

1. In the past three months, on how many days did you consume any of the following drinks:

	Never	Less than one day per month	1-3 days per month	1 day per week	2-5 days per week	More than 5 days per week
1.1 Cow's milk*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2 Other milk including soy, rice, almond, goat or sheep milk*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3 Coffee containing caffeine (includes iced coffee)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4 Decaffeinated coffee (includes iced coffee)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5 Tea containing caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.6 Decaffeinated/herbal tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.7 Other drinks containing caffeine (e.g. cola, Red Bull, V)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.8 Diet, lite or low calorie carbonated or flavoured beverages (e.g. Diet or Coke Zero, Pepsi Max, diet cordial, sugar free energy drinks, light ice tea, Powerade Zero)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.9 Soft drink or flavoured beverages containing Stevia (Coke Life, Pepsi Next, Lipton flavored or green and Fuze iced tea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.10 Regular soft drink or flavoured beverages (e.g. Coke, Sprite, flavored mineral water, tonic water)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* Include flavoured milk and milk added to tea, coffee, cereal, etc.

On the days when you did consume these drinks in the past three months, how much on average did you consume based on the suggested average serving sizes:

	Average serving size	Did not consume	Less than 1 serve	1-2 serves	2-3 serves	More than 3 serves
1.11 Cow's milk*	250 mL glass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.12 Other milk including soy, rice, almond, goat or sheep milk*	250 mL glass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.13 Coffee containing caffeine (includes iced coffee)	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.14 Decaffeinated coffee (includes iced coffee)	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.15 Tea containing caffeine	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.16 Decaffeinated/herbal tea	1 small cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.17 Other drinks containing caffeine (e.g. cola, Red Bull, V)	250 mL can	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.18 Diet, lite or low calorie carbonated or flavoured beverages (e.g. Diet or Coke Zero, Pepsi Max, diet cordial, sugar free energy drinks, light ice tea, Powerade Zero)	250 mL can	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.19 Soft drink or flavoured beverages containing Stevia (Coke Life, Pepsi Next, Lipton flavored or green and Fuze iced tea)	250 mL can	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.20 Regular soft drink or flavoured beverages (e.g. Coke, Sprite, flavored mineral water, tonic water)	250 mL can	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* Include flavoured milk and milk added to tea, coffee, cereal, etc. For example, a small amount of cow's milk in tea may represent a ¼ cup. The milk component of white tea/coffee should be recorded in addition to the tea/coffee itself.

2. In the past three months, how often did you consume the following foods:

	Never	Less than once per month	1-3 days per month	1 day per week	2-5 days per week	More than 5 days per week
2.1 Dairy products including butter, cheeses, cream, yoghurt, custard and ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2 Soy containing products including tofu, miso, soy sauce, soy flour and soy-based dairy substitutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.3 Wheat containing products including breads, biscuits, cakes, breakfast cereals, pastries, pasta, couscous, dim sims and wontons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.4 Barley or rye containing products including barley water, many minestrone-style soups and rye bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.5 Rice and/or rice containing products including rice milk, rice cereals, rice cakes, rice noodles and rice flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.6 Corn and/or corn containing products including popcorn, polenta, corn flakes, corn tortillas and corn flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.7 Oats or oat containing products including porridge, oatmeal, muesli, ANZAC biscuits, bran and oat flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.8 Artificial sweeteners (e.g. Equal, Splenda) for use in baking or tea/coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.9 Stevia/Natvia products for use in baking or tea/coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please provide details of any dietary supplements you have taken in the past three months, the frequency you took them and size of the dose (for example, 1 tablet, 5 mL, etc.). The frequency is based on the estimated number of days you took the supplement. For example, if you took a multivitamin every 2<sup>nd</sup> day this would equate to 45 days in the past three months and therefore you would tick the "31-60 days" box.

		Frequency					Amount taken
		Never	0-30 days	31-60 days	61-90 days	Daily	
3.1	Pregnancy/lactation supplement brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.2	Other Multivitamin brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.3	Omega-3/fish oil/cod-liver oil brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.4	Iron brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.5	Other: brand: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

In the past three months, have you taken any probiotics, including supplements, powders and fortified foods?

		Frequency					Amount taken
		Never	0-30 days	31-60 days	61-90 days	Daily	
3.6	Brand/food: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

4. Did you take any antibiotics in the past three months? Please provide details about the type of antibiotic and dosage.

No

Unsure

Yes

Type and Brand: \_\_\_\_\_

Dose volume: \_\_\_\_\_

Doses per day: \_\_\_\_\_

Number of days: \_\_\_\_\_

Date started: \_\_\_\_\_

Date completed: \_\_\_\_\_

5. In the past three months, how many cigarettes did you smoke on average (tick one item only):

	I did not smoke and have never been a smoker	<input type="checkbox"/>
	I did not smoke but have previously been a smoker	<input type="checkbox"/>
	Less than 1 cigarette per week	<input type="checkbox"/>
5.1	2 - 6 cigarettes per week	<input type="checkbox"/>
	1 - 5 cigarettes per day	<input type="checkbox"/>
	6 - 10 cigarettes per day	<input type="checkbox"/>
	More than 10 cigarettes per day	<input type="checkbox"/>

- Which one of the following best describes your current household (tick one item only)?

	Members of my household smoke at home, inside the house	<input type="checkbox"/>
	Members of my household smoke at home, only outside the house and never inside	<input type="checkbox"/>
5.2	Members of my household are smokers but they don't smoke at home, inside or outside	<input type="checkbox"/>
	Nobody in my household is a smoker	<input type="checkbox"/>

6. How many of the following people, including yourself, currently reside in your household:

Adults: \_\_\_\_\_

Children: \_\_\_\_\_

7. Which of the following describes your household now (tick all that apply):

7.1	We have a dog that comes inside	<input type="checkbox"/>
7.2	We have a dog that lives outside and doesn't come inside	<input type="checkbox"/>
7.3	We have a cat that comes inside	<input type="checkbox"/>
7.4	We have a cat that lives outside and doesn't come inside	<input type="checkbox"/>
7.5	We have a furred pet that is not a cat or dog	<input type="checkbox"/>
7.6	We do not have any furred pets – cats, dogs or otherwise	<input type="checkbox"/>

8. Have you had any vaccinations during your pregnancy that have not been previously reported (tick all that apply and provide the date of vaccination):

8.1	Influenza vaccine	<input type="checkbox"/>	Date: ___/___/___
8.2	Pertussis (whooping cough) vaccine	<input type="checkbox"/>	Date: ___/___/___
8.3	Other (please specify) _____	<input type="checkbox"/>	Date: ___/___/___

9. In the past three months have you followed any of the following diets (tick all that apply):

9.1	Vegetarian	<input type="checkbox"/>
9.2	Gluten free	<input type="checkbox"/>
9.3	Low carbohydrate	<input type="checkbox"/>
9.4	High protein	<input type="checkbox"/>
9.5	Vegan	<input type="checkbox"/>
9.6	Other (please specify) _____	<input type="checkbox"/>

***Please now complete the Pregnancy Physical Activity Questionnaire. Thank you.***