



**SECTION A: BABY'S FEEDING AND HEALTH**

**If your baby is regularly cared for by someone else, it is very important that you ask your child care provider to give you information for the feeding questions.  
If you have older children, please think only about your youngest baby when you answer the questions.**

**Section A-1: Feeding**

1. In the past 7 days, how often was your baby fed each food listed below? Include feedings by everyone who feeds the baby and include snacks and night-time feedings.

If your baby was fed the food once a day or more, write the number of feedings per day in the first column. If your baby was fed the food less than once a day, write the number of feedings per week in the second column. **Fill in only one column for each item.** If your baby was not fed the food at all during the past 7 days, write in 0 in the second column.

	<u>FEEDINGS PER DAY</u>	<u>FEEDINGS PER WEEK</u>
Breast milk.....	_____	_____
Formula.....	_____	_____
Cow's milk.....	_____	_____
Other milk: soy milk, rice milk, goat milk, etc.....	_____	_____
Other dairy foods: yogurt, cheese, ice cream, pudding, etc.....	_____	_____
Other soy foods: tofu, frozen soy desserts, etc.....	_____	_____
100% fruit or 100% vegetable juice.....	_____	_____
Sweet drinks: juice drinks, soft drinks, soda, sweet tea, Kool-Aid, etc.....	_____	_____
Baby cereal.....	_____	_____
Other cereals and starches: breakfast cereals, teething biscuits, crackers, breads, pasta, rice, etc.....	_____	_____
Fruit.....	_____	_____
Vegetables.....	_____	_____
French fries.....	_____	_____
Meat, chicken, combination dinners.....	_____	_____
Fish or shellfish.....	_____	_____
Peanut butter, other peanut foods, or nuts.....	_____	_____
Eggs.....	_____	_____
Sweet foods: candy, cookies, cake, etc.....	_____	_____

2. In the past 7 days, how many times was your baby usually fed in a 24-hour period? Please include breast feedings, bottles, meals, snacks, and night-time feedings.

- 1 to 2 .....     3.....     4.....     5.....     6.....     7.....     8 or more.....

3. Which of the following was your baby given in vitamin or mineral drops or pills at least 3 days a week during the past 2 weeks? If your baby was given drops or pills that contained more than one of the items listed, please mark each of the separate items. **(PLEASE "X" ALL THAT APPLY)**

- Fluoride.....                       Vitamin D.....                       None of these.....   
 Iron.....                               Other vitamins.....

4. Has your baby used a pacifier in the past 7 days?                      Yes.....                       No.....

5. During the past 2 weeks, how often was your baby put to bed with a bottle of formula, breast milk, juice, juice drink, or any other kind of milk?

- At most bedtimes, including naps.....   
 At most night bedtimes, but not naps.....   
 At most naps, but not night bedtimes.....   
 Only occasionally at bedtimes, including naps.....   
 Never.....

6. How often have you added each of the following items to your baby's bottle of formula or pumped (or expressed) breast milk in the past 2 weeks? If you have not given your baby a bottle in the past 2 weeks, "X" here  and go to Question 7.

	<u>NEVER</u>	<u>ONLY RARELY</u>	<u>EVERY FEW DAYS</u>	<u>ABOUT ONCE A DAY</u>	<u>AT MOST FEEDINGS</u>	<u>EVERY FEEDING</u>
Vitamins or minerals.....	<input type="checkbox"/>					
Baby cereal.....	<input type="checkbox"/>					
Sweetener.....	<input type="checkbox"/>					
Medicine.....	<input type="checkbox"/>					
Other (Specify).....	<input type="checkbox"/>					

7. In the past 2 weeks, have you chewed up food and then given it to your baby, so the food was already chewed up before you fed it to your baby?  
Yes.....                       No.....

**IF YOUR BABY WAS FED FORMULA IN THE PAST 7 DAYS, PLEASE CONTINUE.  
ALL OTHERS GO TO INSTRUCTION ABOVE QUESTION 14 ON PAGE 2.**

8. How often does your baby drink all of his or her cup or bottle of formula?

- Never.....     Rarely.....     Sometimes.....     Most of the time.....     Always.....

9. In the past 7 days, about how many ounces of formula did your baby drink at each feeding?

- 1 to 2.....                       3 to 4.....                       5 to 6.....                       7 to 8.....                       More than 8.....

10. How often is your baby encouraged to finish a cup or bottle if he or she stops drinking before the formula is all gone?

- Never.....     Rarely.....     Sometimes.....     Most of the time.....     Always.....

11. Which formula was fed to your baby in the past 7 days? Infant formulas are listed alphabetically on the Formula List insert along with a group number. Please "X" the group number for each infant formula your baby was fed. **(PLEASE "X" ALL THAT APPLY)**

- Group 1                      Group 2                      Group 3                      Group 4                      Group 5                      Group 6

12. What type of formula was your baby fed? **(PLEASE "X" ALL THAT APPLY)**

- Ready-to-feed.....                       Powder from a can that makes more than one bottle.....   
 Liquid concentrate.....                       Powder from single serving packs.....

13. Which of the following describes the iron content of the formula you usually use?  
 With iron .....  Low iron (additional iron may be necessary) .....

**IF YOUR BABY WAS BREASTFED OR FED BREAST MILK IN THE PAST 7 DAYS, PLEASE CONTINUE. ALL OTHERS GO TO INSTRUCTION ABOVE QUESTION 21 ON THIS PAGE.**

14. Does your baby usually feed from both breasts at each feeding?  
 Yes .....  No .....  Baby is only fed pumped milk .....  →(GO TO QUESTION 17)
15. Does your baby usually let go of the breast him or herself?  
 Yes, both breasts .....  Yes, first breast only .....  Yes, second breast only .....  No .....
16. About how long does an average breastfeeding last?  
 Less than 10 minutes .....  20 to 29 minutes .....  40 to 49 minutes .....   
 10 to 19 minutes .....  30 to 39 minutes .....  50 or more minutes .....
17. In an average 24-hour period, what is the LONGEST time for you, the mother, between breastfeedings or pumping milk? Please count the time from the start of one breastfeeding or pumping session to the start of the next. Please think of time between feedings during both night and day to find the longest time. (WRITE IN THE NUMBER OF HOURS AND MINUTES)  
 \_\_\_\_\_ HOURS AND \_\_\_\_\_ MINUTES
18. How many times in the past 7 days was your baby fed pumped breast milk to drink? Include breast milk you expressed in any way as pumped milk. (Write in 0 if your baby was not fed pumped milk to drink.)  
 \_\_\_\_\_ TIMES → (IF 0, GO TO INSTRUCTION ABOVE QUESTION 21 ON THIS PAGE)
19. How often does your baby drink all of his or her cup or bottle of pumped milk?  
 Never .....  Rarely .....  Sometimes .....  Most of the time .....  Always .....
20. How often is your baby encouraged to finish a cup or bottle if he or she stops drinking before the pumped breast milk is all gone?  
 Never .....  Rarely .....  Sometimes .....  Most of the time .....  Always .....

**IF YOUR BABY IS FED ANY FOODS OR DRINKS BESIDES BREAST MILK OR FORMULA, PLEASE CONTINUE. ALL OTHERS GO TO SECTION A-2 ON THIS PAGE.**

21. How important was each of the following reasons for feeding your baby solid food for the very first time? Solid foods are foods such as cereal, baby foods, or table food. (PLEASE ANSWER EACH ITEM) If your baby has not been fed solid food, "X" here  and go to Question 22.
- |   | NOT AT ALL IMPORTANT     | NOT VERY IMPORTANT       | SOMEWHAT IMPORTANT       | VERY IMPORTANT           |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| My baby was nursing too much .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby was drinking too much formula .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby seemed hungry a lot of the time.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I didn't have enough milk.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby was not gaining enough weight.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wanted to feed my baby something in addition to breast milk or formula.....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It would help my baby sleep longer at night .....                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby was old enough to begin eating solid food.....                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby had a medical condition that might be helped by feeding solid food.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A doctor or other health professional said my baby should begin eating solid foods..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Friends or relatives said my baby should begin eating solid foods .....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby wanted food I ate or in other ways showed an interest in solid food.....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

22. For each food category listed below, about how much of the food fed to your baby over the past 7 days was commercial baby food? *Commercial baby foods are those sold especially for babies.* Foods that are not commercial baby foods include fresh fruit, fruit juices other than those especially sold for babies, foods you prepare especially for the baby, and table food. (PLEASE "X" ONE ANSWER IN EACH ROW)
- |  | ALL COMMERCIAL BABY FOOD | MOSTLY COMMERCIAL BABY FOOD | SOME COMMERCIAL BABY FOOD | NO COMMERCIAL BABY FOOD  | NOT FED IN PAST 7 DAYS   |
|--|--------------------------|-----------------------------|---------------------------|--------------------------|--------------------------|
| Fruit and vegetable juice .....          | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fruit.....                               | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Vegetables.....                          | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Meat, chicken, combination dinners ..... | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |

23. If you fed your baby fruit juice that was not sold especially for babies, how often was the juice fortified with calcium?  
 Never .....  Don't know .....   
 Rarely .....  Never fed any juice or never fed juice that was not sold for babies.....   
 Sometimes.....   
 Always .....
24. If you gave your baby cow's milk in the past 7 days, what kind of cow's milk did you give him or her? (Do not include formula made with cow's milk). (PLEASE "X" ALL THAT APPLY)
- |                               |                          |                             |                          |
|-------------------------------|--------------------------|-----------------------------|--------------------------|
| Did not give cow's milk ..... | <input type="checkbox"/> | Skim milk (nonfat).....     | <input type="checkbox"/> |
| Whole milk.....               | <input type="checkbox"/> | Whole evaporated milk ..... | <input type="checkbox"/> |
| Reduced fat (2%) milk.....    | <input type="checkbox"/> | Skim evaporated milk.....   | <input type="checkbox"/> |
| Lowfat (1%) milk.....         | <input type="checkbox"/> | Lactose reduced milk .....  | <input type="checkbox"/> |
25. About how often did you introduce new foods (such as a specific type of cereal, fruit, vegetable, or meat) to your baby over the past 2 weeks?  
 No new foods in the past 2 weeks .....  About 1 new food every 2 days .....   
 About 1 new food per week or less often.....  About 1 new food every day.....   
 About 1 new food every 4 or 5 days .....  More than 1 new food every day.....   
 About 1 new food every 3 days .....
26. In the past 2 weeks, how often was salt added to the foods fed to your baby?  
 Never .....  Rarely .....  Sometimes .....  Most of the time .....  Always .....
27. Do you use iodized salt for the baby's food?  
 Yes .....  No .....

**Section A-2 Health**

28. Did your baby receive any of the following medicines in the past 2 weeks? (Please do not include vitamins or minerals.)
- |                                   | Yes                      | No                       |
|-----------------------------------|--------------------------|--------------------------|
| Antibiotics.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Other prescription medicines..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Non-prescription medicines.....   | <input type="checkbox"/> | <input type="checkbox"/> |

29. Which of the following problems did your baby have during the past 2 weeks? (PLEASE "X" ALL THAT APPLY)

- Fever .....  Runny nose or cold.....
- Diarrhea.....  Respiratory Syncytial Virus (RSV).....
- Vomiting.....  Cough or wheeze .....
- Ear infection.....  Asthma.....
- Colic.....  Food allergy .....
- Fussy or irritable .....  Eczema (atopic dermatitis) .....
- Reflux .....  None of these .....

30. Was your baby given any herbal or botanical preparation or any kind of tea in the past 2 weeks? (Do not count preparations applied to the baby's skin or anything the baby may have received through breastfeeding after you took an herbal or botanical preparation.)

Yes .....  No .....  →(GO TO QUESTION 33)

31. Please list all the kinds of herbal or botanical preparations or teas your baby was given in the past 2 weeks.

\_\_\_\_\_

32. Why was your baby given the preparations or teas listed in Question 31? (PLEASE "X" ALL THAT APPLY)

- To ease diaper rash.....  To ease a cold or other respiratory symptoms .....
- To ease colic .....  To ease an illness other than a cold or respiratory symptoms .....
- To ease digestion .....  To stimulate the baby's immune system .....
- To ease fussiness.....  Other (SPECIFY) \_\_\_\_\_
- To help the baby relax.....

33. How many stools (dirty diapers) does your baby usually have in a 24-hour period? If less than one a day, how many days usually pass between stools?

\_\_\_\_\_ NUMBER OF STOOLS IN 24 HOURS OR ONE STOOL EVERY \_\_\_\_\_ DAYS

34. How would you describe your baby's stool in the past 7 days? (PLEASE "X" ALL THAT APPLY)

Hard.....  Formed.....  Soft .....  Semi-watery .....  Watery .....

35. Has your baby been hospitalized for any reason or has your baby been taken to a hospital for any outpatient procedure or surgery in the past 4 weeks?

Yes .....  No .....  →(GO TO QUESTION 37)

36. How many nights was your baby in the hospital for the most recent problem? (Write in 0 if your baby did not stay overnight.)

\_\_\_\_\_ NIGHTS

37. How many teeth does your baby have now? (Write in 0 if none.) \_\_\_\_\_ NUMBER OF TEETH

**SECTION B: STOPPED BREASTFEEDING**

1. Did you ever breastfeed this baby (or feed this baby your pumped milk)?

Yes .....  →(CONTINUE) No.....  →(GO TO SECTION C ON PAGE 4)

2. Have you completely stopped breastfeeding and pumping milk for your baby?

Yes .....  →(CONTINUE) No.....  →(GO TO SECTION C ON PAGE 4)

3. Have you filled out **SECTION B: Stopped Breastfeeding** since you stopped breastfeeding?

Yes .....  →(GO TO SECTION C ON PAGE 4) No .....  →(CONTINUE)

4. Did you breastfeed as long as you wanted to?

Yes .....  No .....

5. How old was your baby when you completely stopped breastfeeding and pumping milk?

\_\_\_\_\_ WEEKS OR \_\_\_\_\_ MONTHS

6. How important was each of the following reasons for your decision to stop breastfeeding your baby? (PLEASE ANSWER EACH ITEM)

	NOT AT ALL IMPORTANT	NOT VERY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
My baby had trouble sucking or latching on .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My baby became sick and could not breastfeed .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My baby began to bite .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My baby lost interest in nursing or began to wean him or herself .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My baby was old enough that the difference between breast milk and formula no longer mattered .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast milk alone did not satisfy my baby .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I thought that my baby was not gaining enough weight.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A health professional said my baby was not gaining enough weight .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had trouble getting the milk flow to start.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I didn't have enough milk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My nipples were sore, cracked, or bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My breasts were overfull or engorged .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My breasts were infected or abscessed .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My breasts leaked too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding was too painful .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding was too tiring .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was sick or had to take medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding was too inconvenient.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I did not like breastfeeding .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted to be able to leave my baby for several hours at a time .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted to go on a weight loss diet .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted to go back to my usual diet .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted to smoke again or more than I did while breastfeeding .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had too many household duties.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I could not or did not want to pump or breastfeed at work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pumping milk no longer seemed worth the effort that it required .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was not present to feed my baby for reasons other than work .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted or needed someone else to feed my baby.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone else wanted to feed the baby .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I did not want to breastfeed in public.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted my body back to myself .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I became pregnant or wanted to become pregnant again.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Did any of the following people want you to stop breastfeeding? (Mark "does not apply" if you do not have the person listed, such as "employer" if you do not work for pay.)

Table with 3 columns: YES, NO, DOES NOT APPLY/DON'T KNOW. Rows include: The baby's father, Your mother, Your mother-in-law, Your grandmother, Another family member, A doctor or other health professional, Your employer or supervisor.

8. Using 1 to mean "Very unfavorable" and 5 to mean "Very favorable," how do you feel about the experience of having breastfed your baby?

Scale from 1 (VERY UNFAVORABLE) to 5 (VERY FAVORABLE) with checkboxes.

9. Using 1 to mean "Not at all likely" and 5 to mean "Very likely," how likely is it that you would breastfeed again if you had another child?

Scale from 1 (NOT AT ALL LIKELY) to 5 (VERY LIKELY) with checkboxes.

SECTION C: FOOD ALLERGY SECTION

1. Has your baby ever had problems caused by food, such as an allergic reaction, sensitivity, or intolerance?

Yes [ ] No [ ] (GO TO SECTION E ON PAGE 5)

2. Since your baby was 4 months old, has he or she had problems caused by food, such as an allergic reaction, sensitivity, or intolerance?

Yes [ ] No [ ] (GO TO SECTION E ON PAGE 5)

3. Were these problems new since your baby was 4 months old, or a repeat occurrence of problems reported to us earlier?

Options: New reactions only, Repeat of earlier reported problems only, Both, Can't remember. Includes (GO TO QUESTION 6 ON THIS PAGE).

4. Did your baby have a reaction the first time he or she ate the food that caused a new reaction?

Yes [ ] No [ ] Not sure [ ]

5. How old was your baby the first time he or she had a problem with food that caused the new reaction? (Include food your baby reacted to through breast milk.)

4 months, 5 months, 6 months, 7 months, 8 months, 9 months, Older than 9 months.

6. Were the problems caused by . . (PLEASE "X" ALL THAT APPLY)

Food your baby ate (including infant formula), Food your baby was exposed to through breast milk because of something you ate.

7. Have you taken your baby to a medical doctor because of these problems with food since he or she was 4 months old?

Yes [ ] No [ ] (GO TO QUESTION 10 ON THIS PAGE)

8. If your baby was tested or examined for food allergy, what method was used? (PLEASE "X" ALL THAT APPLY)

If your baby was not tested or examined for food allergy, "X" here [ ] and go to Question 9. Methods: Parents' description of symptoms, A skin test, A blood test such as RAST, or CAP-RAST, An esophageal or intestinal study, Food elimination, Food challenge, Other (SPECIFY).

9. Was your baby diagnosed by a medical doctor as having an allergy to any food?

Yes [ ] No [ ]

10. What symptoms of a problem with food has your baby had since he or she was 4 months old? (PLEASE "X" ALL THAT APPLY)

Grid of symptoms: Congestion, Runny nose, Asthma or wheezing, Trouble breathing, Coughing, Swollen eyes and or lips, Hives or welts, Flushing, Skin rash or eczema, Spitting up, Gassiness or stomach cramps, Vomiting, Diarrhea, Constipation, Colic, Irritability, Sleeplessness, Blood in stool, Loss of consciousness.

11. How have these symptoms been treated since your baby was 4 months old? (PLEASE "X" ALL THAT APPLY)

Treated in a doctor's office or emergency room, Treated by emergency medical technician, Admitted to a hospital, Given epinephrine, such as with an EpiPen, Given benedryl or other anti-histamine, Prescribed an EpiPen or other epinephrine, None of the above.

12. Think of the foods that have caused a problem since your baby was 4 months old. Please indicate which foods caused a problem for your baby in column 12a, including food your baby reacted to through breast milk. In column 12b, indicate the foods that your baby has been diagnosed as allergic to. (If your baby has had a problem with a food and has been diagnosed as allergic to the food, mark both columns for that food.) (PLEASE "X" ALL THAT APPLY)

Table with 2 columns: 12A. BABY HAD A PROBLEM WITH, 12B. BABY DIAGNOSED AS ALLERGIC TO. Rows include Cow's milk, Soy milk, Eggs, Peanuts, Nuts, Sesame seed, Fish, Beef, Wheat, Other grain, Fruit, Vegetable, and Other food.

IF YOUR BABY HAS HAD A PROBLEM WITH INFANT FORMULA SINCE HE OR SHE WAS 4 MONTHS OLD, PLEASE CONTINUE. ALL OTHERS GO TO SECTION E.

13. Which infant formula has your baby had a problem with? Infant formulas are listed alphabetically on the insert along with a group number. Please "X" the group number for each formula your baby had a problem with. (PLEASE "X" ALL THAT APPLY)

- Group 1, Group 2, Group 3, Group 4, Group 5, Group 6 with checkboxes.

14. How many of the different formulas listed on the insert has your baby had a problem with? 1, 2, 3, 4, 5 or more with checkboxes.

SECTION E: INFANT FORMULA

- 1. Was your baby fed infant formula in the past 2 weeks, by you or by anyone else?
2. During the past 2 weeks, what type of water have you and others who feed your baby used for mixing your baby's formula?
3. How often have you and others who feed your baby heated your baby's bottle of formula in a microwave oven?

Babies are fed formula in a lot of different situations, and formula may have to be prepared in a lot of different places. Please think of all of these situations and places as you answer the next few questions.

4. During the past 2 weeks, how often were the bottle nipples used to feed formula cleaned in the following ways before being used again? If you don't use bottle nipples, "X" here and go to Question 5.

Table with 4 columns: NEVER, SOME OF THE TIME, MOST OF THE TIME, ALL OF THE TIME. Rows include Rinsed with water only, Washed in an automatic dish washer, Washed by hand with dish detergent, Boiled or sterilized, Not cleaned between uses.

5. During the past 2 weeks, how often did you clean your hands in each of the following ways before preparing formula?

Table with 4 columns: NEVER, SOME OF THE TIME, MOST OF THE TIME, ALL OF THE TIME. Rows include Rinsed my hands with water only, Wiped my hands only, Washed with soap, Used hand sanitizer, Prepared formula without cleaning my hands.

6. How long were bottles of prepared formula usually kept at room temperature and then fed to your baby in the past 2 weeks?

- Less than 1 hour, 1 to 2 hours, 3 to 4 hours, 5 to 8 hours, 9 to 11 hours, 12 to 16 hours, More than 16 hours, I do not keep prepared formula at room temperature.

7. How did you decide to use the formula you fed your baby in the past 7 days? (PLEASE "X" ALL THAT APPLY)

- A doctor or other health professional recommended the formula, I chose the same formula fed to my baby at the hospital, I heard that the formula is better for my baby in some way, I chose the formula I received samples or coupons for, I saw an advertisement for the formula and wanted to try it, I chose a formula labeled as useful for a problem my baby had, I use the formula given by WIC, I chose the same formula I fed an older child, Friends or relatives recommended the formula, I chose a formula based on low price.

8. Did you discuss your choice of formula with the baby's doctor?

- Yes, No with checkboxes.

9. During the past 2 weeks, how many times have you switched the formula you feed your baby?

- None, 1, 2, 3, 4, 5 or more with checkboxes and a GO TO SECTION H arrow.

10. Which formulas did you stop using in the past 2 weeks? Infant formulas are listed alphabetically on the Formula List insert along with a group number. Please "X" the group number for each infant formula you stopped using. (PLEASE "X" ALL THAT APPLY)

- Group 1, Group 2, Group 3, Group 4, Group 5, Group 6 with checkboxes.

11. Did you switch formula because your baby had a problem with the formula you were using?

- Yes, No with checkboxes and a GO TO SECTION H ON PAGE 6 arrow.

12. What type of problem did your baby have with the formula(s)? (PLEASE "X" ALL THAT APPLY)

- An allergic reaction or intolerance .....
- Constipation.....
- Diarrhea.....
- Too much mucus.....
- Too much gas.....
- Too much spit up.....
- Vomiting.....
- Other problem (Please specify \_\_\_\_\_)

**SECTION H: SLEEPING ARRANGEMENTS, WORK, CHILD CARE, AND OTHER INFORMATION**  
**Section H-1: Sleeping Arrangements**

Please complete the information below for your baby's sleeping arrangements in the past 4 weeks. Some of the questions ask you to think about "night." If your major time for sleeping is some time other than at night (for example, if you work at night and sleep during the day), please think of your major sleep period when the question asks about "night."

1. What was the longest time your baby usually slept at night without waking in the past 4 weeks?

- 2 hours or less .....
- 3 to 4 hours .....
- 5 to 6 hours .....
- 7 to 8 hours .....
- 8 hours or more .....

2. In what position did you most often lay your baby down for naps in the past 4 weeks?

- Side.....
- Stomach.....
- Back.....

3. In what position did you most often lay your baby down to sleep at night in the past 4 weeks?

- Side.....
- Stomach.....
- Back.....

4. In the past 4 weeks, where did your baby usually sleep at night?

- In your room.....
- In a different room.....

5. What did your baby usually sleep in at night in the past 4 weeks?

- Bassinet.....
- Crib.....
- Co-sleeper (attaches to the side of your bed).....
- In bed or other place with you.....
- In something else.....

6. In the past 4 weeks, did you lie down with or sleep with your baby at night? (PLEASE "X" ALL THAT APPLY)

- Yes, with the baby in a co-sleeper.....
- Yes, in a bed (standard mattress).....
- Yes, in a water bed.....
- Yes, on a mattress on the floor.....
- Yes, on a couch or other place that is not a bed.....
- No.....  → (GO TO QUESTION 12 ON THIS PAGE)

7. On the nights you lay down with or slept with your baby, did you usually have the baby with you all night or part of the night? (Include time the baby was in a co-sleeper.)

- All night.....
- The first part of the night only.....
- The last part of the night only.....
- Several short times throughout the night.....

8. How many nights per week did you and your baby usually lie down together or sleep together?

- Baby did not usually lie down or sleep with me .....
- Less than 1 night a week .....
- 1 to 2 nights .....
- 3 to 4 nights .....
- 5 to 6 nights .....
- 7 nights per week .....

9. When you and your baby lay down together or slept together, did you usually:

- Stay with the baby and also sleep .....
- Keep awake until your baby was asleep or finished feeding, and then put the baby somewhere else while you slept?.....

10. On the nights in the past 4 weeks when you and your baby lay down together or slept together, who else usually lay down with or slept with you? (PLEASE "X" ALL THAT APPLY)

- Your husband or partner.....
- Your other child or children.....
- Other people.....
- No one else.....

11. What are your reasons for bringing your baby to bed with you? (PLEASE "X" ALL THAT APPLY)

- It is commonly done in my family.....
- Sleeping with my baby helps the baby or me to sleep better....
- I think it is safer if my baby sleeps with me or us.....
- A doctor or nurse advised sleeping with baby.....
- To breastfeed.....
- To bottle feed.....
- To help with a blocked milk duct or other breastfeeding problem.....
- To be close/bond.....
- To comfort when fussy.....
- To comfort when sick.....

IF YOU BROUGHT YOUR BABY TO BED WITH YOU, GO TO SECTION H-2 ON THIS PAGE.

12. What are your reasons for not bringing your baby to bed with you? (PLEASE "X" ALL THAT APPLY)

- It is not commonly done in my family.....
- We wake each other up, or baby wakes me or others in the bed.....
- I think it is safer if my baby does not sleep with me or us.....
- I don't think the baby should sleep with me because I smoke, take sedative medicine, or other reason.....
- A doctor or nurse advised not sleeping with my baby.....
- I think it will be too hard to get my baby to sleep in a crib when he or she is older.....

**Section H-2: Employment**

13. Did you work for pay any time during the past 4 weeks?

- Yes .....
- No.....  →(GO TO SECTION H-3 ON PAGE 7)

14. How old was your baby when you began working after your delivery? (If you are not sure, give your best estimate.)

\_\_\_\_\_ MONTHS AND \_\_\_\_\_ WEEKS

15. How many hours per week did you usually work at your job during the past 4 weeks? (Answer for whatever time you have been working if less than 4 weeks) (If you work at two or more jobs, answer for the total number of hours you work.)
- |                               |                          |                                   |                          |
|-------------------------------|--------------------------|-----------------------------------|--------------------------|
| 1 to 9 hours per week .....   | <input type="checkbox"/> | 30 to 34 hours per week .....     | <input type="checkbox"/> |
| 10 to 19 hours per week ..... | <input type="checkbox"/> | 35 to 40 hours per week .....     | <input type="checkbox"/> |
| 20 to 29 hours per week ..... | <input type="checkbox"/> | More than 40 hours per week ..... | <input type="checkbox"/> |

16. Using 1 to mean "None" and 5 to mean "Very much," how much satisfaction do you get from your paid work?

<u>NONE</u>					<u>VERY MUCH</u>
<b>1</b>		<b>2</b>		<b>3</b>	<b>4</b>
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				<b>5</b>	
				<input type="checkbox"/>	

17. About how much of your family's income comes from the money you earn from work?  
 Less than half .....       About half .....       More than half.....

18. What do you do with your baby while you are working? (PLEASE "X" ALL THAT APPLY)

- |   |                          |   |                          |
|---|--------------------------|---|--------------------------|
| My baby is cared for by a family member .....         | <input type="checkbox"/> | I keep my baby with me while I work at home .....         | <input type="checkbox"/> |
| My baby is cared for by someone not in my family..... | <input type="checkbox"/> | I keep my baby with me while I work outside my home ..... | <input type="checkbox"/> |

19. In your opinion, how supportive of breastfeeding is your place of employment?

- |                             |                          |                           |                          |
|-----------------------------|--------------------------|---------------------------|--------------------------|
| Not at all supportive ..... | <input type="checkbox"/> | Somewhat supportive ..... | <input type="checkbox"/> |
| Not too supportive .....    | <input type="checkbox"/> | Very supportive.....      | <input type="checkbox"/> |

20. Did you breastfeed for any time in the past 4 weeks?

Yes .....       No .....  ➔(GO TO SECTION H-3 ON THIS PAGE)

21. Which of the following circumstances describe your situation during the past 4 weeks? (If you have stopped breastfeeding, please answer for the time you were breastfeeding) (PLEASE "X" ALL THAT APPLY)

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| I keep my baby with me while I work and breastfeed during my work day..... | <input type="checkbox"/> | I pump milk during my work day and save it for my baby to drink later.....            | <input type="checkbox"/> |
| I go to my baby and breastfeed him or her during my work day .....         | <input type="checkbox"/> | I pump milk during my work day, but I do not save it for my baby to drink later ..... | <input type="checkbox"/> |
| My baby is brought to me to breastfeed during my work day .....            | <input type="checkbox"/> | I neither pump milk nor breastfeed during my work day .....                           | <input type="checkbox"/> |

22. Have you had any of the following experiences during the past 4 weeks? Mark "No" if the item does not describe your circumstances, such as if you have no coworkers for the first item. (If you have stopped breastfeeding during the past 4 weeks, please answer for the time you were breastfeeding during this period.)

	<u>YES</u>	<u>NO</u>
A coworker made negative comments or complained to me about breastfeeding .....	<input type="checkbox"/>	<input type="checkbox"/>
My employer or my supervisor made negative comments or complained to me about breastfeeding .....	<input type="checkbox"/>	<input type="checkbox"/>
It was hard for me to arrange break time for breastfeeding or pumping milk .....	<input type="checkbox"/>	<input type="checkbox"/>
It was hard for me to find a place to breastfeed or pump milk .....	<input type="checkbox"/>	<input type="checkbox"/>
It was hard for me to arrange a place to store pumped breast milk.....	<input type="checkbox"/>	<input type="checkbox"/>
It was hard for me to carry the equipment I needed to pump milk at work .....	<input type="checkbox"/>	<input type="checkbox"/>
I felt worried about keeping my job because of breastfeeding.....	<input type="checkbox"/>	<input type="checkbox"/>
I felt worried about continuing to breastfeed because of my job.....	<input type="checkbox"/>	<input type="checkbox"/>
I felt embarrassed among coworkers, my supervisor, or my employer because of breastfeeding .....	<input type="checkbox"/>	<input type="checkbox"/>

**Section H-3: Child Care**

23. Was your baby cared for by someone other than you on a regular schedule during the past 4 weeks? That is, did someone else usually keep your baby at least once a week for three or more hours at a time? (Include arrangements in which the exact day or time may change if the child care usually occurred at least once a week.)

Please mark "yes" if your baby is regularly cared for by anyone other than you, including the baby's father or other close relative.

Yes .....       No .....  ➔(GO TO SECTION J ON PAGE 8)

24. Who usually kept your baby regularly during the past 4 weeks? (PLEASE "X" ALL THAT APPLY)

- |                            |                          |                                  |                          |
|----------------------------|--------------------------|----------------------------------|--------------------------|
| Baby's father .....        | <input type="checkbox"/> | Other family member(s).....      | <input type="checkbox"/> |
| Baby's grandparent(s)..... | <input type="checkbox"/> | Someone not in your family ..... | <input type="checkbox"/> |

25. Where did the child care usually occur? (PLEASE "X" ALL THAT APPLY)

- |  |                          |  |                          |
|--|--------------------------|--|--------------------------|
| Baby's home with no other children.....                            | <input type="checkbox"/> | Other private home with no other children .....                            | <input type="checkbox"/> |
| Baby's home with other children or baby's brothers or sisters..... | <input type="checkbox"/> | Other private home with other children or baby's brothers or sisters ..... | <input type="checkbox"/> |
| Day care or child care center.....                                 | <input type="checkbox"/> | Other .....  | <input type="checkbox"/> |

26. How many days in an average week was your baby cared for by your regularly scheduled child care provider(s)? (Include days your baby was cared for by family members if they regularly provide child care while you are away from the baby)

1 .....     2 .....     3.....     4 .....     5.....     6.....     7 .....

27. On an average day when your baby was with your regular child care provider(s), how many hours was he or she with the child care provider(s)?  
 \_\_\_\_\_ HOURS

**FOR QUESTIONS 28-30, IF YOUR ANSWER IS DIFFERENT FOR DIFFERENT CHILD CARE PROVIDERS, ANSWER FOR THE ONE WHO FEEDS YOUR BABY THE MOST TIMES PER WEEK.**

28. In your opinion, how supportive of breastfeeding is your child care provider?

- |                            |                          |                          |                          |                  |                          |
|----------------------------|--------------------------|--------------------------|--------------------------|------------------|--------------------------|
| Not at all supportive..... | <input type="checkbox"/> | Somewhat supportive..... | <input type="checkbox"/> | Don't know ..... | <input type="checkbox"/> |
| Not too supportive .....   | <input type="checkbox"/> | Very supportive .....    | <input type="checkbox"/> |                  |                          |

29. On an average day when your baby was with your child care provider, how many times did the child care provider feed him or her? Please include feedings of breast milk, formula, and all other foods, and include meals and snacks.

\_\_\_\_\_ TIMES PER DAY FED BABY      None.....  ➔(GO TO INSTRUCTION BEFORE QUESTION 31)

30. How often did you find out what your regularly scheduled child care provider fed your baby?

Seldom or never ..... Sometimes ..... Always or most of the time.....

IF YOUR BABY IS ONLY CARED FOR IN YOUR HOME, GO TO SECTION J ON THIS PAGE.

ANSWER QUESTIONS 31-33 FOR YOUR CHILD CARE THAT IS OUTSIDE OF YOUR HOME. IF YOU HAVE MORE THAN ONE CHILD CARE PROVIDER OUTSIDE OF YOUR HOME, ANSWER FOR THE ONE WHO FEEDS YOUR BABY THE MOST TIMES PER WEEK.

31. Under your regular child care arrangements in the past 4 weeks, who usually provided the formula, if any, and food that your baby drank and ate? Include meals and snacks. (PLEASE "X" ALL THAT APPLY). If your child provider does not feed your baby, "X" here  and go to Question 32.

	THE CHILD CARE PROVIDER	YOU, THE MOTHER	SOMEONE ELSE	BABY WAS NOT FED THIS ITEM
Who provided the baby's formula? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Who provided the baby's food for meals?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Who provided the baby's snacks? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Does your child care provider:

	YES	NO	DON'T KNOW
Feed a mother's pumped breast milk to her baby? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allow mothers to breastfeed at the child care place before or after work? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allow mothers to come in and breastfeed during their lunch or other breaks?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thaw and prepare bottles of pumped milk if needed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep extra breast milk in a freezer for use if they run out during the day? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. How long does your child care provider keep fresh and thawed breast milk in the refrigerator?

	THROWS MILK OUT OR SENDS IT HOME DAILY	KEEPS MILK OVER 1 NIGHT	KEEPS MILK OVER 2 NIGHTS	KEEPS MILK 3 NIGHTS OR LONGER (SUCH AS OVER A WEEKEND)	DON'T KNOW
Fresh breast milk .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thawed breast milk .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION J: OTHER INFORMATION

1. During the past 2 weeks, have you had any health conditions which made it hard or impossible for you to take care of your baby? Yes ..... No .....

2. On the average, how many cigarettes do you smoke a day now? (Write in 0 if you do not smoke). \_\_\_\_\_ CIGARETTES PER DAY

3. How many people including yourself smoke inside your home most days? (Include yourself, family members, friends, and anyone else.) 0..... 1..... 2..... 3..... 4 or more.....

4. What is your weight now? \_\_\_\_\_ POUNDS

5. In the past month, were you or your baby enrolled in the WIC program or did you get WIC food or vouchers for yourself or for your baby? (WIC is a program that gives food to pregnant and nursing women, babies, and young children.) (PLEASE "X" ALL THAT APPLY)

Yes, I was enrolled or got WIC food for myself..... Yes, my baby was enrolled or got WIC formula or food ..... No.....

6. On a typical day over the past 7 days, how many minutes per day was your baby outside? Please think about all of the times your baby was outside with you or with anyone else.

None..... <input type="checkbox"/>	30 to 39 minutes..... <input type="checkbox"/>
Less than 10 minutes..... <input type="checkbox"/>	40 to 49 minutes..... <input type="checkbox"/>
10 to 19 minutes..... <input type="checkbox"/>	50 to 59 minutes..... <input type="checkbox"/>
20 to 29 minutes..... <input type="checkbox"/>	An hour or more..... <input type="checkbox"/>

7. What was your baby usually wearing when he or she was outside over the past 7 days? Please mark one answer for each category.

a. What was your baby usually wearing on his or her head?

Hat or hood..... Nothing.....

b. What was your baby usually wearing on his or her upper body?

No top..... Short sleeved top.....  
Sleeveless top..... Long sleeved top, jacket, coat, or blanket.....

c. What was your baby usually wearing on his or her lower body?

Diaper only.....  
Shorts, skirt, or dress (legs bare).....  
Long pants, tights, blanket (legs covered).....

d. While outside over the past week, was your baby usually in a stroller? My baby was not usually in a stroller

With canopy/sun shade..... Without canopy/sun shade..... My baby was not usually in a stroller.....

8. When you take your baby outside, do you usually put sunscreen on him or her?

Yes..... No.....

9. Does your baby have any serious, long-term medical problems?

No..... Yes..... →(PLEASE EXPLAIN BRIEFLY) \_\_\_\_\_

10. Date you completed this form:

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_