

Questionnaire AGORA data- and biobank

Important information before using this questionnaire

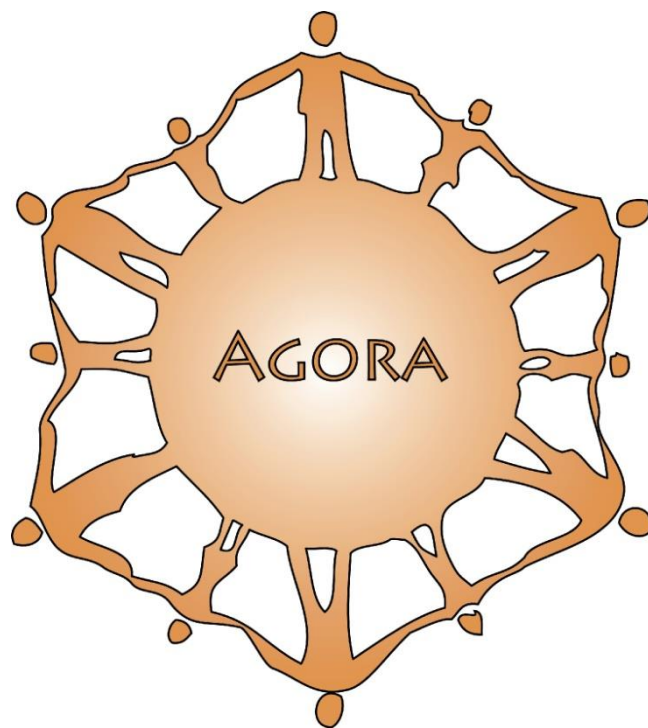
The AGORA questionnaire was designed by a team of reproductive epidemiologists and clinicians for use among participants in the AGORA data- and biobank. The questions are aimed at mothers of children with a birth defect or a healthy child living in The Netherlands and may not be usable in different settings. **Therefore, (questions from) the AGORA questionnaire should only be used after consultation with the AGORA study team (loes.vanderzanden@radboudumc.nl).**

When using the AGORA questionnaire, either fully or in part, please include a reference to the manuscript describing the AGORA data- and biobank

(van Rooij *et al.* (2016), PMID: 27150573 DOI: <https://doi.org/10.1002/bdra.23512>).

The questionnaire shown below is the translation of the original AGORA questionnaire (in Dutch). Based on the feedback provided by participants and concerns about the validity and/or usefulness of some data that were gathered, the 2022 version of the AGORA questionnaire contains several important updates. Please contact the AGORA study team for more information.

Mother



AGORA

Aetiologic research into
Genetic and
Occupational / environmental
Risk factors for
Anomalies in children

If you do not want to or are not able to fill in the questionnaire

If you do not want to or are not able to fill in the questionnaire, would you please give the reason for this?

- I am not the biological mother of the child
 - I have problems understanding the English of this questionnaire
 - I do not have the time to fill in the questionnaire
 - I am not in the mood to fill in the questionnaire
 - I think this questionnaire is useless
 - I never participate in research
 - I find the questions too personal
 - Other reasons:
-
-
-
-
-

! *Would you please send the questionnaire back in the enclosed envelope?
By doing this, we would not approach you again for this research.
Thank you in advance.*

About this questionnaire

This questionnaire consists of 7 parts. There are questions about you and your relatives, general questions about your pregnancy(ies) and questions about your health, life style, leisure time, living environment, your occupation and about your diet. It will take you about 40 minutes to fill in this questionnaire.

The majority of questions concern the pregnancy from which your child that participates in this study was born. A lot of questions concern your life style, diet, occupation and hobbies just before and during this pregnancy. It does not automatically mean that all these things are involved in the aetiology of the malformation of your child. That is exactly what we want to study with this questionnaire.

You might find some events hard to remember. We still want you to fill in this questionnaire as good as possible. Maybe you want to use an old calendar or diary. You could also inquire of your gynaecologist. When you are really not able to answer a question, please note a question mark.

In this questionnaire you will find different types of questions:

- questions at which you have to put a cross in one or more boxes where appropriate
- questions at which you have to write down your answer on the dotted line
- questions at which you have to put a cross in a box and then give an explanation on the dotted line

An example:

Have any of your relatives ever been diagnosed with one or more of the following congenital malformations?

a. Congenital heart defect

yes → who (father, mother, brothers or sisters) and what type of heart defect?

..... *1 brother, an opening between both heart chambers*

no

unknown

For some questions you have to fill in a period, such as the period in which you used medications.

For example: because of blood anaemia you used iron supplements starting from week 14 of pregnancy.

You should fill in the answer as follows:

Did you use iron supplements before or during pregnancy?

yes → in the 3 months before to pregnancy

in pregnancy months 1-2 (week 0-9)

in pregnancy months 3-4 (week 10-18)

in pregnancy months 5-9 (week 19-42)

name: *Ferrous fumarate*

no

* Watch the arrows (→) behind some answers. After an arrow you will find an explanation or an additional question. An exclamation mark (!) indicates important information.

* When you make a mistake, put a cross in the right box and circle the correct answer. If you want to clarify something, you can write it down next to the question. On the last page of the questionnaire there is additional space to write things down.

Good luck with the questionnaire!

1. Questions about you and your relatives

1. What is your date of birth?

day		month		year			

2. What is your country of birth?

3. a. What is the ethnic background of your mother?

(if more than one option is true, put a cross in the box 'other' and give an explanation)

- Dutch
 - European (other than Dutch)
 - Turkish
 - Moroccan
 - Surinam, Antillean, African
 - Asian
 - other:
-

3. b. What is the ethnic background of your father?

(if more than one option is true, put a cross in the box 'other' and give an explanation)

- Dutch
 - European (other than Dutch)
 - Turkish
 - Moroccan
 - Surinam, Antillean, African
 - Asian
 - other:
-

4. What is the highest level of education you have completed?

- no education completed
 - primary school
 - secondary school
 - lower vocational education
 - intermediate vocational education
 - higher vocational education
 - university
 - other:
-

5. a. Have you ever been diagnosed with one or more congenital malformations?

- yes → heart defect
- neural tube defect
- cleft lip and/or cleft palate (orofacial cleft)
- kidney- or bladder malformation
- digestive tract malformations (such as oesophagus, intestine, anus)
- other
- no

5. b. Please specify these congenital malformation(s):

.....
.....

6. Have you ever been diagnosed with any form of cancer?

- yes → what form and when?.....
.....
- no

7. Have you ever been diagnosed with fertility problems?

- yes
- no → skip to question 9

8. What is the (probable) cause of these fertility problems?

- the cause is:
.....
- unknown cause

9. Are you and the father of your child (participating in this study) relatives?

- yes, the family relation is:
- no

! *The next question concerns congenital malformations occurring in your close relatives. With close relatives we mean your biological father, mother, brothers and sisters, but not your children. Please write down which relative has the congenital malformation and specify the malformation on the dotted lines.*

10. Have any of your relatives ever been diagnosed with one or more of the following congenital malformations?

a. Congenital heart defect

yes → who (father, mother, brothers or sisters) and what type of heart defect?

.....

no

unknown

b. Neural tube defect

yes → who (father, mother, brothers or sisters) and what type of neural tube defect?

.....

no

unknown

c. Cleft lip and/or cleft palate (orofacial cleft)

yes → who (father, mother, brothers or sisters) and what type of orofacial cleft?

.....

no

unknown

d. Congenital kidney or bladder malformation

yes → who (father, mother, brothers or sisters) and what type of kidney or bladder defect?

.....

no

unknown

e. Congenital digestive tract malformations (such as oesophagus, intestine, anus)

yes → who (father, mother, brothers or sisters) and what type of malformation?

.....

no

unknown

f. Cryptorchidism (testicle(s) not descended into the scrotum before the age of 1 year)

yes → who (father or brothers)?

.....

no

unknown

g. Hypospadias (an abnormally placed urethral opening in the penis)

yes → who (father or brothers)?

.....

no

unknown

h. Another congenital malformation

yes → who (father, mother, brothers or sisters) and what type of malformation?

.....

.....

.....

no

unknown

11. a. Have any of your relatives ever been diagnosed with cancer?

yes → who (father, mother, brothers or sisters) and what type of cancer?

.....

.....

→ At what age was the cancer diagnosed?

.....

.....

no

Unknown

11. b. Has one of your children ever been diagnosed with cancer?

yes → who (son or daughter) and what type of cancer?

.....

.....

→ At what age was the cancer diagnosed?

.....

.....

no

2. Questions about your pregnancy

! *The next questions concern the pregnancy from which your child that participates in this study was born.*

12. What is your child's date of birth?
day month year
13. What is the gender of your child?
 Boy
 Girl
14. What is your child's birth weight? gram
15. How many weeks and days did your pregnancy last?
 weeks + days
16. Is your child one of twins?
 yes, a twin
 yes, a triplet
 yes, a multiplet consisting of children
 no → skip to question 18a
17. Is this a monozygotic or dizygotic twin?
 monozygotic
 dizygotic (multizygotic)
 unknown
18. a. Has your child been diagnosed with one or more congenital malformations or a syndrome?
 yes → heart defect
 neural tube defect
 cleft lip and/or cleft palate (orofacial cleft)
 kidney- or bladder malformation
 cryptorchidism (testicle(s) not descended into the scrotum before the age of 1)
 hypospadias (an abnormally placed urethral opening in the penis)
 digestive tract malformations (such as oesophagus, intestine, anus)
 syndrome (e.g.: Down, Li-Fraumeni, Beckwith-Wiedemann, Denys-Drash)
 other
 no → skip to question 19

18b. b. Please specify these congenital malformation(s):

.....
.....

19. Was this pregnancy an unexpected pregnancy?

- yes → skip to question 22
- no

20. When you tried to get pregnant, did you get pregnant in the first month?

- yes → skip to question 22
- no

21. How many months did it take you to get pregnant?

(Start counting from the moment you stopped using contraceptives or you tried to get pregnant on purpose)

--	--

 months

22. Did you conceive naturally or did you and/or your partner get a medical treatment for it?

- naturally → skip to question 25
- with medical treatment

23. What type of medical treatment(s) did you and/or your partner get?

(more answers are possible)

- treatment with hormones or ovulation stimulants
- IVF (*in vitro fertilization*)
- ICSI (*Intracytoplasmic sperm injection: IVF in which a sperm cell is injected into an egg cell*)
- AI or IUI (*artificial insemination or intrauterine insemination: sperm cells are artificially brought into the vagina or uterine*)
- AID (*artificial insemination with sperm of a donor*)
- other treatment:

24. With which of these treatments did you get pregnant in the end?

- none, because this pregnancy was nevertheless originated naturally
- treatment: (*type of treatment*)

25. Did you use oral contraception/birth control pills in the year before you got pregnant?

- yes
- no

26. Did you use other hormonal methods of contraception in the year before you got pregnant?
(E.g. hormonal intrauterine device, contraceptive injection)

- yes → which hormonal contraception?
- no

27. When did you stop using oral contraception or other contraception with hormones?

- more than 3 months before you got pregnant
- between 3 months before and the date of conception
- after conception, in pregnancy week:

--	--
- I did not use oral contraception or other contraceptives with hormones

28. Pregnancy history

The next questions imply all your pregnancies, including the pregnancy of the child that participates in this study. Please answer questions a to h for all of your pregnancies, starting with your first pregnancy (also look at the next page). With more than 5 pregnancies, please continue at the last page of this questionnaire.

	1 st pregnancy	2 nd pregnancy
a. Was the outcome of your (1 st /2 nd /etc.) pregnancy a live birth, stillbirth, a miscarriage or an abortion?	<input type="checkbox"/> live birth <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion	<input type="checkbox"/> live birth <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion
b. How many weeks and days did your pregnancy last?	<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 24px;">+</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> weeks days </div>	<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 24px;">+</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> weeks days </div>

The next questions only concern the live born and stillborn children:

c. What was the date of birth?	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 60px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> day month year </div>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 60px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> day month year </div>
d. What was the birth weight?	<div style="border: 1px solid black; width: 60px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> gram	<div style="border: 1px solid black; width: 60px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> gram
e. What was the sex of the child?	<input type="checkbox"/> boy <input type="checkbox"/> girl	<input type="checkbox"/> boy <input type="checkbox"/> girl
f. Did or does this child have a congenital malformation? If yes, which one?	<input type="checkbox"/> yes → which one?..... <input type="checkbox"/> no	<input type="checkbox"/> yes → which one?..... <input type="checkbox"/> no
g. Does this child have the same father as the child that participates in this study?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> this child participates in this study	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> this child participates in this study

For stillborn children:

h. What was the cause of death?
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Continue with other pregnancies:

3 rd pregnancy	4 th pregnancy	5 th pregnancy
<input type="checkbox"/> live birth <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion	<input type="checkbox"/> live birth <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion	<input type="checkbox"/> live birth <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion
<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> + <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: center; align-items: center;"> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px; font-size: 8px;"> weeks days </div>	<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> + <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: center; align-items: center;"> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px; font-size: 8px;"> weeks days </div>	<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> + <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: center; align-items: center;"> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px; font-size: 8px;"> weeks days </div>

The next questions only concern the live born and stillborn children:

<div style="display: flex; justify-content: space-around; font-size: 8px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="border: 1px solid black; width: 60px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px; font-size: 8px;"> day month year </div>	<div style="display: flex; justify-content: space-around; font-size: 8px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="border: 1px solid black; width: 60px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px; font-size: 8px;"> day month year </div>	<div style="display: flex; justify-content: space-around; font-size: 8px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="border: 1px solid black; width: 60px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px; font-size: 8px;"> day month year </div>
<div style="border: 1px solid black; width: 60px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px; font-size: 8px;"> gram </div>	<div style="border: 1px solid black; width: 60px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px; font-size: 8px;"> gram </div>	<div style="border: 1px solid black; width: 60px; height: 30px; display: flex; justify-content: space-between; padding: 2px;"> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px; font-size: 8px;"> gram </div>
<input type="checkbox"/> boy <input type="checkbox"/> girl	<input type="checkbox"/> boy <input type="checkbox"/> girl	<input type="checkbox"/> boy <input type="checkbox"/> girl
<input type="checkbox"/> yes → which one?..... <input type="checkbox"/> no	<input type="checkbox"/> yes → which one?..... <input type="checkbox"/> no	<input type="checkbox"/> yes → which one?..... <input type="checkbox"/> no
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> this child participates in this study	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> this child participates in this study	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> this child participates in this study

For stillborn children:

.....
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3. Questions about your health before and during pregnancy

! We continue with questions about the period before and during the pregnancy of your child that participates in this study. With the period before pregnancy we mean 3 months before conception: this period started in most cases a year before the birth of your child.

If you are asked to fill in the weeks of pregnancy, please start counting from the first day of your last menstrual period (or the number of weeks your gynaecologist is working with).

29. What was your weight and length in the 3 months before you got pregnant?

weight: kilogram length: centimetre

30. Did you have a chronic disease in the 3 months before you got pregnant or during pregnancy? (E.g. epilepsy, asthma, thyroid disease or diabetes, but not a disease that was a consequence of your pregnancy)

yes → what chronic disease?

no

31. Did you experience an inflammation of the bladder or the kidney during pregnancy?

yes → in pregnancy week until

no

32. Did you have a heavy cold during pregnancy?

yes → in pregnancy week until

no

33. Did you have an infection during pregnancy? (such as influenza, rubella or jaundice)?

yes → what infection?

no → in pregnancy week until

34. Did you have a fever with a temperature above 38° C during pregnancy?

yes → what was the cause of this fever?

→ in pregnancy week until

→ number of days fever?

no

35. Did you get a vaccination during pregnancy? (E.g. for polio, tetanus, typhus, hepatitis A of B)

- yes → what type of vaccine?
- in pregnancy week:

--	--
- no

36. Did you have any of the following complications or illnesses during pregnancy?
 In which week of the pregnancy did you experience these complications? (More answers are possible)

Complication or illness:

Pregnancy weeks:

- | | | | | |
|---|--------|--|-------|--|
| <input type="checkbox"/> extreme nausea (hyperemesis) | → week | | until | |
| <input type="checkbox"/> high blood pressure | → week | | until | |
| <input type="checkbox"/> preeclampsia or toxemia | → week | | until | |
| <input type="checkbox"/> gestational diabetes | → week | | until | |
| <input type="checkbox"/> thyroid problems | → week | | until | |
| <input type="checkbox"/> pelvic problems | → week | | until | |
| <input type="checkbox"/> anaemia | → week | | until | |
| <input type="checkbox"/> vaginal bleeding | → week | | until | |
| <input type="checkbox"/> other complications or illnesses:
..... | → week | | until | |
| | → week | | until | |
- no, I did not have any complications or illnesses

37. Were you admitted to a hospital during pregnancy?
 (We do not mean admittance because of the delivery of your baby)

- yes → what was the cause of the admittance?
- in pregnancy week

--	--

 until

--	--
- no

38. Did you have an operation or another medical treatment, wherein you received anaesthetics during pregnancy?

- yes → what operation/treatment?
- in pregnancy week

--	--

 until

--	--
- No

39. Have you had X-rays during pregnancy? (E.g. at the dentist or in the hospital)

- yes → what parts of your body were X-rayed?
- in pregnancy week:

--	--
- no

40. Did you use any prescriptive medications in the 3 months before or during pregnancy?
(Examples of medications can be seen at question 38)

- yes
- no → skip to question 42

41. Please fill in for each medication in the table below whether you have taken it and in what period.
(You are allowed to fill in more than one period)

Example: diuretics?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname: *amlodipine*
- no

a. Iron supplements?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

b. Morning sickness medicines?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

c. Sleeping pills or tranquillizers?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

d. Pills for anxiety or depression (antidepressants)?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

e. Pills for asthma or chronic bronchitis?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

f. Anticonvulsants or pills for seizures?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

g. Blood pressure tablets?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

h. Pills for diabetes (inclusive insulin)?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

i. Antibiotics?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

j. Prescriptive pain relievers?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

k. Prescriptive anti-inflammatory drugs?

- yes → in the 3 months before pregnancy
 in pregnancy month 1-2 (week 0-9)
 in pregnancy month 3-4 (week 10-18)
 in pregnancy month 5-9 (week 19-42)
brandname:
- no

l. Other prescriptive drugs?

- yes → which drugs and in what period?
1.
 2.
 3.
 4.
- no

4. Questions about life style

42. Did you use folic acid supplements in the 3 months before or during pregnancy?
(for multivitamins go to question 44)

- yes
 no → skip to question 44

43. a. Did you use folic acid supplements before you got pregnant?

- yes → more than 4 weeks before getting pregnant
 less than 4 weeks before getting pregnant
 no

43. b. Did you use folic acid supplements during the pregnancy?

- yes → from pregnancy week until week
 no

44. Did you use multivitamin supplements in the 3 months before or during pregnancy?

- yes → multivitamins especially made for pregnant women (E.g. Gravitamon)
 other multivitamins:
 no → skip to question 46

45. a. Did you use multivitamin supplements before you got pregnant?

- yes → more than 4 weeks before getting pregnant
 less than 4 weeks before getting pregnant
 no

45. b. Did you use multivitamin supplements during the pregnancy?

- yes → from pregnancy week until week
 no

46. Did you smoke in the 3 months before or during pregnancy?

- yes
 no → skip to question 49 on the next page

47. Did you stop smoking during pregnancy?

- yes → in pregnancy week:
 no

48. How many cigarettes did you smoke per day?
(Try to fill this in for every period. When you did not smoke during a certain period, please fill in 0. When you smoked only a part of the period, please fill in the number of cigarettes you smoked before you stopped)

In the 3 months before pregnancy:

--	--

 cigarettes per day

In pregnancy months 1-2 (week 0-9):

--	--

 cigarettes per day

In pregnancy months 3-4 (week 10-18):

--	--

 cigarettes per day

In pregnancy months 5-9 (week 19-42):

--	--

 cigarettes per day

49. Did you drink any alcohol in the 3 months before or during pregnancy?

- yes
- no → skip to question 52

50. Did you stop drinking alcohol during pregnancy?

- yes → in pregnancy week:

--	--
- no

51. How many glasses of alcohol did you drink on average per week? *(Try to fill this in for every period. When you did not drink alcohol during a certain period, please fill in 0. When you drank only a part of the period, please fill in the number of glasses you drank before you stopped drinking)*

In the 3 months before pregnancy:

--	--

 glasses per week

In pregnancy months 1-2 (week 0-9):

--	--

 glasses per week

In pregnancy months 3-4 (week 10-18):

--	--

 glasses per week

In pregnancy months 5-9 (week 19-42):

--	--

 glasses per week

52. Did you use (soft)drugs in the 3 months before or during pregnancy?

- yes → What type of drugs?
- no → skip to question 55

53. Did you stop using (soft)drugs during pregnancy?

- yes → in pregnancy week:

--	--
- no

54. How often did you use (soft)drugs in the 3 months before or during pregnancy?
(If you stopped using (soft)drugs, please fill in for the period before you stopped)

- (almost) daily
- one or a few times a week
- one or a few times a month
- incidental

55. How many glasses of cola or cola light did you drink on average per week in the 3 months before or during pregnancy?

(Try to fill this in for every period. When you did not drink cola during a certain period, please fill in 0)

In the 3 months before pregnancy: glasses per week

In pregnancy months 1-2 (week 0-9): glasses per week

In pregnancy months 3-4 (week 10-18): glasses per week

In pregnancy months 5-9 (week 19-42): glasses per week

56. How many cups of coffee with caffeine did you drink on average per day in the 3 months before or during pregnancy?

(Try to fill this in for every period. When you did not drink coffee during a certain period, please fill in 0)

In the 3 months before pregnancy: cups per day

In pregnancy months 1-2 (week 0-9): cups per day

In pregnancy months 3-4 (week 10-18): cups per day

In pregnancy months 5-9 (week 19-42): cups per day

57. How many cups of tea did you drink on average per day in the 3 months before or during pregnancy?

(Try to fill this in for every period. When you did not drink tea during a certain period, please fill in 0)

In the 3 months before pregnancy: cups per day

In pregnancy months 1-2 (week 0-9): cups per day

In pregnancy months 3-4 (week 10-18): cups per day

In pregnancy months 5-9 (week 19-42): cups per day

58. Did you experience a period of (acute) stress or an emotional event, which had its influence on your state of mind in the 3 months before or during pregnancy?

(E.g. death of a loved one, relational or financial problems, being fired)

- yes
- no → skip to question 60

59. When did you experience this period of stress or the emotional event and how long did it last?

- in the 3 months before pregnancy duration:

--	--

 weeks
- in pregnancy months 1-2 (week 0-9) duration:

--	--

 weeks
- in pregnancy months 3-4 (week 10-18) duration:

--	--

 weeks
- in pregnancy months 5-9 (week 19-42) duration:

--	--

 weeks

60. Did you dye your hair in the 3 months before or during pregnancy?

(We mean real hair dye and not a temporary colour)

- yes
- no → skip to question 62

61. When did you dye your hair? (More answers are possible)

- in the 3 months before pregnancy
- in pregnancy months 1-2 (week 0-9)
- in pregnancy months 3-4 (week 10-18)
- in pregnancy months 5-9 (week 19-42)

62. Which one of the following personal care products did you use almost on a daily basis in the 3 months before or during pregnancy? (More answers are possible)

- | | |
|--|--|
| <input type="checkbox"/> deodorant | <input type="checkbox"/> hand cream |
| <input type="checkbox"/> perfume or eau de toilette | <input type="checkbox"/> facial cream |
| <input type="checkbox"/> hairspray | <input type="checkbox"/> foundation or make-up cream |
| <input type="checkbox"/> other hair products (gel, wax) | <input type="checkbox"/> powder or rouge |
| <input type="checkbox"/> nail polish | <input type="checkbox"/> eye shadow |
| <input type="checkbox"/> body lotion or body milk | <input type="checkbox"/> mascara, eye pencil or eyeliner |
| <input type="checkbox"/> sun screen (incidental use as well) | <input type="checkbox"/> lip stick or lip balm |
| <input type="checkbox"/> other products: | |
| | |
| <input type="checkbox"/> none | |

5. Questions about leisure time and living environment



Again, in the following questions, with the period before pregnancy we mean 3 months before conception: this period started in most cases a year before the birth of your child.

63. Did you paint in or around your own house or someone else's in the 3 months before or during pregnancy?

- yes
 no → skip to question 66

64. What kind of paint did you use? Did you paint inside or outside the house?
(more answers are possible)

- water-based paint, like latex or acryl paint → inside
 outside
 oil-based paint (paints with solvents like turpentine) → inside
 outside

65. How many days did you paint?
(Try to fill in every period. When you did not paint during a certain period, please fill in 0)

In the 3 months before pregnancy: days
 In pregnancy months 1-2 (week 0-9): days
 In pregnancy months 3-4 (week 10-18): days
 In pregnancy months 5-9 (week 19-42): days

66. Did someone else paint in your house or lay carpets with oil-based paint or adhesives in the 3 months before or during pregnancy? *(no water-based paint or adhesives)*

- yes → how many days? in the 3 months before pregnancy: days
 in pregnancy months 1-2 (week 0-9): days
 in pregnancy months 3-4 (week 10-18): days
 in pregnancy months 5-9 (week 19-42): days
 no

67. Did you have a hobby where you used oil-based paint, varnish, adhesives, or thinners on a weekly basis for more than a month in the 3 months before or during pregnancy?
- yes → which?
- no → skip to question 69

68. How many hours per week did you work with these oil-based paint, varnish, adhesives, or thinners in your hobby?
(Try to fill in every period. When you did not carry out your hobby during a certain period, please fill in 0)

In the 3 months before pregnancy:

--	--

 hours per week

In pregnancy months 1-2 (week 0-9):

--	--

 hours per week

In pregnancy months 3-4 (week 10-18):

--	--

 hours per week

In pregnancy months 5-9 (week 19-42):

--	--

 hours per week

69. Did you use pesticides in your garden in the 3 months before or during pregnancy?
(To destroy herbicides, insects, fungicides, etc.)

- yes
- no → skip to the text (!) above question 71

70. When did you use these pesticides? *(more answers are possible)*

- in the 3 months before pregnancy → how many times per months?

--	--
- in pregnancy months 1-2 (week 0-9) → how many times per months?

--	--
- in pregnancy months 3-4 (week 10-18) → how many times per months?

--	--
- in pregnancy months 5-9 (week 19-42) → how many times per months?

--	--

! *The next questions concern your living environment in the 3 months before pregnancy. When you have moved house in this period or during pregnancy, you can indicate this at question 75.*

71. Did you and/or partner have a company at home where chemicals were used in the 3 months before pregnancy?

- yes, a company with paint, varnish, adhesives or thinners (e.g. painting business)
- yes, a company with pesticides (e.g. farm or greenhouse)
- yes, a company with other chemicals (describe your company and the chemicals):
-
-
- no, no company at home with chemicals

72. Did you and/or your partner have a cattle farm in the 3 months before pregnancy?

- yes → what kind of cattle? cows sheep / goats
 pigs horses
 poultry other:
.....
- no

73. How would you describe your living environment in the 3 months before pregnancy?

- town - in the centre
 town - outside the centre
 village - in the heart of the centre
 village - outside the centre or in the country
 other:

74. Did you live close to a waste incineration plant in the 3 months before pregnancy?

- yes → distance between house and plant: kilometre
 no

75. Did you move house in the 3 months before or during pregnancy?

- yes
 no → skip to question 78 on the next page

76. When did you move?

Month:

Year:

77. Has your living environment been changed because you moved house. These changes include aspects asked in questions 71 to 74? (*The questions about a company at home, cattle farm, house location and the distance to the waste incineration plant*)

- yes → what has changed?
.....
.....
- no

6. Questions about your job

78. Did you have a job in the 3 months before or during pregnancy?
(With a job, we mean a paid job or voluntary work, working in your own company, (unpaid) assisting in your own company or moonlighting, for a minimum of 8 hours per week)

- yes
 no → skip to question 95 on page 26

79. When did you stop working or did you get your maternity leave?

- before you got pregnant → skip to question 81
 in pregnancy week:

--	--

 on the day of the delivery

80. Have you been absent from work for more than 3 weeks during pregnancy, before you stopped working? *(E.g. sickness or holiday)*

- yes → in pregnancy week

--	--

 until

--	--

in pregnancy week

--	--

 until

--	--

 no

81. How many hours per week did you work in the 3 months before or during pregnancy?
(You might have stopped working in the middle of a period. Please, fill in the hours you worked before you stopped. When you did not work at all during a period, please fill in 0)

- In the 3 months before pregnancy:

--	--

 hours per week
In pregnancy months 1-2 (week 0-9):

--	--

 hours per week
In pregnancy months 3-4 (week 10-18):

--	--

 hours per week
In pregnancy months 5-9 (week 19-42):

--	--

 hours per week

! **Questions 82 to 90 only concern your job activities in the 3 months before pregnancy. When you have changed jobs in this period or during pregnancy, you can indicate this at question 91. When your work remained the same, but your work activities changed during your pregnancy (e.g. less heavy lifting), you can indicate this at question 94.**

82. In what type of business/industry/trade did you work in the 3 months before pregnancy?

E.g.: In a supermarket.....
.....
.....

83. What was your job title/description?

E.g.: Counter clerk

.....

84. Please describe your main activities at work:

E.g.: Serving at the cash register, ordering the shop, pricing articles

.....

85. Please indicate in this table whether you worked with the following chemicals in the 3 months before pregnancy? **Notice: only use at your work.** (Please fill in the complete table)

	Did you work with these products in the 3 months before pregnancy?	
Personal care products (at work) <i>(like hairspray, hair dye, nail polish and creams)</i>	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
X-rays (at work)	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Anaesthetics - or working with patients who received anaesthetics	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Cytostatics <i>(chemotherapy)</i> - or working with patients who received cytostatics	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Disinfectants <i>(like alcohol and formaldehyde)</i>	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Domestic cleaning agents (at work) <i>(like all-purpose cleaner, interior cleaner and abrasive)</i>	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Industrial cleaning agents and solvents	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Water-based paint, varnish, adhesives, ink, or thinner (at work)	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Oil-based paint, varnish, adhesives, ink, or thinner (at work)	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
Other chemicals (at work):	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>
.....	<input type="checkbox"/> yes → how many hours per week? <input type="checkbox"/> no	<input type="text"/> <input type="text"/>

86. Were you exposed to exhaust fumes at work in the 3 months before pregnancy?
(E.g. at a loading platform or with fork-lifts)

yes → how many hours per week?

--	--

no

87. Were you exposed to fumes related with production processes at work in the 3 months before pregnancy? (E.g. welding fumes, plastic fumes and gasoline, but not for personal use)

yes → what kind of fumes?

no → how many hours per week?

--	--

88. Did you work with pesticides in the 3 months before pregnancy?
(To destroy herbicides, insects, fungicides, etc.)

yes → how many times per month?

--	--

no

89. Did others in your work environment use pesticides in the 3 months before pregnancy? (While you were working or in the evening or at night, after which you went working in that area the next day)

yes → how many times per month?

--	--

no

90. What kinds of pesticides were used? (More answers are possible)

insecticides

herbicides

fungicides

soil disinfectants

other:

no pesticides were used by me or in my work environment

91. Did you change jobs in the 3 months before or during pregnancy?

yes

no → skip to question 94

92. When did you change jobs?

Month:

Year:

--	--	--	--

93. Please describe your new job?

(Note the type of company, your job title and your main working activities; look at question 82, 83 and 84)

.....
.....
.....
.....
.....

94. Did your activities at work change in the 3 months before or during pregnancy?

(E.g. because you changed jobs or because you were pregnant. Especially think about the use of pesticides and other chemicals; look at question 85 to 90)

yes → what changed and from what week before or during pregnancy?

.....
.....
.....
.....
.....
.....
.....
.....

no

7. Questions about your diet

95. Did you have a vegetarian, vegan or other special diet during pregnancy? (*More answers are possible*)

- | | | | | |
|--|---------------------|----------------------|-------|----------------------|
| <input type="checkbox"/> vegetarian (<i>no meat or fish</i>) | → in pregnancy week | <input type="text"/> | until | <input type="text"/> |
| <input type="checkbox"/> vegan (<i>no animal products</i>) | → in pregnancy week | <input type="text"/> | until | <input type="text"/> |
| <input type="checkbox"/> low-salt or salt-free | → in pregnancy week | <input type="text"/> | until | <input type="text"/> |
| <input type="checkbox"/> slimming diet, please describe: | → in pregnancy week | <input type="text"/> | until | <input type="text"/> |

.....

- | | | | | |
|--|---------------------|----------------------|-------|----------------------|
| <input type="checkbox"/> other, please describe: | → in pregnancy week | <input type="text"/> | until | <input type="text"/> |
|--|---------------------|----------------------|-------|----------------------|

.....

- no

96. Did you use slimming supplements during pregnancy? (*like slimming bars, shakes, drinks or meals*)

- | | | | | |
|--|-----|---------------------|----------------------|-------|
| <input type="checkbox"/> yes, on a daily basis | } → | → which ones? | | |
| <input type="checkbox"/> yes, every now and then | | → in pregnancy week | <input type="text"/> | until |
| <input type="checkbox"/> no | | | | |

! **Questions 98 to 102 concern diet habits at this moment (currently) and during the first 4 months of pregnancy (week 0-18). Because you know your diet habits at this moment the best, you can use these diet habits to think about your diet habits during pregnancy. In other words: what did you eat differently or what did you eat more often or less often during pregnancy compared to nowadays?**

97. When were the first 4 months of pregnancy? (*mnemonic device for yourself*)

month 1: until month 4:

year:

year:

98. Please fill in this table completely. Per product you have to fill in the upper row about how often you eat this product currently. In the lower row you have to fill in how often you ate this product in the first 4 months of pregnancy.

		<u>never</u>	every now and then	1-2x per week	3-5x per week	6-7x per week
Example: Chips	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Sausage (as bread topping or at dinner)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Meat: cold cuts (as bread toppings)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Meat: beef, pork, veal, lamb, minced meat, etc. (at dinner)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Chicken and turkey (at dinner)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Organ meat (like liver, heart, kidneys)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Meat: snacks	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Fish and shellfish (like salmon, vissticks, mussels, etc)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Potatoes	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Pasta or noodles (including lasagne, macaroni, spaghetti, etc.)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Rice or cereals (like buckwheat and couscous)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Beans and other legumes (like peas and lentil, but no soy)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Salads and raw vegetables	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Green vegetables and cabbages (like broccoli, spinach, sprouts, cauliflower and kale)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other vegetables (like tomatoes, peppers, carrots and onions)	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

		<u>never</u>	every now and then	1-2x per week	3-5x per week	6-7x per week
Quorn <i>(meat replacement without soy)</i>	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
'Soy meat', soy beans, tempeh, tofu or tahoe	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Soy milk or soy drinks <i>(also in deserts)</i>	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Other soy products or meat replacements:	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Flaxseed <i>(loose seeds, oil or homeopathic use)</i>	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Nuts <i>(like cashew peanuts and walnuts)</i>	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Chocolate <i>(including bonbons, Mars, Nuts, Smarties, etc.)</i>	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Eggs	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Cheese <i>(including cream cheese, goat's milk cheese, cheese spread, etc.)</i>	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Yoghurt and pudding	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Breakfast cereals <i>(like cornflakes, oatmeal and muesli)</i>	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Crackers and rusk	currently: first 4 months of pregnancy:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

99. What kind of bread do you usually eat currently and how many slices per day on average? How many slices did you eat in the first 4 months of pregnancy?

	Currently:		In the first 4 months of pregnancy:				
<input type="checkbox"/> white, brown, wholemeal	→	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day			<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day		
<input type="checkbox"/> rye bread	→	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day			<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day		
<input type="checkbox"/> glut-free bread	→	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day			<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day		
<input type="checkbox"/> other:	→	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day			<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> slices per day		
.....							

100. How many pieces of fruit do you eat currently on average per week? How many did you eat in the first 4 months of pregnancy?

Currently:	In the first 4 months of pregnancy:
<input type="checkbox"/> none or less than 1 piece per week	<input type="checkbox"/> none or less than 1 piece per week
<input type="checkbox"/> 1-3 pieces per week	<input type="checkbox"/> 1-3 pieces per week
<input type="checkbox"/> 4-7 pieces per week	<input type="checkbox"/> 4-7 pieces per week
<input type="checkbox"/> 8-14 pieces per week (<i>1-2 pieces per day</i>)	<input type="checkbox"/> 8-14 pieces per week (<i>1-2 pieces per day</i>)
<input type="checkbox"/> 15 or more pieces per week	<input type="checkbox"/> 15 or more pieces per week

101. How many glasses of fruit juice do you drink currently on average per week? How many glasses did you drink in the first 4 months of pregnancy? (*E.g. orange juice, apple juice or multifruit juice*)

Currently:	In the first 4 months of pregnancy:
<input type="checkbox"/> none or less than 1 glass per week	<input type="checkbox"/> none or less than 1 glass per week
<input type="checkbox"/> 1-3 glasses per week	<input type="checkbox"/> 1-3 glasses per week
<input type="checkbox"/> 4-7 glasses per week	<input type="checkbox"/> 4-7 glasses per week
<input type="checkbox"/> 8-14 glasses per week (<i>1-2 glasses per day</i>)	<input type="checkbox"/> 8-14 glasses per week (<i>1-2 glasses per day</i>)
<input type="checkbox"/> 15 or more glasses per week	<input type="checkbox"/> 15 or more glasses per week

102. How many glasses of milk or milk products do you drink currently on average per week? How many glasses did you drink in the first 4 months of pregnancy? (*Also milk with the cornflakes, chocolate milk, fruit milks like Fristi and Yoghy-drink*)

Currently:	In the first 4 months of pregnancy:
<input type="checkbox"/> none or less than 1 glass per week	<input type="checkbox"/> none or less than 1 glass per week
<input type="checkbox"/> 1-3 glasses per week	<input type="checkbox"/> 1-3 glasses per week
<input type="checkbox"/> 4-7 glasses per week	<input type="checkbox"/> 4-7 glasses per week
<input type="checkbox"/> 8-14 glasses per week (<i>1-2 glasses per day</i>)	<input type="checkbox"/> 8-14 glasses per week (<i>1-2 glasses per day</i>)
<input type="checkbox"/> 15 or more glasses per week	<input type="checkbox"/> 15 or more glasses per week

103. Perhaps there are things in your living environment, life style or medical history of which you think that they might (also) play a role in the aetiology of the malformation of your child. Please write down these factors below.

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104. When you have any other questions or comments about this questionnaire, please feel free to write them down below.

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Finally



We will remove this page from the questionnaire and store it separately.

Your name and address

Name:

Address:

.....

Telephone number:

Email:

Date of filling in this questionnaire:

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day month year

105. Do you allow us to contact you in case something is unclear in this questionnaire?

- yes
- no

106. Do you allow us to contact you to ask for participation in a follow-up study when necessary?
(You can always decide at that time whether you will or will not participate definitively)

- yes
- no

107. Would you like to receive a report about the most important results of this study?

- yes
- no

Thank you very much for filling in the questionnaire!