**Supplemental file**

Questionnaire to determine the mothers’ history of antecedent β-hemolytic streptococcal infection

Did you ever have any cough, sore throat, or other respiratory symptoms from the time period 3 months prior to this pregnancy until today?

* NO
* YES

Have you ever had any fever(s) over 100o from the time period 3 months prior to this pregnancy until today?

* NO
* YES

Did you get strep throat or tonsillitis during this pregnancy?

* NO
* YES

Did you get strep throat or tonsillitis 3 months prior to this pregnancy?

* NO
* YES

Did you have contact with anyone who had strep throat or tonsillitis during this pregnancy?

* NO
* YES by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have contact with anyone who had strep throat or tonsillitis prior to this Pregnancy (i.e., from 3 months before until the estimated date of conception)?

* NO
* YES by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on any antibiotics or have you taken any antibiotics during this pregnancy?

* NO
* YES

Have you ever had Rheumatic Fever?

* NO
* YES

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had Scarlet Fever?

* NO
* YES

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past did you have repeated bouts of or a recurrent problem with strep throat or tonsillitis?

* NO
* YES

Did you have complications related to strep throat infection or tonsillitis?

* NO
* YES explain (skin rash\_\_\_, tonsil removal\_\_ other\_\_)

How old were you when you first began having trouble with strep throat or tonsillitis?

* < 5 years
* 5-15 years
* 16 years and older

When you had strep throat or tonsillitis, did you ever get a rash?

* NO
* YES

When was the last time you had strep throat?

* < 1 year ago
* 1-3 years ago
* > 3 years ago

Have you had your tonsils removed?

* NO
* YES

If your tonsils were removed because of strep throat, did you continue to get strep throat after you had your tonsils removed?

* NO
* YES

How many are your biological children?

No. of Boys \_\_\_\_\_\_\_\_\_\_

No. of Girls \_\_\_\_\_\_\_\_\_\_

Have any of your children had recurrent strep throat or tonsillitis (i.e., more than once)?

* NO
* YES

Have any of your children been diagnosed as carriers of strep throat or tonsillitis?

* NO
* YES

Have any of your children had their tonsils removed?

* NO
* YES