Estimated time to
complete diary: 10 min

Subject ID: _____

Date Completed: _____

Markers of Autism Risk in Babies – Learning Early Signs

MARBLES

Weekly Symptom Diary

Version 01/23/2015

Weekly diary for week beginning on __/__/____(MM/DD/YYYY) and ending on __/__/____(MM/DD/YYYY)
Week of pregnancy:_____

1. Please write down whether you experienced any of the following symptoms this week.

						Severity							
						Mild			Severe	Medication Used (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. Braxton-Hicks contractions	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. Cramping, _____ (where)	No		Yes			1	2	3	4	No		Yes	
g. Cough	No		Yes			1	2	3	4	No		Yes	
h. Diarrhea (frequent watery stools)	No		Yes			1	2	3	4	No		Yes	
i. Dry eyes	No		Yes			1	2	3	4	No		Yes	
j. Dry mouth	No		Yes			1	2	3	4	No		Yes	
k. Feelings of depression	No		Yes			1	2	3	4	No		Yes	
l. Fever*	No		Yes			1	2	3	4	No		Yes	
m. Gingivitis (inflammation of gums)	No		Yes			1	2	3	4	No		Yes	
n. Hair loss	No		Yes			1	2	3	4	No		Yes	
o. Headache	No		Yes			1	2	3	4	No		Yes	
p. Heartburn	No		Yes			1	2	3	4	No		Yes	
q. Itchiness	No		Yes			1	2	3	4	No		Yes	
r. Joint pain	No		Yes			1	2	3	4	No		Yes	
s. Nausea	No		Yes			1	2	3	4	No		Yes	
t. Rash	No		Yes			1	2	3	4	No		Yes	
u. Runny nose	No		Yes			1	2	3	4	No		Yes	
v. Sore throat	No		Yes			1	2	3	4	No		Yes	
w. Sun sensitivity	No		Yes			1	2	3	4	No		Yes	
x. Uterine contractions	No		Yes			1	2	3	4	No		Yes	
y. Vaginal spotting or bleeding	No		Yes			1	2	3	4	No		Yes	
z. Vomiting	No		Yes			1	2	3	4	No		Yes	
aa. Wheezing	No		Yes			1	2	3	4	No		Yes	
bb. None of the above			Yes										
Other symptoms: (Please list below)													
cc.						1	2	3	4	No		Yes	
dd.						1	2	3	4	No		Yes	
ee.						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

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2. Did you use any **medications, vitamins, supplements, or herbal remedies** this week?

No ☐ Yes ☐

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

3. Did you have any of the following this week? No ☐ Yes ☐

	Date	Specifics	Comments
a. Obstetric care appointment			
b. Audible fetal heart rate assessment			
c. Ultrasound		Abdominal ☐ Vaginal? ☐ Both? ☐	
d. Amnioscentesis			
e. Chorionic Villous Sampling (CVS)			
f. Antenatal Testing		Non-Stress Test (NST) ☐ Ultrasound check for fluid (AFI) ☐ Biophysical Profile (BPP) ☐	
g. Dental Appointment (if you had a filling removed or placed, please circle which type of filling)		Cleaning ☐ Filling ☐ X-ray ☐ *Filling type (circle)* Amalgam Composite Glass Ionomer Vaneer Crown	
h. Visit to Labor & Delivery or ER		Contractions ☐ Decreased Movement ☐ Bleeding ☐	
i. Non-OB health care appointment		Well Care ☐ Illness ☐	
j. Vaccination		RhoGam ☐ Flu vaccine ☐ Tetanus vaccine ☐	

4. Did you use the following personal care products this week? No ☐ Yes ☐

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 _____		

5. Did you use the following pesticide or pet products this week? No ☐ Yes ☐

			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 ☐	→				_____

6. 6a. On average, how much time did you spend outdoors each day this week between 8am to 5pm?
none ☐ less than 15 min ☐ 15 min – 1hr ☐ more than 1 hr ☐

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

6c. 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_____

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