OptEC Trial: Optimizing early child development in the primary care practice setting: Pragmatic randomized trial of iron treatment for young children with non-anemic iron deficiency

## Follow-up Data Collection Form - Data linking sheet

 (To be stored separately from study data)ID String \# $\qquad$
Age $\qquad$ (months)

Home Telephone \# $\qquad$
Name of caregiver interviewed $\qquad$
Relationship to child $\qquad$

OptEC Trial: Optimizing early child development in the primary care practice setting:
Pragmatic randomized trial of iron treatment for young children with non-anemic iron deficiency (NAID)

## Follow-up Data Collection Form

1. How many days last week did your child receive the provided study drug (circle one)?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |

2. Since starting this study, has your child taken any iron supplements regularly other than the ones provided for this study (fill in all that apply)?

- No
- Iron: Ferinsol __ ml per $\qquad$ (day, week, month, year)
- Iron: Other ml per ml per $\qquad$ (day, week, month, year)

3. Since starting this study, has your child taken any other vitamins or supplements regularly (fill in all that apply)?

- No
- Vitamin D: Drops _mer per $\qquad$ (day, week, month, year)
- Vitamin D: Liquid ml per $\qquad$ (day, week, month, year)
- Multivitamin (without iron) ml per $\qquad$ (day, week, month, year)
- Other-Please explain

4. How hard or easy has it been to give the provided study drug?

5. Did your child like taking the study drug (circle one)?

- Yes
- No
- Indifferent

6. In a typical week, how many days did your child receive the study drug (please circle)?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |

7. If your child received the study drug 6days/week or less, please state the reason (circle all that apply)?

- Takes too long

Yes
No
Yes
No
Yes
No

- Not convinced that it will benefit my child
Yes
No
- Too hard to give it
Yes
No
- Forgot
Yes
No
- Other reason(s)
Yes
No

8. Did your child experience any of the following while administering the study drug (circle all that apply)?

| - Coughing | Yes | No |
| :--- | :--- | :--- |
| - Spitting up | Yes | No |
| - Choking, gagging | Yes | No |
| - Unhappy with the taste | Yes | No |

9. Did your child experience any of the following during the past 4 months (circle all that apply)?

- Staining of the teeth Yes No
- Constipation Yes No
- Loose stool Yes No
- Passage of black stool Yes No

10. Is your child currently breastfeeding (please circle)?

- Yes
- No - at what age did you stop breastfeeding? $\qquad$ months
- Not applicable, did not breastfeed

11. Please specify your child's diet for the past 3 days. Please check all that apply.Breast milk
Infant formula
$\square$ Red meat (beef, veal, pork, lamb, etc.)
$\square \quad$ Poultry (chicken, turkey, duck, etc.)
$\square \quad$ Fish (salmon, halibut, haddock, cod, tuna, etc.)
$\square \quad$ Shellfish (lobster, crab, shrimp, etc.)
$\square$ Eggs
Milk $\square$ Skim $\square 1 \% \quad \square \mathbf{2 \%} \square$ Homo
Fruits
Vegetables
$\square$ Cheese
$\square$ Yogurt
$\square \quad$ Margarine

- Honey
$\square$ Whole grain products (bread, bagel, bun, cereal, pasta, rice, roti, tortillas, etc.)
$\square$ Fast Food
$\square \quad$ Infant cereal
$\square$ Vegetarian: does not eat red meat, poultry, fish or shellfish
$\square \quad$ Vegan: does not eat red meat, poultry, fish, shellfish, eggs, dairy or honey

12. Circle how many cups of each drink your child has currently in a typical day. ( 1 cup $=8$ ounces $=250 \mathrm{ml}$ )

| Cow's milk | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Infant formula |  | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |
| Infant cereal | 0 | $1 / 4$ | $1 / 2$ | $3 / 4$ | 1 | 2 | 3 | 4 |
| Soy milk |  | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |
| Other milk (rice, goat etc) | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |  |
| $100 \%$ Juice (apple, orange etc) | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |  |
| Sweetened drinks (Kool aid, Sunny D, etc.) | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |  |
| Tea | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |  |
| Soda or Pop | 0 | $1 / 2$ | 1 | 2 | 3 | 4 | $5+$ |  |

13. Did your child's diet include the following foods during the last 4 months? Please check all that apply?
$\square$ Whole grain products (example - iron enriched breakfast cereals, enriched pasta and rice, beans such as chick peas, kidney beans, lentils and canned baked beans)
$\qquad$ times per $\qquad$ (day, week, month)
$\square$ Tofu $\qquad$ times per $\qquad$ (day, week, month)
$\square$ Citrus fruits (example - oranges, grapefruit, lemon juice, tomatoes, cantaloupe, kiwi fruit)
$\qquad$ times per $\qquad$ (day, week, month) $\square$ Citrus vegetables (example - spinach, cabbage, broccoli, Brussels sprouts, bell pepper, cauliflower)
$\qquad$ times per $\qquad$ (day, week, month)
14. Has your child been ill within the past 4 months?

No

Yes, (complete all that apply below)

- Colds or flus, how many times? $\qquad$
- Asthma attack, how many times? $\qquad$
- Pneumonia, how many times? $\qquad$
- Ear infection, how many times? $\qquad$


## For office use only

| Height |  |
| :--- | :--- |
| Weight | cm |
| BMI |  |
| Waist circumference $\quad \mathrm{kg}$ |  |
| $\mathrm{kg} / \mathrm{m}^{2}$ |  |

