**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 usually fed in a 24-hour period? Include feedings by everyone who feeds the baby and include snacks and night-time feedings.

<table>
<thead>
<tr>
<th>FEEDINGS PER DAY</th>
<th>FEEDINGS PER WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast milk</td>
<td></td>
</tr>
<tr>
<td>Formula</td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
</tr>
<tr>
<td>Other milk</td>
<td></td>
</tr>
<tr>
<td>Other dairy foods: yogurt, cheese, ice cream, pudding, etc.</td>
<td></td>
</tr>
<tr>
<td>Other soy foods: tofu, frozen soy desserts, etc.</td>
<td></td>
</tr>
<tr>
<td>100% fruit or 100% vegetable juice</td>
<td></td>
</tr>
<tr>
<td>Sweet drinks: juice drinks, soft drinks, soda, sweet tea, Kool-Aid, etc</td>
<td></td>
</tr>
<tr>
<td>Baby cereal</td>
<td></td>
</tr>
<tr>
<td>Other cereals and starches: breakfast cereals, teething biscuits, crackers, breads, pasta, rice, etc</td>
<td></td>
</tr>
<tr>
<td>Fruit</td>
<td></td>
</tr>
<tr>
<td>Vegetables</td>
<td></td>
</tr>
<tr>
<td>French fries</td>
<td></td>
</tr>
<tr>
<td>Fish or shellfish:</td>
<td></td>
</tr>
<tr>
<td>Peanut butter, other peanut foods, or nuts</td>
<td></td>
</tr>
<tr>
<td>Eggs</td>
<td></td>
</tr>
</tbody>
</table>

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.

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)**

<table>
<thead>
<tr>
<th>Vitamin or minerals</th>
<th>Vitamin D</th>
<th>None of these</th>
<th>Iron</th>
<th>Other vitamins</th>
</tr>
</thead>
</table>

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?

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.

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?

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

9. In the past 7 days, how many times did your baby drink at each feeding?

<table>
<thead>
<tr>
<th>1 to 2</th>
<th>3 to 4</th>
<th>5 to 6...</th>
<th>7 to 8....</th>
<th>More than 8....</th>
</tr>
</thead>
</table>

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?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

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)**

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ready-to-feed</th>
<th>Powder from a can that makes more than one bottle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liquid concentrate</td>
<td>Powder from single serving packs</td>
</tr>
</tbody>
</table>
13. Which of the following describes the iron content of the formula you usually use?
   - With iron
   - Low iron (additional iron may be necessary)
   - Other prescription medicines
   - Other non-prescription medicines

14. Does your baby usually feed from both breasts at each feeding?
   - Yes □
   - No □

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 □
   - 10 to 19 minutes □
   - 20 to 29 minutes □
   - 30 to 39 minutes □
   - 40 to 49 minutes □
   - 50 or more minutes □

17. In an average 24-hour period, what is the longest time for you, the mother, between breastfeeding 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 □

21. 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?
   - About 1 new food every 3 days □
   - About 1 new food every 4 or 5 days □
   - About 1 new food every 7 days □
   - More than 1 new food every day □
   - No new foods in the past 2 weeks □

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)
   - Commercial baby food
   - Mostly commercial baby food
   - Some commercial baby food
   - No commercial baby food
   - Not fed in past 7 days

23. If you fed your baby fruit juice that was not sold especially for babies, how often was the juice fortified with calcium?
   - Never □
   - Rarely □
   - Sometimes □
   - Usually □
   - Always □
   - Don't know □

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. 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 □
   - More than 1 new food every day □

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 □

28. Did your baby receive any of the following medicines in the past 2 weeks? (Please do not include vitamins or minerals.)
   - Antibiotics □
   - Other prescription medicines □
   - Non-prescription medicines □
29. Which of the following problems did your baby have during the past 2 weeks? (PLEASE “X” ALL THAT APPLY)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
<th>(GO TO QUESTION 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fussy or irritable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflux</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Syncytial Virus (RSV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough or wheeze</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food allergy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema (atopic dermatitis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of these</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>No</th>
<th>(GO TO QUESTION 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ease diaper rash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ease a cold or other respiratory symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ease colic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ease an illness other than a cold or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ease digestive symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ease fussiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To help the baby relax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To stimulate the baby’s immune system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>NUMBER OF STOOLS IN 24 HOURS</th>
<th>OR</th>
<th>ONE STOOL EVERY</th>
<th>NUMBER OF DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Stool</th>
<th>Hard</th>
<th>Semi-watery</th>
<th>Watery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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       ☐  No       ☐  (CONTINUE)

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

Yes       ☐  No       ☐  (CONTINUE)

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

Yes       ☐  No       ☐  (GO TO SECTION C ON PAGE 4)

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

Yes       ☐  No       ☐  (CONTINUE)

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

WEEKS     MONTHS

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

<table>
<thead>
<tr>
<th>Reason</th>
<th>NOT AT ALL IMPORTANT</th>
<th>NOT VERY IMPORTANT</th>
<th>SOMEWHAT IMPORTANT</th>
<th>VERY IMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>My baby had trouble sucking or latching on</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My baby became sick and could not breastfeed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My baby began to bite</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My baby lost interest in nursing or began to wean him or herself</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My baby was old enough that the difference between breast milk and</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>formula no longer mattered</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breast milk alone did not satisfy my baby</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A health professional said my baby was not gaining enough weight</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I had trouble getting the milk flow to start</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I didn’t have enough milk</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My nipples were sore, cracked, or bleeding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My breasts were overfull or engorged</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My breasts were infected or abscessed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My breasts leaked too much</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breastfeeding was too painful</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breastfeeding was too tiring</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I was sick or had to take medicine</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breastfeeding was too inconvenient</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I did not like breastfeeding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I wanted to be able to leave my baby for several hours at a time</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I wanted to go on a weight loss diet</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I wanted to go back to my usual diet</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I wanted to smoke again or more than I did while breastfeeding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I had too many household duties</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I could not or did not want to pump or breastfeed at work</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pumping milk no longer seemed worth the effort that it required</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I was not present to feed my baby for reasons other than work</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I wanted or needed someone else to feed my baby</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Someone else wanted to feed the baby</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I did not want to breastfeed in public</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I wanted my body back to myself</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I became pregnant or wanted to become pregnant again</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>The baby’s father</th>
<th>Yes</th>
<th>No</th>
<th>DOES NOT APPLY/ DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your mother-in-law</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your grandmother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another family member</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A doctor or other health professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your employer or supervisor</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>VERY UNFAVORABLE</th>
<th>VERY FAVORABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>NOT AT ALL LIKELY</th>
<th>VERY LIKELY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

**SECTION C: FOOD ALLERGY SECTION**

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>(GO TO SECTION E ON PAGE 5)</th>
</tr>
</thead>
</table>

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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>(GO TO SECTION E ON PAGE 5)</th>
</tr>
</thead>
</table>

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

- New reactions only
- Repeat of earlier reported problems only
- Both
- Can’t remember

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
</table>

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......
- 6 months......
- 8 months......
- Older than 9 months......

6. Were the problems caused by...

<table>
<thead>
<tr>
<th>(PLEASE “X” ALL THAT APPLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food your baby ate (including infant formula)</td>
</tr>
<tr>
<td>Food your baby was exposed to through breast milk because of something you ate</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>(GO TO QUESTION 10 ON THIS PAGE)</th>
</tr>
</thead>
</table>

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.

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)...

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
</table>

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)

- Congestion
- Runny nose
- Asthma or wheezing
- Trouble breathing
- Coughing
- Swollen eyes and or lips
- Hives or welts
- Flushing
- Skin rash or eczema
- Splitting 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
12A. BABY HAD A PROBLEM WITH

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, barley) ...................................................... □ □
Fruit or fruit juice ............................................................................................. □ □
Vegetable .......................................................................................................... □ □
Other food (SPECIFY) .................................................................................... □ □

12B. BABY DIAGNOSED AS ALLERGIC TO

Go to Question 5 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

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 □

SECTION E: INFANT FORMULA

1. Was your baby fed infant formula in the past 2 weeks, by you or by anyone else?

Yes □ (CONTINUE) No □ (GO TO SECTION H ON PAGE 6)

2. During the past 2 weeks, what kind of water have you and others who feed your baby used for mixing your baby’s formula? (PLEASE "X" ALL THAT APPLY)

Tap water from the cold faucet □ □
Warm tap water from the hot faucet □ □
Boiled or sterilized □ □
Prepared formula without cleaning my hands □ □
Rinsed with hand sanitizer (such as gel or wipes) □ □
Washed with soap □ □
Washed by hand with dish detergent □ □
Rinsed my hands with water only □ □

3. How often have you and others who feed your baby cleaned the bottle nipples used to feed formula in the following ways before being used again? If you

Never □ Sometimes, but less than half the time □ About half the time □ Most of the time □

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 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.

Rinsed with water only □ □
Washed in an automatic dishwasher □ □
Washed by hand with dish detergent □ □
Boiled or sterilized □ □
Not cleaned between uses – used to feed more formula without rinsing or washing □ □

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

Rinsed my hands with water only □ □
Wiped my hands only □ □
Washed with soap □ □
Used hand sanitizer (such as gel or wipes) □ □
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 □ More than 16 hours □
9 to 11 hours □ 12 to 16 hours □

7. How often 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 a formula based on low price □ □
I chose the same formula I fed an older child □ □
I do not keep prepared formula at room temperature □ □

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

Yes □ No □

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 □

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

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

Yes □ No □
12. What type of problem did your baby have with the formula(s)? (PLEASE "X" ALL THAT APPLY)
   - An allergic reaction or intolerance
   - Too much gas
   - Constipation
   - Too much spit up
   - Diarrhea
   - Vomiting
   - Too much mucus
   - 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
   - 4 to 5 hours
   - 5 to 6 hours

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
   - In bed or other place with you
   - In something else

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

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
    - Other people
    - Your other child or children
    - Your pet
    - Other

11. What are your reasons for bringing your baby to bed with you? (PLEASE "X" ALL THAT APPLY)
    - To breastfeed
    - To comfort when fussy
    - To be close/bond
    - To help with a blocked milk duct or other breastfeeding problem
    - To be close/bond
    - To comfort when sick
    - To bottle feed

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 sleeps 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
    - A doctor or nurse advised sleeping with 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

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
20. 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
   - My baby is cared for by someone not in my family
   - Baby's grandparent(s)
   - Baby's home with no other children
   - Baby's home with other children or baby's brothers or sisters
   - Day care or child care center
   - Other

21. Who usually kept your baby regularly during the past 4 weeks? (PLEASE "X" ALL THAT APPLY)
   - My baby was brought to me to breastfeed during my work day
   - My baby is brought to me to breastfeed during my work day
   - I keep my baby with me while I work and breastfeed during my work day
   - 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
   - I pump milk during my work day and save it for baby
   - I neither pump milk nor breastfeed during my work day

22. In your opinion, how supportive of breastfeeding is your place of employment? (PLEASE "X" ALL THAT APPLY)
   - Very supportive
   - Somewhat supportive
   - Not too supportive
   - Not at all supportive

23. In your opinion, how supportive of breastfeeding is your child care provider? (PLEASE "X" ALL THAT APPLY)
   - Very supportive
   - Somewhat supportive
   - Not too supportive
   - Not at all supportive

24. Using 1 to mean "None" and 5 to mean "Very much," how much satisfaction do you get from your paid work?
   - About half
   - More than half
   - About half
   - More than half

25. 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
   - 10 to 19 hours per week
   - 20 to 29 hours per week
   - 30 to 44 hours per week
   - More than 40 hours per week

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.)

24. 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
   - Baby's home with no other children
   - Baby's home with other children or baby's brothers or sisters
   - Day care or child care center
   - Other

25. Where did the child care usually occur? (PLEASE "X" ALL THAT APPLY)
   - Day care or child care center
   - Baby's 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

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
   - Somewhat supportive
   - Not too supportive
   - Very supportive

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.

TIME PER DAY FED BABY

---

(R868-09) Page 7
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 PROVIDER 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.

Who provided the baby’s formula? □
Who provided the baby’s food for meals? □
Who provided the baby’s snacks? □

32. Does your child care provider:
Feed a mother’s pumped breast milk to her baby? □
Allow mothers to breastfeed at the child care place before or after work? □
Thaw and prepare bottles of pumped milk if needed? □
Keep extra breast milk in a freezer for use if they run out during the day? □

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

<table>
<thead>
<tr>
<th>THROWS MILK OUT OR SENDS IT HOME DAILY</th>
<th>KEEPS MILK OVER 1 NIGHT</th>
<th>KEEPS MILK OVER 2 NIGHTS (SUCH AS OVER A WEEKEND)</th>
<th>KEEPS MILK 3 NIGHTS OR LONGER</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh breast milk □ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td>Thawed breast milk □ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
</tbody>
</table>

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).

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

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)

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.

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 □

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?

10. Date you completed this form:
Month ______ Day ______ Year ______