Job No: R868-04
OMB # 0910-0558
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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.*

	FEEDINGS PER DAY	FEEDINGS PER WEEK
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.	_____	_____
Other (Please specify) _____	_____	_____

2. What type of baby cereal was your baby fed in the past 7 days? **(PLEASE "X" ALL THAT APPLY)**
   Baby was not fed baby cereal ☐ Dry cereal that you added a liquid to ☐ Cereal in a jar already mixed ☐

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.

	NEVER	ONLY RARELY	EVERY FEW DAYS	ABOUT ONCE A DAY	AT MOST FEEDINGS	EVERY FEEDING
Vitamins or minerals	☐	☐	☐	☐	☐	☐
Baby cereal	☐	☐	☐	☐	☐	☐
Sweetener	☐	☐	☐	☐	☐	☐
Medicine	☐	☐	☐	☐	☐	☐
Other (Specify)_____	☐	☐	☐	☐	☐	☐

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 ☐

8. Have you have obtained information about feeding babies from any of the following sources for this baby or a previous one? Think of information you have received about breastfeeding, formula feeding, feeding solid foods, or any other infant feeding information.

	YES	NO
Doctor, nurse, or other health professional	☐	☐
WIC food program	☐	☐
Baby care class or support group	☐	☐
Relative or friend	☐	☐
Books or videos	☐	☐
Newsletters	☐	☐
Newspapers or magazines	☐	☐
Television or radio	☐	☐
The web site www.4woman.gov	☐	☐
The web site www.womenshealth.gov	☐	☐
Other web site	☐	☐

IF YOUR BABY WAS FED FORMULA IN THE PAST 7 DAYS, PLEASE CONTINUE. ALL OTHERS GO TO INSTRUCTION ABOVE

QUESTION 15 ON PAGE 2.

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

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

10. 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 ..... ☐

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

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

12. 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**
☐	☐	☐	☐	☐	☐

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

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

14. 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 SECTION A-2 ON THIS PAGE.

15. Does your baby usually feed from both breasts at each feeding?

Yes ..... ☐ No ..... ☐ Baby is only fed pumped milk ..... ☐ ➔**(GO TO QUESTION 18)**

16. Does your baby usually let go of the breast him or herself?

Yes, both breasts ..... ☐ Yes, first breast only ..... ☐ Yes, second breast only ..... ☐ No ..... ☐

17. About how long does an average breastfeeding last?

Less than 10 minutes ..... ☐
10 to 19 minutes ..... ☐
20 to 29 minutes ..... ☐
30 to 39 minutes ..... ☐
40 to 49 minutes ..... ☐
50 or more minutes ..... ☐

18. 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

19. 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 SECTION A-2 ON THIS PAGE)**

20. 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 ..... ☐

21. 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 ..... ☐

Section A-2 Health

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

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

23. Did your baby receive any of the following medicines in the past 2 weeks? *(Please do not include vitamins or minerals.)*

	YES	**NO**
Antibiotics	☐	☐
Other prescription medicines	☐	☐
Non-prescription medicines	☐	☐

24. 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 27)**

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

_____

26. Why was your baby given the preparations or teas listed in Question 25? **(PLEASE "X" ALL THAT APPLY)**

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

27. 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

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

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

29. 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 31)**

30. 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

31. 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 THIS PAGE)**

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

Yes ..... ☐ ➔**(CONTINUE)** No..... ☐ ➔**(GO TO SECTION C ON THIS PAGE)**

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

Yes ..... ☐ ➔**(GO TO SECTION C ON THIS PAGE)** 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?

_____ DAYS (if younger than 2 weeks) **OR** _____ WEEKS

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

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.)*

	YES	NO	DOES NOT APPLY/ DON'T KNOW
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?

VERY UNFAVORABLE				VERY FAVORABLE
1	2	3	4	5
☐	☐	☐	☐	☐

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?

NOT AT ALL LIKELY				VERY LIKELY
1	2	3	4	5
☐	☐	☐	☐	☐

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 J ON PAGE 4)**

2. Did your baby have a reaction the first time he or she ate the food?

☐

Yes ..... ☐ No ..... ☐ Not sure.....

3. 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 ..... ☐

4. How old was your baby the first time he or she had a problem with food? *(Include food your baby reacted to through breast milk.)*

1 month or less ..... ☐ 3 months..... ☐ 5 months ..... ☐
2 months ..... ☐ 4 months..... ☐ 6 months ..... ☐

5. Did you take your baby to a medical doctor because of these problems with food?

Yes ..... ☐ No ..... ☐➔ **(GO TO QUESTION 8)**

6. 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 7.

Parents' description of symptoms..... ☐
A skin test ..... ☐
A blood test such as RAST, or CAP-RAST ..... ☐
An esophageal or intestinal study..... ☐
Food elimination (withdrawal of the specific food to see if symptoms disappeared)..... ☐
Food challenge (introduction of a specific food to see if symptoms reappeared) ..... ☐
Other (**SPECIFY**)_____ ☐

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

Yes ..... ☐ No ..... ☐

8. What symptoms of a problem with food has your baby had? **(PLEASE "X" ALL THAT APPLY)**

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

9. How have these symptoms been treated? **(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 ..... ☐

10. Please indicate which foods caused a problem for your baby in column 10a, including food your baby reacted to through breast milk. In column 10b, 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)**

	10A. BABY HAD A PROBLEM WITH	**10B. BABY DIAGNOSED AS ALLERGIC TO**
Cow's milk or other dairy products (including infant formula made with cow milk)	☐	☐
Soy milk or other soy food (including infant formula made with soy)	☐	☐
Eggs	☐	☐
Peanuts, peanut butter, or peanut oil	☐	☐
Nuts (such as, almonds, pecans, walnuts).....	☐	☐
Sesame seed, tahini, or sesame seed oil	☐	☐
Fish, shellfish, or other seafood	☐	☐
Beef, chicken or turkey.....	☐	☐
Wheat, gluten, or wheat starch	☐	☐
Other grain or cereal (such as oats, barely).....	☐	☐
Fruit or fruit juice	☐	☐
Vegetable	☐	☐
Other food (**SPECIFY**) _____	☐	☐

IF YOUR BABY HAS HAD A PROBLEM WITH INFANT FORMULA, PLEASE CONTINUE. ALL OTHERS GO TO SECTION J.

11. 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
☐	☐	☐	☐	☐	☐

12. How many of the different formulas listed on the insert has your baby had a problem with?

1 ..... ☐ 2 ..... ☐ 3 ..... ☐ 4 ..... ☐ 5 or more..... ☐

SECTION J: OTHER INFORMATION

1. 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..... ☐

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

No..... ☐ Yes ..... ☐ ➔(**PLEASE EXPLAIN BRIEFLY**) _____

3. Date you completed this form: Month _____ Day _____ Year _____