3 4				No		Yes	
l. Pain on stooling	No		Yes		1 2 3 4				No		Yes	
m.Diaper rash	No		Yes		1 2 3 4				No		Yes	
n. Drooling	No		Yes		1 2 3 4				No		Yes	
o. Fever*	No		Yes		1 2 3 4				No		Yes	
p. Fussy	No		Yes		1 2 3 4				No		Yes	
q. Oral sores	No		Yes		1 2 3 4				No		Yes	
r. Rash: where? _____	No		Yes		1 2 3 4				No		Yes	
s. Runny nose	No		Yes		1 2 3 4				No		Yes	
t. Difficulty swallowing	No		Yes		1 2 3 4				No		Yes	
u. Vomiting	No		Yes		1 2 3 4				No		Yes	
v. Blood in vomit	No		Yes		1 2 3 4				No		Yes	
w. Wheezing / Noisy breathing	No		Yes		1 2 3 4				No		Yes	
x. None of the above			Yes						No		Yes	
y. Other symptoms: (Please list below)			Yes									
z.					1 2 3 4				No		Yes	
aa.					1 2 3 4				No		Yes	
bb.					1 2 3 4				No		Yes	

*If yes to fever, what was the highest temperature of the fever that your baby experienced? _____°F _ or _____ Don't know

2. Did your baby have any reactions in the last month? No ☐ Yes ☐
(reactions may include a rash, swelling, vomiting, etc.)

Reaction To	No	Yes	If yes, what was the reaction and where was it? (i.e., if rash, was it on the face, chest, arms, etc.?)
a. Food			
b. Soap			
c. Household Product			
d. Environment / Plant			
e. Medication			
f. Other (known)_____			
g. Other (unknown)			

3. During the last month, has the hair on the back of your baby's head been:
Falling Out ☐ Growing In ☐ No Change ☐

4. In the last month, has your baby had a tooth:
Fall Out ☐ Grow In ☐ No Change ☐

5. Did your baby use any **medications, vitamins, supplements, or herbal remedies** last month?
No ☐ Yes ☐

Medication Name		# of times per day		# of days this month		Dosage (ex. 100 mg) #	Dosage (ex. 100 mg) Unit	Reason
a.								
b.								
c.								
d.								

6. We are interested in what your child ate in the last month. Please fill out the following chart.

Food	Date started (if new this month)	# of times per day		# of days per week		Amount	Brand/Type
a. Breast Milk						Duration each time: ____ min	N/A
b. Instant Formula							
c. Cow's Milk							
d. Cereal 1							
e. Cereal 2							
f. Water							
g. Juice							
h. Vegetable 1							
i. Vegetable 2							
j. Fruit 1							
k. Fruit 2							
l. Meat 1							
m. Meat 2							
n. Crackers							
o. Other Table Food							

7. Did your child have any of the following in the last month? No ☐ Yes ☐

	Date Symptoms Started	Date Symptoms Stopped	Date Diagnosis Made	Comments
a. Medical appointment – Well Child				
b. Vaccination (for:_____)				
c. Medical appointment – Sick Child				
d. Medical appointment – Ear Infection				
e. Medical appointment – Eye Infection				
f. Medical appointment – Lung Infection				
g. Medical appointment – Injury				
h Medical appointment – Poisoning				
i Medical appointment – Bruising				
j. Medical appointment – Seizures				
k. Dental appointment				
l. Chelation				
m. Hospitalization				

8. 8a. In the last month, did your child develop any dietary restrictions? No ☐ Yes ☐

8b. In the last month, did your child develop any strong food dislikes? No ☐ Yes ☐

8c. In the last month, has any gastrointestinal diagnosis been given to your child? No ☐ Yes ☐
If Yes, specify _____

9. 9a. What type of bottle does your baby usually use?

☐ Hard-plastic bottle (go to question 9b) ☐ No bottle (go to question 10)
☐ Bottle with disposable liner (go to question 10) ☐ Other, specify _____ (go to Q 10)

9b. What is the brand of the hard-plastic bottle? _____ ☐ Don't know

10. We are interested in the personal care products you used on your baby during the past month. Please indicate if you used any of the following products and the brand name of each product.

a. Soap	No		Yes		Brand #1 _____
					Brand #2 _____
					Brand #3 _____
b. Shampoo	No		Yes		Brand _____
c. Powder	No		Yes		Brand _____
d. Lotion	No		Yes		Brand _____
e. Baby oil	No		Yes		Brand _____
f. Diapers	No		Yes		Brand _____
g. Diaper wipes	No		Yes		Brand _____
h. Diaper Cream / Ointment	No		Yes		Brand _____
i. Pacifier	No		Yes		Brand _____
j. Teething Toys	No		Yes		Brand _____
k. Sunscreen	No		Yes		Brand _____
l. Insect repellant	No		Yes		Brand _____

11. Did YOU use the following pesticide or pet products in the last month?

						Indoor and/or Outdoor?				Brand?
a. Ant traps	No		Yes		→	Indoor		Outdoor		_____
b. Roach traps	No		Yes		→	Indoor		Outdoor		_____
c. Insect sprays	No		Yes		→	Indoor		Outdoor		_____
d. Fogger	No		Yes		→	Indoor		Outdoor		_____
e. Pet flea treatments										
1. Neck drops	No		Yes		→					_____
2. Powders or sprays	No		Yes		→					_____
3. Shampoos or soaps	No		Yes		→					_____
f. Change cat litter	No		Yes		→					_____

12. 12a. On average, how much time did your baby spend outdoors each day this month between 8am to 5pm?
none ☐ less than 15 min ☐ 15 min – 1hr ☐ more than 1 hr ☐

12b. During what time of day is your baby usually outdoors?
before 8am ☐ 8-10am ☐ 10am-2pm ☐ 12-2pm ☐ 2-4 pm ☐ 4-6pm ☐ after 6pm ☐

12c. When outdoors, does your baby usually wear sunscreen?
No ☐ Yes ☐ If Yes, SPF: _____

13. 13a. Are you still breastfeeding your baby? No ☐→ Go to Q13b Yes ☐→ Go to Q13d

13b. When did you start weaning your baby? _____ (mm/dd/yyyy)
(*only answer if you didn't answer this question in a previous monthly diary)*

13c. When did you stop breastfeeding your baby? _____ (mm/dd/yyyy)
(*only answer if you didn't answer this question in a previous monthly diary)*

If you are no longer breastfeeding you are done with this diary.

13d. Do you pump milk into a container to feed your baby? No ☐→ Go to Q14 Yes ☐→ Go to Q13e

13e. On average, how long does the milk sit in the container before you feed it to your baby?

_____ hours OR _____ days

13f. What is the brand of the pump you use? _____

Breastfeeding Mothers, please continue:

14. Please write down whether **YOU** experienced any of the following symptoms in the last month.

						Severity Mild → Severe				Medication to Treat (Details on next page)			
a. Anxiousness	No		Yes			1	2	3	4	No		Yes	
b. Body aches	No		Yes			1	2	3	4	No		Yes	
c. Breast pain / mastitis	No		Yes			1	2	3	4	No		Yes	
d. Congestion	No		Yes			1	2	3	4	No		Yes	
e. Constipation	No		Yes			1	2	3	4	No		Yes	
f. Cough	No		Yes			1	2	3	4	No		Yes	
g. Diarrhea (frequent watery stools)	No		Yes			1	2	3	4	No		Yes	
h. Dry eyes	No		Yes			1	2	3	4	No		Yes	
i. Dry mouth	No		Yes			1	2	3	4	No		Yes	
j. Feelings of depression	No		Yes			1	2	3	4	No		Yes	
k. Fever*	No		Yes			1	2	3	4	No		Yes	
l. Gingivitis (inflammation of gums)	No		Yes			1	2	3	4	No		Yes	
m. Hair loss	No		Yes			1	2	3	4	No		Yes	
n. Headache	No		Yes			1	2	3	4	No		Yes	
o. Heartburn	No		Yes			1	2	3	4	No		Yes	
p. Itchiness	No		Yes			1	2	3	4	No		Yes	
q. Joint pain	No		Yes			1	2	3	4	No		Yes	
r. Nausea	No		Yes			1	2	3	4	No		Yes	
s. Rash	No		Yes			1	2	3	4	No		Yes	
t. Runny nose	No		Yes			1	2	3	4	No		Yes	
u. Sore throat	No		Yes			1	2	3	4	No		Yes	
v. Sun sensitivity	No		Yes			1	2	3	4	No		Yes	
w. Vaginal spotting or bleeding	No		Yes			1	2	3	4	No		Yes	
x. Vomiting	No		Yes			1	2	3	4	No		Yes	
y. Wheezing	No		Yes			1	2	3	4	No		Yes	
z. None of the above			Yes										
Other symptoms: (Please list below)													
aa.						1	2	3	4	No		Yes	
bb.						1	2	3	4	No		Yes	
cc.						1	2	3	4	No		Yes	

*If yes to fever, what was the highest temperature of the fever that you experienced?
_____°F or _____ Don't know

15. Did YOU use any medications in the last month? No ☐ Yes ☐

Medication Name	Reason	# of days taken this month		# of times per day		Dosage (ex. 100 mg) #	Dosage (ex. 100 mg) Unit
a.							
b.							
c.							
d.							

16. Did you have any of the following this month? No ☐ Yes ☐

	Date	Specifics / Treatment	Comments
a. Health care appointment – Well Care			
b. Health care appointment – Illness			
c. Dental Appointment (if you had a filling removed or placed, please circle which type of filling you had/have)		Cleaning ☐ Periodontal Care ☐ Filling Removed ☐ Filling Placed ☐ X-ray ☐ *Type of Filling (circle)* Amalgam Composite Glass Ionomer Vaneer Crown	
d. Visit to Emergency Room			
e. Hospitalization			
f. Illness in family / household member (please say who was ill and what symptoms were present)			

17. Did YOU use the following personal care products in the last month?

a. Hair color	No		Yes		Brand _____
b. Nail polish	No		Yes		Brand _____
c. Perfume	No		Yes		Brand #1 _____ Brand #2 _____ Brand #3 _____
d. Insect repellant	No		Yes		Brand #1 _____ Brand #2 _____ Brand #3 _____

18. 18a. On average, how much time did you spend outdoors each day this month between 8am to 5pm?
none ☐ less than 15 min ☐ 15 min – 1hr ☐ more than 1 hr ☐

18b. During what time of day are you usually outdoors?
before 8am ☐ 8-10am ☐ 10am-2pm ☐ 12-2pm ☐ 2-4 pm ☐ 4-6pm ☐ after 6pm ☐

18c. Do you usually wear sunscreen or use products such as make-up or lotions that have an SPF?
No ☐ Yes ☐

If Yes, specify brand and SPF for up to 3 products.

Product brand #1:_____SPF_____
Product brand #2:_____SPF_____
Product brand #3:_____SPF_____