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Global Opinion Panels

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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.

	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baby cereal.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweetener.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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.....

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.

	<u>YES</u>	<u>NO</u>
Doctor, nurse, or other health professional.....	<input type="checkbox"/>	<input type="checkbox"/>
WIC food program.....	<input type="checkbox"/>	<input type="checkbox"/>
Baby care class or support group.....	<input type="checkbox"/>	<input type="checkbox"/>
Relative or friend.....	<input type="checkbox"/>	<input type="checkbox"/>
Books or videos.....	<input type="checkbox"/>	<input type="checkbox"/>
Newsletters.....	<input type="checkbox"/>	<input type="checkbox"/>
Newspapers or magazines.....	<input type="checkbox"/>	<input type="checkbox"/>
Television or radio.....	<input type="checkbox"/>	<input type="checkbox"/>
The web site www.4woman.gov	<input type="checkbox"/>	<input type="checkbox"/>
The web site www.womenshealth.gov	<input type="checkbox"/>	<input type="checkbox"/>
Other web site.....	<input type="checkbox"/>	<input type="checkbox"/>

IF YOUR BABY WAS FED FORMULA IN THE PAST 7 DAYS, PLEASE CONTINUE. ALL OTHERS GO TO INSTRUCTION ABOVE QUESTION 15 ON THIS PAGE.

9. How often does your baby drink all of his or her cup or 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 cup or 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..... Powder from a can that makes more than one bottle.....
 Liquid concentrate..... 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 INSTRUCTION ABOVE QUESTION 22 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..... 20 to 29 minutes..... 40 to 49 minutes.....
 10 to 19 minutes..... 30 to 39 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 INSTRUCTION ABOVE QUESTION 22 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.....

IF YOUR BABY IS FED ANY FOODS OR DRINKS BESIDES BREAST MILK OR FORMULA, PLEASE CONTINUE. ALL OTHERS GO TO SECTION A-2 ON PAGE 3.

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
 Sometimes..... juice that was not sold for babies.....
 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..... Skim milk (nonfat).....
 Whole milk..... Whole evaporated milk.....
 Reduced fat (2%) milk..... Skim evaporated milk.....
 Lowfat (1%) milk..... Lactose reduced milk.....
25. In the past 7 days, how many times did your baby eat restaurant food at a restaurant? Include food eaten in any type of restaurant, such as a fast food, cafeteria, or table service restaurant.
- 0..... 2 to 3..... 6 to 7.....
 1..... 4 to 5..... 8 or more.....
26. In the past 7 days, how many times did your baby eat food delivered or carried out from a restaurant? Include food from any restaurant, such as a take-out, drive-thru, or delivery restaurant.
- 0..... 2 to 3..... 6 to 7.....
 1..... 4 to 5..... 8 or more.....

27. 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

28. 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

29. Do you use iodized salt for the baby's food?

- Yes
- No

Section A-2 Health

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

- | | |
|---------------------------------------------------|-----------------------------------------------------------------|
| Fever <input type="checkbox"/> | Runny nose or cold..... <input type="checkbox"/> |
| Diarrhea..... <input type="checkbox"/> | Respiratory Syncytial Virus (RSV)..... <input type="checkbox"/> |
| Vomiting..... <input type="checkbox"/> | Cough or wheeze <input type="checkbox"/> |
| Ear infection..... <input type="checkbox"/> | Asthma..... <input type="checkbox"/> |
| Colic..... <input type="checkbox"/> | Food allergy <input type="checkbox"/> |
| Fussy or irritable <input type="checkbox"/> | Eczema (atopic dermatitis) <input type="checkbox"/> |
| Reflux <input type="checkbox"/> | None of these <input type="checkbox"/> |

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

- | | <u>YES</u> | <u>NO</u> |
|-----------------------------------|--------------------------|--------------------------|
| 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"/> |

32. 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 35)

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

34. Why was your baby given the preparations or teas listed in Question 33? (PLEASE "X" ALL THAT APPLY)

- | | |
|------------------------------------------------------|---------------------------------------------------------------------------------------------|
| To ease diaper rash..... <input type="checkbox"/> | To ease a cold or other respiratory symptoms <input type="checkbox"/> |
| To ease colic <input type="checkbox"/> | To ease an illness other than a cold or respiratory symptoms <input type="checkbox"/> |
| To ease digestion <input type="checkbox"/> | To stimulate the baby's immune system <input type="checkbox"/> |
| To ease fussiness..... <input type="checkbox"/> | Other (SPECIFY) _____ <input type="checkbox"/> |
| To help the baby relax..... <input type="checkbox"/> | |

35. Whether or not you give your baby herbal or botanical preparations, please mark where you have gotten information about these products in the past few years. (PLEASE "X" ALL THAT APPLY)

- | | |
|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| A sales person at a store..... <input type="checkbox"/> | Lactation consultant..... <input type="checkbox"/> |
| Product labels or advertisements..... <input type="checkbox"/> | Relative or friend..... <input type="checkbox"/> |
| Doctor or physician assistant..... <input type="checkbox"/> | Birthing, baby care, or breastfeeding class..... <input type="checkbox"/> |
| Nurse, nurse midwife, or nurse practitioner..... <input type="checkbox"/> | Pregnancy or breastfeeding support group..... <input type="checkbox"/> |
| An alternative medicine practitioner, herbalist or chiropractor..... <input type="checkbox"/> | Books or videos..... <input type="checkbox"/> |
| Pharmacist..... <input type="checkbox"/> | Newsletters..... <input type="checkbox"/> |
| Nutritionist or dietitian..... <input type="checkbox"/> | Newspapers or magazines..... <input type="checkbox"/> |
| | A web site..... <input type="checkbox"/> |

36. 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

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

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

38. 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 40)

39. 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

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

