



Job No: R868-06
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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 | _____ | _____ |
| 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. 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 BELOW QUESTION 13 ON THIS PAGE.

8. How often does your baby drink all of his or her 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..... 4..... 5..... 6 7..... 8 or more

10. 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.....

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)

| <u>GROUP 1</u> | <u>GROUP 2</u> | <u>GROUP 3</u> | <u>GROUP 4</u> | <u>GROUP 5</u> | <u>GROUP 6</u> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |

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 BELOW QUESTION 20 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 BELOW QUESTION 20)

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 PAGE 3.

21. For each food category listed below, about how much of the food fed to the 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)**

| | <u>ALL COMMERCIAL BABY FOOD</u> | <u>MOSTLY COMMERCIAL BABY FOOD</u> | <u>SOME COMMERCIAL BABY FOOD</u> | <u>No COMMERCIAL BABY FOOD</u> | <u>NOT FED IN PAST 7 DAYS</u> |
|---|---|--|--|--|-----------------------------------|
| 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"/> |

22. 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.....

23. 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.....

Section A-2 Health

24. 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.....

25. 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"/> |

26. 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 29)

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

28. Why was your baby given the preparations or teas listed in Question 27? **(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
- To ease digestion..... respiratory symptoms
- To ease fussiness To stimulate the baby's immune system
- To help the baby relax..... Other (**SPECIFY**).....

29. 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

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

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

31. 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 33 ON THIS PAGE)

32. 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

33. 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 H ON PAGE 5)
2. Have you completely stopped breastfeeding and pumping milk for your baby?
 Yes →(CONTINUE) No..... →(GO TO SECTION H ON PAGE 5)
3. Have you filled out **SECTION B: Stopped Breastfeeding** since you stopped breastfeeding?
 Yes →(GO TO SECTION H ON PAGE 5) 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.)

| | YES | NO | DOES NOT APPLY/ DON'T KNOW |
|--|--------------------------|--------------------------|-------------------------------|
| The baby's father..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your mother..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your mother-in-law..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your grandmother..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Another family member..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A doctor or other health professional..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your employer or supervisor..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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..... <input type="checkbox"/> | 7 to 8 hours..... <input type="checkbox"/> |
| 3 to 4 hours..... <input type="checkbox"/> | 8 hours or more..... <input type="checkbox"/> |
| 5 to 6 hours..... <input type="checkbox"/> | |

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?

Bassinette.....
 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 PAGE 6)

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.... <input type="checkbox"/> | 3 to 4 nights..... <input type="checkbox"/> |
| Less than 1 night a week..... <input type="checkbox"/> | 5 to 6 nights..... <input type="checkbox"/> |
| 1 to 2 nights..... <input type="checkbox"/> | 7 nights per week..... <input type="checkbox"/> |

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..... <input type="checkbox"/> | Other people..... <input type="checkbox"/> |
| Your other child or children..... <input type="checkbox"/> | No one else..... <input type="checkbox"/> |

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..... To bottle feed
- Sleeping with my baby helps the baby or me to sleep better To help with a blocked milk duct or other breastfeeding problem
- I think it is safer if my baby sleeps with me or us .. To be close/bond
- A doctor or nurse advised sleeping with baby..... To comfort when fussy.....
- To breastfeed..... 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..... 30 to 34 hours per week
- 10 to 19 hours per week..... 35 to 40 hours per week
- 20 to 29 hours per week..... More than 40 hours per week.....

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> |
| 1 | 2 | 3 | 4 | 5 |
| <input type="checkbox"/> |

17. 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 I keep my baby with me while I work at home
- My baby is cared for by someone not in my family I keep my baby with me while I work outside my home

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

- Not at all supportive..... Somewhat supportive
- Not too supportive Very supportive

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

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

20. 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 I pump milk during my work day and save it for my baby to drink later
- I go to my baby and breastfeed him or her during my work day I pump milk during my work day, but I do not save it for my baby to drink later
- My baby is brought to me to breastfeed during my work day I neither pump milk nor breastfeed during my work day.....

21. 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

22. 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)

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

Baby's father..... Other family member(s).....
Baby's grandparent(s)..... Someone not in your family

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

Baby's home with no other children Other private home with no other children.....
Baby's home with other children
or baby's brothers or sisters Other private home with other children
or baby's brothers or sisters
Day care or child care center Other

25. 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)

_____ DAYS PER WEEK

26. 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 27-29, IF YOUR ANSWER IS DIFFERENT FOR DIFFERENT CHILD CARE PROVIDERS, ANSWER FOR THE ONE WHO FEEDS YOUR BABY THE MOST TIMES PER WEEK.

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

Not at all supportive Somewhat supportive Don't know.....
Not too supportive Very supportive.....

28. 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 INSTRUCTION AFTER QUESTION 29)

29. 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 PAGE 8.

ANSWER QUESTIONS 30-32 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.

30. 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)

| | 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"/> |

31. 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"/> |

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

No Yes..... →**(PLEASE EXPLAIN BRIEFLY)** _____

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