

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.....	_____	_____
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 Instruction above 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"/>

