**RESEARCH PROJECT**

*RESPIR*

**“*Registro y Análisis Epidemiológico de las Sibilancias y el Asma en una Población Infantil en La Ribera* (Registry and Epidemiological Analysis of Wheezing and Asthma in a Childhood Population of La Ribera)”**

**Dear parents,**

**Continuing with the RESPIR study protocol in which your child is participating, we submit the questionnaire corresponding to 6 years of age. Please read the questions carefully and mark (X) the corresponding answer. You can return the questionnaire to us in the supplied pre-stamped envelope or deliver it to the Alzira Primary Care Center. Thank you again for your attention.**

QUESTIONNAIRE 6 YEARS OF AGE

1 Has your child ever experienced Yes ❑

 “whistling sounds” in the chest No ❑

 between 3 and 6 years of age?

2 Has your child experienced Yes ❑

 “whistling sounds” in the chest No ❑

 In the last 12 months?

3 How many None ❑

 “whistling sound” episodes in the chest has your child Less than 3 ❑

experienced in the last 12 months? 3 or more ❑

*IF YOU HAVE ANSWERED “NO” IN BOTH AND ” NONE”, GO DIRECTLY TO QUESTION 11*

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NOTE: ALL THE QUESTIONS REFER TO WHAT HAS HAPPENED **ONLY** BETWEEN 3 AND 6 YEARS OF AGE. THE INFORMATION CORRESPONDING TO EARLIER AGES WAS ALREADY COLLECTED IN PREVIOUS QUESTIONNAIRES.

4 Have you needed to visit the Yes, less than 3 times ❑

 pediatrician because of this (“whistling”)? Yes, more than 3 times ❑

 No ❑

5 Have you needed to visit the emergency Yes, less than 3 times ❑

 room because of this? Yes, more than 3 times ❑

 No ❑

6 Has your child been hospitalized Yes, once ❑

 more than 24 hours because of this? Yes, 2 or more times ❑

 No ❑ No ❑

7 Has your child been seen in private centers Yes ❑

 (pediatrician, emergency service or hospital) or No ❑

 other public services outside La Ribera because of this?

8 What type of medicine does the pediatrician Inhaled (aerosol) ❑

 prescribe when your child Syrup ❑

 develops “whistling sounds” in the chest? Both ❑

 None ❑

9 Has your child received some medicine None ❑

 for daily use to prevent “whistling” Inhaled (aerosol) ❑

during more than 3 months? Oral (packet) ❑

 Both ❑

If affirmative, indicate whether it is

any of the following medicines:

 Pulmicort® ❑ Pulmictan® ❑ Budesonide® ❑ Flixotide® ❑

 Flusonal® ❑ Inalacor® ❑ Singulair® ❑ Seretide® ❑ Plusvent® ❑

 Other ❑ (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

10 Has your child received oral corticosteroids in the last 3 years? No ❑

 (e.g., Estilsona®, Zamene® or Dezacort®) Yes ❑

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11 Has any doctor indicated that No ❑

 your child has asthma? Yes ❑

12 Has your child experienced skin itching No ❑

 or wheals on the elbows, ankles, knees Yes ❑

 or buttocks between 3 and 6 years of age?

13 Has any doctor indicated that your child No ❑

 has atopic dermatitis or atopic eczema Yes ❑

 between 3 and 6 years of age?

14 Do you have any pet at home? Dog ❑

 Cat ❑

 Other hairy animal ❑

 Birds ❑

 Other / No animal ❑

 If affirmative, how long have you had it? Less than 1 year ❑

 More than 1 year ❑

15 Is the mother of the child an active smoker at present? No ❑

 Yes ❑

16 Is the father of the child an active smoker at present? No ❑

 Yes ❑

17 Does anyone smoke in the home of the child

 at present? No ❑

 Yes ❑

If affirmative, how many cigarettes in total are smoked a day in the home?

(e.g.,: the mother smokes 4 + the father smokes 5 + other people smoke 3 = 12 cigarettes)

Less 10 cigarettes ❑

10-20 cigarettes ❑

More than 20 cigarettes ❑

After your child reaches 6 years of age, we propose allergy tests, which will provide information about the risk of suffering asthma later in life. The tests (known as skin tests or prick-tests) will be made with the usual method, are not painful, and will allow the results to be known immediately.

If you are interested, please mark the corresponding box and provide a telephone number for us to contact you and arrange an appointment. Please feel free to ask us any questions you may have by calling us at the provided telephone number.

Yes, I wish our child to undergo the allergy tests ❑

 Contact telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No, I prefer no testing of our child ❑