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ESBIO

Development of a coherent approach to human biomonitoring in Europe

Coordination Action

Priority 8.1

D2.3.2

Questionnaire for the Pilot Study

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Dissemination Level		
PU	Public	
PP	Restricted to other programme participants (including Commission Services)	
RE	Restricted to a group specified by the consortium (including the Commission Services)	X
CO	Confidential, only for members of the consortium (including the Commission Services)	

Final Draft

Questionnaire for the Pilot Study

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Table of content	page
I. Introduction	2
II. In-/Exclusion	3
III. Socio-Demography	7
IV. Environment and Food Frequency	10
V. Admission and Sampling	22

I. Introduction

The first draft of this paper was disseminated among ESBIO/IG members in June 2006. Comments and suggestions received were reviewed and taken into account for elaboration of the second draft in December 06. Further in-put and minor refinements lead to this very final deliverable.

It was emphasized that the utilization of questionnaires is the most practical and economical procedure for exposure assessment purposes. The group proposes a self-explanatory auto-questionnaire which shall be completed by the participants within 45 minutes. Accordingly, questions should be plain and related answers - preferentially dichotomized/categorized - should allow for ticking .

The questionnaire is divided into four sections which will be outlined briefly.

In-/Exclusion is aiming at the (pre-selected) mothers and addresses eligibility criteria of the human biomonitoring study, e.g. common household of mother and child, duration of residency and language ability. Additionally, the willingness to participate and potential motives for refusal, respectively, can be explored. It offers the opportunity to evaluate determining factors for non-responders.

Socio-Demography shall be filled by participants only and addresses social determinants such as migrational, educational and occupational background. Usually, models for social stratification include a monetary parameter such as the household income. However, corresponding questions are crucial and might provoke legal restrictions in some MS.

Environment and Food Frequency shall be filled by the participating mothers and is supposed to facilitate the individual and overall exposure assessments by elucidating the participants' association with known (or suspected) exposure sources of various domains (indoor/ambient, food, lifestyle habits). Some information concerning the child shall be provided by its mother. This section of the questionnaire is tailored for the 'basic' biomarkers (Pb, Cd, Meth-Hg, Cotinine) plus PAHs. Depending on the extension of further biomarkers, adjustments and additional questions might be necessary.

Admission and Sampling addresses very basic health-related matters and the guided documentation of specimen (blood, urine and hair) collection. This section shall be managed by health officials only.

II. In-/Exclusion (to be filled by the MOTHER)

BRIEF DESCRIPTION

Add introductory text about the context of the survey.

Firstly, we would like to ask a few questions about your person.

1. What is your date of birth?

--	--	--	--	--	--	--	--	--	--

Day Month Year

ALTERNATIVELY, IF THE LAWS OF THE COUNTRY DO NOT ALLOW THE INCLUSION OF THE DATE OF BIRTH OR IF DATE OF BIRTH NOT GIVEN/KNOWN:

How old are you?

--	--

 years

2. How long have you been resident in [*member state*]?

Since birth

 Please go to Question 3.

For

--	--

 years

: if less than 1 year, please fill in 0 = Zero

If you do NOT know the number of years exactly, please tick for estimation in terms of:

- less than 5 years


- more than 5 years

3. How long have you been resident at your current address?

For

--	--

 years

: if less than 1 year, please fill in 0 = Zero

If you do NOT know the number of years exactly, please tick for estimation in terms of:

- less than 3 years

- more than 3 years

7. With whom does your child stay predominantly?

 Please tick only one option

both biological parents	<input type="checkbox"/>
mother	<input type="checkbox"/>
mother and her spouse/partner	<input type="checkbox"/>
father	<input type="checkbox"/>
father and his spouse/partner	<input type="checkbox"/>
grandparents	<input type="checkbox"/>
other relatives	<input type="checkbox"/>
adopting parents	<input type="checkbox"/>
foster parents	<input type="checkbox"/>
children's home	<input type="checkbox"/>
other.....	<input type="checkbox"/>

8. a) Does your child stay permanently at this place/address marked above?

YES

 Please go to Question 8.c).

NO

 Please go to Question 8.b).


b) How many days per month does your child stay at this place?

days per month

 Example: 5 days per week x 4 = 20 days per month

c) How many years has your child stayed at this place?

For years

 if less than 1 year, please fill in 0 = Zero

If you do NOT know the number of years exactly, please tick for estimation in terms of:

- less than 3 years


- more than 3 years

That is the end of this questionnaire and we would like to thank you very much for your kind co-operation and efforts provided.


After you have gained insights about the scope of this health-exercise, we would like to ask you one more question concerning the further conduction of the survey.

9. Would you be interested to participate with your child in this forthcoming survey?

YES

- Likely** if:
- I/we gain more information about the procedures.
 - my child wants to participate.
 - I/we gain consent from my spouse/partner/family.
 - the study is approved by an ethics committee and data protection is assured.
 - MD/Health Authority supports the idea of the survey.
 - the time schedule is appropriate/convenient for us.
 - I/we stand to benefit from the participation.
 - others .

Your personal comments.....
.....
.....

- NO** because
- I/we can hardly spare time for such activities.
 - the transport to the sampling centre is too expensive.
 - I do not support surveys in general.
 - I/we prefer privacy in private matter.
 - I am currently ill/pregnant/awaiting hospital admission.
 - I am severely disabled/suffering from chronic disease.
 - my child is currently ill/awaiting hospital admission.
 - my child is severely disabled/suffering from chronic disease.
 - my child probably will not like to participate.
 - I/we refuse the sampling of blood/urine.
 - we are moving to another location soon.
 - the questions are difficult; I can not understand/answer all of them.
 - others .

Your personal comments.....

III. Socio-Demography

We would like to ask some questions about you and your household.

1. Who is answering/filling this questionnaire?

Please tick only once!

Mother	<input type="checkbox"/>
Father/Spouse/Partner	<input type="checkbox"/>
Mother and Father/Spouse/Partner	<input type="checkbox"/>
Grandparents/ other relatives	<input type="checkbox"/>
Adopting parents/ foster parents	<input type="checkbox"/>
Other person.....	<input type="checkbox"/>

2. Where were you born? Please answer for both parents if possible.

Mother:

In [memberstate] In a different country
 Which one

Father/Spouse/Partner:


In [memberstate] In a different country
 Which one

3. a) Since when do you live in [memberstate] ?

Please answer again for both parents if possible.


Mother:

Since birth since (year) |_|_|||_|_|

if less than 5 years
 please go to b) 
 otherwise go to 4.

Father/Spouse/Partner:

Since birth since (year) |_|_|||_|_|

if less than 5 years
 please go to b) 
 otherwise go to 4.

b) Where did you live previously?

Mother: in.....

Father/Spouse/Partner: in.....

4. Which languages do you speak at home?

[languages of memberstate] Other languages

Which ones

.....

5. What is your highest level of education?

Please answer for both mother (M) and father/spouse/partner (F/S/P) if possible.

	M	F/S/P
Primary education, or first stage of basic education, or less (ISCED 0-1)	<input type="checkbox"/>	<input type="checkbox"/>
Lower secondary education, or second stage of basic education (ISCED 2)	<input type="checkbox"/>	<input type="checkbox"/>
(Upper) secondary education (ISCED 3)	<input type="checkbox"/>	<input type="checkbox"/>
Post-secondary non-tertiary education (ISCED 4)	<input type="checkbox"/>	<input type="checkbox"/>
First stage of tertiary education (ISCED 5)	<input type="checkbox"/>	<input type="checkbox"/>
Second stage of tertiary education (ISCED 6)	<input type="checkbox"/>	<input type="checkbox"/>
I do NOT know	<input type="checkbox"/>	<input type="checkbox"/>

THE RESPONSE CATEGORIES SHOULD BE NAMED ACCORDING TO THE EDUCATIONAL SYSTEM OF THE MEMBER STATE.

6. Are you at present:

Please answer again for both if possible.

	M	F/S/P
Employed / self-employed	<input type="checkbox"/>	<input type="checkbox"/>
Looking for work / a job	<input type="checkbox"/>	<input type="checkbox"/>
Unable to seek work because of temporary illness or injury	<input type="checkbox"/>	<input type="checkbox"/>
Permanently unable to work	<input type="checkbox"/>	<input type="checkbox"/>
Retired	<input type="checkbox"/>	<input type="checkbox"/>
At school / college / university	<input type="checkbox"/>	<input type="checkbox"/>
Looking after the home or family	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>
I do not know	<input type="checkbox"/>	<input type="checkbox"/>

We would like to ask some questions about the income of your household.

7. The following list shows various possible sources of income. Can you please tick the ones which constitute your household income?

Please tick all that apply

Earnings from employment	<input type="checkbox"/>
Earnings from self-employment	<input type="checkbox"/>
Pension from a former employer	<input type="checkbox"/>
State Pension	<input type="checkbox"/>
Child Benefit	<input type="checkbox"/>
Income Support	<input type="checkbox"/>
Other State Benefits	<input type="checkbox"/>
Interest from savings etc.	<input type="checkbox"/>
Other kinds of regular allowance from outside the household	<input type="checkbox"/>
Other sources e.g. rent	<input type="checkbox"/>
No source of income	<input type="checkbox"/>

8. Perhaps you can provide the approximate net range of your household's total income. Is the monthly amount, after tax and social insurance contributions....?

less than P5	<input type="checkbox"/>
P5 to under P10	<input type="checkbox"/>
P10 to under P20	<input type="checkbox"/>
P20 to under P40	<input type="checkbox"/>
P40 to under P60	<input type="checkbox"/>
P60 to under P80	<input type="checkbox"/>
P80 to under P90	<input type="checkbox"/>
more than P90	<input type="checkbox"/>

CATEGORIES SHOULD BE GIVEN IN AMOUNTS OF CURRENCY AND ADAPTED ACCORDING TO THE NATIONAL INCOME DISTRIBUTION OF THE MEMBER STATE (using registers or other available sources).

IV. Environment and Food Frequency

to be filled by the mother

ID No. of mother	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID No. of child/adolescent	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Date (of interview)	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> . 200 <input type="text"/>
---------------------	--

Residential environment and residence

1. a) Does your child live in this flat/ house on a permanent basis?

Yes..... 👉 Go to Question 2!

No.....

↓

b) How many days per month does your child live in this flat/ house?

days per month

👉 Example: 5 days per week x 4 = 20 days

2. Is this flat/ house located at a

- major/ main road?

- side/ back road?

- residents-only street/ traffic-calmed zone/ field path/ track?.....

D2.3.2 Questionnaire for the Pilot Study

3. Approximately how many metres away is this street from your home?

metres away

4. In what region is your house/ flat located?

a) Size of city/town/village  **NOT county/district/state**

- up to 1,999 inhabitants.....
- 2,000 to 4,999 inhabitants.....
- 5,000 to 19,999 inhabitants.....
- 20,000 to 49,999 inhabitants.....
- 50,000 to 74,999 inhabitants.....
- 75,000 to 99,999 inhabitants.....
- 100,000 to 249,999 inhabitants.....
- 250,000 to 499,999 inhabitants.....
- More than 500,000 inhabitants.....
- Don't know.....

b) Area type


- City centre.....
- Near city centre.....
- Suburbia.....
- Industrial.....
- Rural / village.....
- Don't know.....

5. Is there any of the following within 50 m radius around your home?

	Yes	No
A) a petrol station?.....	<input type="checkbox"/>	<input type="checkbox"/>
B) a car repair shop?.....	<input type="checkbox"/>	<input type="checkbox"/>
C) a printing business (this does not cover copy centres)?.....	<input type="checkbox"/>	<input type="checkbox"/>
D) a dry cleaning business?.....	<input type="checkbox"/>	<input type="checkbox"/>
E) a metalworking business (e.g. a locksmithery, steel constructions)?....	<input type="checkbox"/>	<input type="checkbox"/>
F) a scrap yard?	<input type="checkbox"/>	<input type="checkbox"/>
G) a waste incineration plant?.....	<input type="checkbox"/>	<input type="checkbox"/>
H) a commercial solvent user (e.g. a painting business)?	<input type="checkbox"/>	<input type="checkbox"/>
I) a livestock stable (this does not cover pet shops).....	<input type="checkbox"/>	<input type="checkbox"/>
J) a garden centre, a tree nursery, an orchard, farmland?.....	<input type="checkbox"/>	<input type="checkbox"/>
K) a saw mill, wood storage site, joiner's workshop (this does not cover DIY stores also selling wood)?	<input type="checkbox"/>	<input type="checkbox"/>

6. Let us look into your child's domestic situation.



What **type of house** is the home in which your child mainly lives?

a) It is a	Yes	No
A) single-family house.....		
-- detached house, bungalow.....	<input type="checkbox"/>	<input type="checkbox"/>
-- semi-detached house.....	<input type="checkbox"/>	<input type="checkbox"/>
-- farmhouse.....	<input type="checkbox"/>	<input type="checkbox"/>
B) multi-family house	<input type="checkbox"/>	<input type="checkbox"/>
C) apartment block, multi-storey building.....	<input type="checkbox"/>	<input type="checkbox"/>
D) Other (e.g. caravan, railway car, cabin)..... 	<input type="checkbox"/>	<input type="checkbox"/>
specify: _____		

	Yes	No	Don't know				
b) Garage							
Is there a garage built-in/part of the house?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
7. When was the house built?							
If you don't know precisely, give an estimate.							
Before 1900	<input type="checkbox"/>						
<i>A year has to be entered below for houses built after 1900.</i>							
After 1900	<input type="checkbox"/>						
↓							
In what year?	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						
Don't know.....	<input type="checkbox"/>						
8. How many square metres does your home have?							
If you don't know exactly, please give an estimate.							
<i>Interviewer: Round the figure given by interviewee and enter below</i>							
			<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> m ²				
9. What is the main type of heating in your home?							
👉 One mark only!							
Individual stove in each room (several firing units within the home).....	<input type="checkbox"/>						
Heating system covering one flat/floor (one firing unit within the home).....	<input type="checkbox"/>						
Central heating (one firing unit in the house/basement).....	<input type="checkbox"/>						
District heating (no firing unit in the house).....	<input type="checkbox"/>						
Don't know.....	<input type="checkbox"/>						

10. What is the main fuel or energy source used in this flat/ house for cooking?
 What is the main fuel or energy source for heating?

Please mark for each column but only one mark per column!

	Cooking	Heating
Oil.....	<input type="checkbox"/>	<input type="checkbox"/>
Gas.....	<input type="checkbox"/>	<input type="checkbox"/>
Coal, charcoal, wood.....	<input type="checkbox"/>	<input type="checkbox"/>
Electric power.....	<input type="checkbox"/>	<input type="checkbox"/>
District heating.....		<input type="checkbox"/>
Geothermal energy.....		<input type="checkbox"/>
Solar energy.....	<input type="checkbox"/>	<input type="checkbox"/>
Other..... 	<input type="checkbox"/>	<input type="checkbox"/> 
Please specify:.....	_____	_____
Don't know	<input type="checkbox"/>	<input type="checkbox"/>

11. Are there any additional stoves used in your home that are fired with wood/ coal?

This would cover tile stoves, hot-water heaters, universal burners and open fireplaces.

Yes

No.....

12. Has a clinical thermometer containing mercury (silver-coloured fluid) been broken in your home within the past 12 months?

Yes.....

No.....

Don't know...

Let us now have a look on tobacco smoke.

13. a) Is there anybody **smoking** in this flat/ house?

No

Please go to Question 15!

Yes



b) How many persons usually smoke in this flat/ house?

persons

c) And how many cigarettes/cigars/pipes per day are usually smoked in this flat/ house? Please give an estimate if you don't know exactly.



cigarettes/cigars/pipes per day

14. Please enter below the **age, gender and smoking habits** of **all household members**.

Please think also of mother's help, domestic nurse, subtenant, etc.



	gender		age	smoking habit	
	m	f		non-smoker	smoker
Person interviewed	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child surveyed	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. other person	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. other person	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. other person	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. other person	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. other person	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. other person	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. other person	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. How often do you have visitors who smoke inside this flat/ house?


 Please bear in mind also parties, anniversaries and special occasions 

	daily	4-6 times a week	2-3 times a week	once a week	less often	never	don't know
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


16. How often do you / does your child usually stay in rooms in which people smoke?

 Please provide information on you and your child for each of the locations indicated 

a) How frequently do you usually spend time in rooms in which people smoke?

	daily	4-6 times a week	2-3 times a week	once a week	less often	never
A) at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) at friends/relatives/ neighbours.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) in restaurants, ice-cream parlours, pubs, discotheques, sports clubs, at events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) in means of transport (train, bus, car)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) elsewhere: 	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) How frequently does your child usually spend time in rooms in which people smoke?

	daily	4-6 times a week	2-3 times a week	once a week	less often	never	don't know
A) at home.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B) at friends/relatives/ neighbours.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) in restaurants, ice-cream, parlours, discotheques (for kids), youth centres, youth clubs .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) at kindergarten, after-school care centre / coaching centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) in means of transport (train, bus, car)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) elsewhere: 	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Let us now move on to the subject of water.

17. a) What is your main source of water for drinking? (including the water used to prepare coffee, tea, juices, etc.)

- Public water supply.....
- Commercial producers (bottle, plastic vat/
container, Tetrapak).....
- Own well.....
- Don't know.....

b) What is your main source of water for cooking?

- Public water supply.....
- Commercial producers (bottle, plastic vat/
container, Tetrapak).....
- Own well.....
- Don't know.....

18. Of what material are the water pipes in your flat/ house?

Copper

Iron (zinc-plated steel pipes)

Stainless steel

Lead

Plastic




Other material

Specify: _____

Don't know

Now we would like to ask a few **questions about the foods** you and your child usually eat. We will begin with you.

19. a) How often did you eat the following foods in the last 4 weeks?

	Several times a day	Daily	Several times a week	Once a week	2-3 times a month	Once a month	Al-most never
A) Foods grilled above open fire/hot coals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Rice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Innards..... (liver, kidney, sweetbread, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Game	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Wild mushrooms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Fish / seafood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 Please remind also tuna in a salad or on sandwich/pizza and prawn cocktail, etc. 							
	Several times a day	Daily	Several times per week	Once a week	2-3 times a month	Once a month	Al-most never
F1) Seawater fish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2) Freshwater fish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3) Others... 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e.g. lobster, crayfish, shrimp, prawn, oysters, mussels, squid, calamari)							

b) How often in the last four weeks did your child eat the following foods?

	Several times a day	Daily	Several times a week	Once a week	2-3 times a month	Once a month	Al-most never	Don't know
A) Foods grilled above open fire/hot coals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Innards..... (liver, kidney, sweetbread, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Game	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Wild mushrooms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Fish / seafood..... [👉]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

👉 Please remind also tuna in a salad or on a sandwich/pizza and prawn cocktail, etc. 👉

	Several times a day	Daily	Several times per week	Once a week	2-3 times a month	Once a month	Al-most never	Don't know
F1) Seawater fish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2) Freshwater fish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3) Others..... (e.g. lobster, crayfish, shrimp, prawn, oysters, mussels, squid, calamari)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Do you eat home-grown fruit/vegetables?

No..... **👉 Please go to Question 22!**

Yes.....

↓

a) How often do you eat home-grown fruit/vegetables?
(fresh and preserved by methods such as freezing, pickling, sugaring, drying, etc)

	Several times a day	Daily	Several times a week	Once a week	2-3 times a month	Once a month	Al-most never
A) Fruit/vegetables (fresh)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Fruit/vegetables (preserved)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D2.3.2 Questionnaire for the Pilot Study

b) How often does your child eat home-grown fruit/vegetables?								
	Several times a day	Daily	Several times a week	Once a week	2-3 times a month	Once a month	Al- most never	Don't know
A) Fruit/vegetables (fresh)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Fruit/vegetables (preserved)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you know the origin of these home-grown fruit/vegetables?								
(e.g. your own/relative's/friend's garden, location of the farm you purchase from, etc)								
Yes..... <input type="checkbox"/>				No..... <input type="checkbox"/>				
22. How frequently do you drink alcohol?								
(Expressed in glasses usual in volume of the beverage and according to national custom and usance)								
	1 or more glasses a day	5 - 6 glasses a week	2 - 4 glasses a week	1 glass a week	1 - 3- glasses a month	less than 1 glass a month	never	
A) Beer (250-400 ml)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Wine, fruit wine, sparkling wine (100-200 ml)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Spirits (20-35 ml)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In conclusion, we would like to ask you some **questions on your child's behaviour when being outdoors.**

23. About how much time per day does your child spend outdoor?

Please think of the last 12 months.

A) In summertime..... hours minutes per day

B) In wintertime..... hours minutes per day

24. a) Now a few questions on your child's behaviour when playing outdoors.

Please think of the last 12 months.

 one tick per row

	daily	several times a week	once a week	rarely	never
--	-------	----------------------------	----------------	--------	-------

A) How often has your child had **intensive contact with soil and sand**, e.g. when playing, digging, building caves?....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

B) How often does your child **eat whilst playing outdoors?**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

b) How do the clothes, face and hands of your child look when returning home from playing, doing sports and hobbies? Please think of the last 12 months.

Totally clean.....

Fairly clean

A little dirty

Very dirty

We are at the end of the questionnaire and thank you very much for your time offered!

V. Admission and Sampling

Admission and Specimen Sampling Documentation

ID-No. Participant	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID-No. Examination Centre	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID-No. Examiner	<input type="text"/> <input type="text"/>

ADMISSION

1. Date of examination	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 200 <input type="text"/>	
	day month year	
2. Date of birth	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	day month year	
ALTERNATIVELY, IF THE LAWS OF THE COUNTRY DO NOT ALLOW THE INCLUSION OF THE DATE OF BIRTH OR IF DATE OF BIRTH NOT GIVEN/KNOWN:		
Age in years	<input type="text"/> <input type="text"/> years	
3. Gender	male..... <input type="checkbox"/>	female..... <input type="checkbox"/>
4. Size and weight	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ,	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ,
	size in cm	weight in kg
		<i>Please determine values by using a graduated measurement rod and scales!</i>
5. Dental amalgam fillings	amalgam fillings yes..... <input type="checkbox"/>	
	no..... <input type="checkbox"/>	go to 6.
	don't know.... <input type="checkbox"/>	go to 6.
	number of teeth with amalgam fillings <input type="text"/> <input type="text"/>	
	age of last filling(s) <input type="text"/> <input type="text"/> years	<i>Please indicate age in terms of year and/or month; if age less than 1 month, fill in 0 (zero).</i>
	<input type="text"/> <input type="text"/> months	
	don't know.... <input type="checkbox"/>	

6. Skin bleaching

Previous treatments for skin bleaching? no.....

go to 7.

yes.....

last treatment years ago

months ago

If known:

name of product

7. Fish consumption

today yester- 2 days 3 days > 3 days do not
 day ago ago ago know

When was the last consumption of fish or seafood prior to this visit?

8. Vitamin and mineral supplementation

a) Intake of vitamins and/or minerals for supplementation? no

End of Admission.

yes

which and how often?

Frequency

b) Type of supplement daily 3-5 x a week once a week erratic never

Vitamin C

Multi-Vitamin-preparation

Multi-Mineral-preparation

Multi-Vitamin & Mineral-preparation

Iron-preparation

Calcium-preparation

Selenium-preparation

I do not know

Other preparation

which?

Name or content of supplement:

PROTOCOL FOR MORNING URINE SAMPLE TREATMENT

ID-No. Examiner	<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/>						
Signature Examiner	<hr style="border-top: 1px dotted black;"/>						
1. Sample							
a) Was morning urine delivered?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 0 10px;">yes</td> <td style="padding: 0 10px;">no</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"> reason?</td> </tr> </table>	yes	no		<input type="checkbox"/>	<input type="checkbox"/>	reason?
yes	no						
<input type="checkbox"/>	<input type="checkbox"/>	reason?					
<hr style="border-top: 1px dotted black;"/>							
2. Date and time of urine collection							
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	200 <input style="width: 30px; height: 20px;" type="text"/>						
day month	year						
at <input style="width: 30px; height: 20px;" type="text"/> : <input style="width: 30px; height: 20px;" type="text"/>	hr min						
At what time was the last urination <u>before</u> morning urine collection?	at <input style="width: 30px; height: 20px;" type="text"/> : <input style="width: 30px; height: 20px;" type="text"/>						
hr min							
Remarks <hr style="border-top: 1px dotted black;"/>							
3. Type of container							
1 L bottle	<input type="checkbox"/>						
Toilet insert	<input type="checkbox"/>						
Other type	<input type="checkbox"/> please specify						
Type / Brand	<hr style="border-top: 1px dotted black;"/>						
4. Amount sampled							
Gross weight	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> , <input style="width: 30px; height: 20px;" type="text"/> g						
5. pH-value							
pH	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>						
6. Sub-Samples							
Number of test portions prepared:	<div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; margin: 0;"><i>should-be</i></p> <p style="margin: 5px 0;">X</p> <p style="margin: 5px 0;">Y</p> <p style="margin: 5px 0;">Z</p> </div>						
small tubes <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>							
large tubes <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>							
bottles with screw tops <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>							

7. Any particular observations?

.....

8. Labelling of sub-samples and transport containers

Numbered labels affixed? yes

no → Please do it now done!

9. Date and time of freezing the samples


. 200 at :
day month year hr min

PROTOCOL FOR SAMPLING OF HAIR

ID-No. Examiner	<input type="text"/> <input type="text"/>
Signature Examiner

1. Sampling

yes no

Sampling permitted and possible?  reason?


2. Date of hair sampling


. 200

day month year

3. Structure of hair

a) Chemical hair structure treatment within previous 12 months?
(e.g. for/against curls, permanent waves, etc)

no  go to 3.b)

yes  when?

last application months ago

respectively weeks ago

b) Natural structure of hair

straight


undulated


curly

If less than 1 week, fill in 0 (zero).

4. Colour of hair

a) Hair dyed/toned within previous 6 months?

no  go to 4.b)

yes  when?

last application months ago

respectively weeks ago

If less than 1 week, fill in 0 (zero).

4. contd.

b) Natural colour of hair

tick all applicable 

- black/dark brown
- brown
- brunette
- blond/fair
- red/strawberry blond
- grey/ash blond
- white

5. Last hair wash

When was the last washing prior to sampling? days ago
 respectively hours ago

6. Length of hair

Approximate length from scalp to hair tips cm

Measured at the foreseen sampling area (occipitale)

7. Sampled hair

*Cut from the back of the head (occipitale)
 and close to the skin (proximale)*

Length of sampled hair cm

Weight of sampled hair mg

Should-be:

3-4 cm

100-150 mg

8. Any particular observations?

.....

9. Labelling of sample transport bag

Numbered label affixed? yes
 no → Please do it now done!