Estimated time to complete diary: 15-20 min

Subject ID: __________

Date: ______________

Quarterly Diary

for

Children over 1 Year (and Breastfeeding Mothers)

Markers of Autism Risk in Babies – Learning Early Signs

MARBLES

UC Davis IRB Number: 225645
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Quarterly diary for month beginning on __/__/____(MM/DD/YYYY) and ending on __/__/____(MM/DD/YYYY)
Date completed: _______ Your baby's current age? ____months

1. Please write down whether your baby experienced any of the following symptoms in the past 3 months.

					Severity				Frequency	Date Started	Date Stopped	Medication Used (Details on next page)			
					Mild			Severe							
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

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2. Did your baby have any reactions in the last 3 months? 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** in the last 3 months? No ☐ Yes ☐

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

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6. On average, how often and how much did your child consume each of the following foods in the past 3 months? Please also include the brand(s) or type(s) of each product.

Food	Never or <1/mo	1 – 4 times/mo	1 – 3 times/wk	4 – 6 times/wk	7 or more times/wk	Amount	Brand/Type
a. Breast Milk						___________oz	N/A
b. Instant Formula						___________oz	
c. Cow's Milk						______oz/cups	
d. Cheese						___________oz	
e. Yogurt (not frozen)						______oz/cups	
f. Frozen yogurt or ice cream						#____________	
g. Eggs						#____________	
h. Cereal						_________cups	
i. Crackers						#____________	
j. Noodles						_________cups cooked	
k. Vegetables						_______#/cups	
l. Fruit						_______#/cups	
m. Meat (beef, lamb)						___________oz	
n. Meat (poultry, pork)						___________oz	
o. Fish						___________oz	
p. Juice						______oz/cups	
q. Water						______oz/cups	
e. Other Table Food						_______#/cups	

7. Did your child have any of the following in the last 3 months? 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				

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8. 8a. In the last 3 months, did your child develop any dietary restrictions? No ☐ Yes ☐

8b. In the last 3 months, did your child develop any strong food dislikes? No ☐ Yes ☐

8c. In the last 3 months, 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)
☐ Bottle with disposable liner (go to question 10)
☐ No bottle (go to question 10a)
☐ Other, specify _______________ (go to Q 9b)

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

9c. When did you purchase the hard plastic bottle? (month/year) ___________ ☐ Don't know

10. 10a. What is the brand of the sippy cup your child usually uses? ______________________

☐ Don't know ☐ Doesn't use a sippy cup

10b. When did you purchase the sippy cup? (month/year) _______________ ☐ Don't know

11. We are interested in the personal care products you used on your child during the past 3 months. Please indicate if you used any of the following products and the brand name of each product.

Product	No		Yes		Brand
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 ______________________

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12. Did YOU use the following pesticide or pet products in the last 3 months?

						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		⟶					________________

13. 13a. On average, how much time did your baby spend outdoors each day during the last 3 months between 8am to 5pm?

none ☐ less than 15 min ☐ 15 min – 1hr ☐ more than 1 hr ☐

13b. During what time of day is your baby usually outdoors?

before 8am ☐ 8-10am ☐ 10am-12pm ☐ 12-2pm ☐ 2-4 pm ☐ 4-6pm ☐ after 6pm ☐

13c. When outdoors, does your baby usually wear sunscreen?

No ☐ Yes ☐ If Yes, SPF: __________

14. 14a. Are you still breastfeeding your baby? No ☐ → Go to Q14b Yes ☐ → Go to Q15

14b. When did you start weaning your baby? ____________________________ (mm/dd/yyyy)
(*only answer if you didn't answer this question in a previous monthly diary*)

14c. 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.

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Breastfeeding Mothers, please continue:

15. Please write down whether **YOU** experienced any of the following symptoms in the last 3 months.

					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

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16. Did YOU use any medications in the last 3 months? No ☐ Yes ☐							
Medication Name	Reason	# of days taken this month		# of times per day		Dosage (ex. 100 mg)	
						#	Unit
a.							
b.							
c.							
d.							

17. Did you have any of the following during the last 3 months? 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)			

18. Did YOU use the following personal care products in the last 3 months?					
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 ____________________

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19. 19a. On average, how much time did you spend outdoors each day during the last 3 months between 8am to 5pm?

none ☐ less than 15 min ☐ 15 min – 1hr ☐ more than 1 hr ☐

19b. During what time of day are you usually outdoors?

before 8am☐ 8-10am☐ 10am-12pm☐ 12-2pm☐ 2-4 pm☐ 4-6pm☐ after 6pm☐

19c. 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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