

Child Health and Education in the Seventies

A national study in England, Wales and Scotland of all children born 5th–11th April 1970

Under the auspices of the University of Bristol
and the National Birthday Trust Fund

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The details in this questionnaire should be completed for the child named below. It is important that no question should remain unanswered without explanation. We should be most grateful for any additional information concerning this child to be noted on the back page of the questionnaire.

CONFIDENTIAL

All information will be treated in the strictest confidence.

Survey Number

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Please check that the details given here are correct.

Full name of child

Address

Present address (if different from above)

Sex Date of birth April 1970. NHS number

SECTION 1. THE HOME AND FAMILY

1. Who are the child's parents or guardians at the present time?

a. Mother *Please tick correct box*

- Natural mother
- Mother by legal adoption
- Stepmother
- Foster mother
- Grandmother
- Other mother figure,
- please specify
- No mother figure

If child is not now with natural mother,
when did the present person become the
child's mother?

Please tick correct box

- Before the child's fifth birthday
- After the child's fifth birthday
- Not known when

b. Father *Please tick correct box*

- Natural father
- Father by legal adoption
- Stepfather
- Foster father
- Grandfather
- Other father figure,
- please specify
- No father figure

If child is not now with natural father,
when did the present person become the
child's father?

Please tick correct box

- Before the child's fifth birthday
- After the child's fifth birthday
- Not known when

2. Has the child ever been separated from his/her mother or mother substitute for one month or more?

Please tick correct box in each column to show if this ever happened before or after the child's fifth birthday. It is important for a box to be ticked in both columns.

	Before fifth birthday	After fifth birthday
Yes	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>
Not known	<input type="checkbox"/>	<input type="checkbox"/>

3. People in the household.

A household consists of a group of people who all live at the same address and who are all catered for by the same person.

a. List below all the members of this household. Include the study child, the present parents and others, e.g. relatives or lodgers, who are members of this household. Exclude any who are only at home for short periods; enter these in table **b.** below.

Names help us to understand the family situation but may be omitted if preferred.

Relationship to the child (e.g. father, step-brother) or status in the household (e.g. lodger)	Surname (See note above)	First name(s) (See note above)	Sex	Date of birth
1. Study Child				/4/70
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. List below any members of the family not included in the above table, for example, those who are only home for holidays or leave, and give the reason for absence, for example, at residential school, working away, etc.

Relationship to the child	Surname (See note above)	First name(s) (See note above)	Sex	Date of birth	Reason for absence from home

4. Does the household have sole use of, share with another household or lack any of the following amenities?

Please tick correct box in every row

	Sole use	Shared use	None available
a. Kitchen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Indoor lavatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Hot water supply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How many rooms are there within the accommodation?

Include all rooms except kitchen, bathroom, toilet or any rooms used solely for business purposes.

Number of rooms

6. Is the kitchen used for living in, e.g. for having meals in?

Please tick correct box

- Yes
- No
- No kitchen available

7. Was the child born in Great Britain (i.e. England, Scotland or Wales)?

Please tick correct box

- No
- Yes
- Not known

IF NO, when did he/she first arrive in Great Britain?

Please tick correct box

- Before fifth birthday
- After fifth birthday

8. To which of the following groups does the child and the present parents belong?

Please tick correct box in every column

	Child	Mother	Father
European – UK (i.e. England, Scotland, Wales & Northern Ireland)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
European – not UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
West Indian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not known	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No mother/father at present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. a. How many times has the child moved since birth?

Total number of moves since birth

b. How many of these moves were after his/her fifth birthday?

Total number of moves after fifth birthday

SECTION 2. THE CHILD'S HEALTH

10. Has the child ever had any of the following?

Please tick every box which applies in each row

	No, never	Yes, before first birthday	Yes, between first & fifth birthdays	Yes, after fifth birthday	Not known
a. Any visit at home by Health Visitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Any attendance at Child Health Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Any attendance at hospital outpatients/casualty dept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Any immunisation, e.g. against diphtheria, tetanus, whooping-cough, polio, smallpox, measles, BCG, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Has the child ever been in hospital overnight or longer for any reason whatsoever?

Exclude initial stay in maternity hospital but include any admission included in question 2.

Please tick correct box

- Yes, has been in hospital overnight or longer
- No, has never been in hospital ..
- Not known

IF YES, a. give total number of admissions:

before fifth birthday

after fifth birthday

b. give reasons for each admission:

.....

12. Has the child ever had any form of convulsion, fit, seizure or other turn in which consciousness was lost, or any part of the body made abnormal movements?

Please tick every box which applies in both columns

	Before fifth birthday	After fifth birthday
Yes – Convulsion, fit or epileptic turn (without a temperature)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Febrile convulsion, (i.e. with temperature)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Fainting attack	<input type="checkbox"/>	<input type="checkbox"/>
Breath holding attack	<input type="checkbox"/>	<input type="checkbox"/>
Other turn or loss of consciousness, please specify	<input type="checkbox"/>	<input type="checkbox"/>
No, none of above	<input type="checkbox"/>	<input type="checkbox"/>
Not known	<input type="checkbox"/>	<input type="checkbox"/>

IF YES, please state total number of attacks which occurred:

a. before fifth birthday

.....

b. after fifth birthday

.....

13. Does the child have any physical or mental disability or handicap, or any other condition interfering with normal everyday life or which might be a problem at school?

Please tick correct box

- Yes – but no real handicap
- mild handicap
- severe handicap
- No disability or handicap
- Not known

IF YES, please describe condition

.....

14. Has the child ever had an accident requiring medical advice or treatment? Please include accidents in the road, home and elsewhere, accidental swallowing of medicines/poisons, burns/scalds, fractures, eye injuries, near drowning, bad cuts and other injuries, with or without unconsciousness, and non-accidental injuries.

Please tick every box which applies in both columns

	Before fifth birthday	After fifth birthday
Yes – accidental swallowing of medicines and poisons	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
burn(s), scald(s)	<input type="checkbox"/>	<input type="checkbox"/>
road traffic accident(s)	<input type="checkbox"/>	<input type="checkbox"/>
accident resulting in unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
other accident, please specify	<input type="checkbox"/>	<input type="checkbox"/>
No accident	<input type="checkbox"/>	<input type="checkbox"/>
Not known	<input type="checkbox"/>	<input type="checkbox"/>

IF YES, please state total number of accidents which occurred:

a. before fifth birthday

.....

b. after fifth birthday

.....

15. Has the child ever had an operation? (Exclude operations done under local anaesthetic).

Please tick correct box

- Yes
- No
- Not known

IF YES, please specify operation(s) and child's age when occurred

Operation(s)	Age (Years)

16. Please list all the child's main illnesses or conditions which have ever needed medical attention, EVEN IF THEY HAVE ALREADY BEEN MENTIONED ON THIS FORM

If child has never had an illness or condition requiring medical attention, please put NONE.

Illnesses before fifth birthday	Illnesses after fifth birthday

SECTION 3. EDUCATION

17. When did the child start full-time infant school?

Exclude any nursery school, nursery class or playgroup attendance

Please tick correct box

- Before August 1974
- Between August 1974 and March 1975 inclusive
- Between April 1975 and July 1975 inclusive
- On or after August 1975
- Not known when started full-time infant school

18. Before starting full-time infant school, did he/she attend any of the following for a period of three months or longer?

Please tick every box which applies

- Nursery school –
 Local Education Authority (free)
- Private (fee charged)
- Nursery class attached to infant/primary school –
 Local Education Authority (free)
- Private (fee charged)
- Playgroup
- Day nursery –
 Local Authority
- Private
- Creche, kindergarten
- Paid childminder (for two or more hours weekly)
- Other pre-school educational or day care nursery group,
 please describe
- Never attended any form of educational or day care nursery or group before starting full-time school
- Not known if attended any of above

19. If the child attended more than one type of pre-school nursery or group for three months or longer, which was the one attended just before starting full-time infant school?

Please write in (e.g. Playgroup, LEA nursery class, etc.)

.....

20. Has the child ever been in any of the following situations?

Please tick every box which applies in both columns

	Before fifth birthday	After fifth birthday
Attending a special day school, nursery or unit for physically or mentally handicapped children	<input type="checkbox"/>	<input type="checkbox"/>
Living in a residential institution	<input type="checkbox"/>	<input type="checkbox"/>
"In care" (voluntary or statutory)	<input type="checkbox"/>	<input type="checkbox"/>
None of above	<input type="checkbox"/>	<input type="checkbox"/>
Not known	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 4. PARENTS' OCCUPATIONS

IMPORTANT. The questions in this section refer to the people who are the present father, mother or guardians of the study child.

21. a. Please give the present father's actual job, occupation, trade or profession or last job if unemployed or retired.

If in HM Forces, please state rank in addition to actual job.
If no father or father figure, please give the occupation of the male head of the household.
If no male head of the household, please put NO MALE HEAD.

Actual job at time of child's fifth birthday

Actual job now (if job unchanged, put AS ABOVE)

b. What is the industry or business in which the father is engaged?

Give full details of goods, materials or services

Type of industry engaged in at time of child's fifth birthday

Type of industry engaged in now (if unchanged, put AS ABOVE)

c. Is the father employed or self-employed?

Please tick correct box in both columns

	At time of child's fifth birthday	At present time
Self employed – with employees	<input type="checkbox"/>	<input type="checkbox"/>
without employees	<input type="checkbox"/>	<input type="checkbox"/>
Employed – in managerial position	<input type="checkbox"/>	<input type="checkbox"/>
as foreman, supervisor, chargehand, etc.	<input type="checkbox"/>	<input type="checkbox"/>
not in charge of others	<input type="checkbox"/>	<input type="checkbox"/>
No father or male head of household	<input type="checkbox"/>	<input type="checkbox"/>
Employment status not known	<input type="checkbox"/>	<input type="checkbox"/>

22. Has the present mother ever been in regular paid employment since the time of the child's birth?

Please tick every box which applies in both columns

	Before fifth birthday	After fifth birthday
Yes – regular job out of the home (part-time or full-time)	<input type="checkbox"/>	<input type="checkbox"/>
regular job at home (part-time or full-time)	<input type="checkbox"/>	<input type="checkbox"/>
No – occasional or seasonal job(s) only	<input type="checkbox"/>	<input type="checkbox"/>
mother a full-time housewife	<input type="checkbox"/>	<input type="checkbox"/>
Not known, cannot remember	<input type="checkbox"/>	<input type="checkbox"/>

IF YES, please give total number of years in paid employment:

a. before fifth birthday

b. after fifth birthday

23. Was the mother in regular paid employment actually around the time of the child's fifth birthday?

Please tick correct box

Yes -

regular job out of the home (part-time or full-time)

regular job at home (part-time or full-time)

IF YES, for how many years was the mother doing this particular job up to the time of the child's fifth birthday?

Number of years

No -

occasional or seasonal job(s) only

mother a full-time housewife

Not known, cannot remember

24. Date this questionnaire was completed

25. a. Name and status of interviewer

b. Name of Area Health Authority/Health Board

c. Name of Health District (if applicable)

Please use the space below to give any additional information concerning this child which you consider important: