Job No: R868-12
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.	_____	_____

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 ..... ☐
   Iron ..... ☐
   Vitamin D..... ☐
   Other vitamins ..... ☐
   None of these ..... ☐

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 ..... ☐

IF YOUR BABY WAS FED FORMULA IN THE PAST 7 DAYS, PLEASE CONTINUE. ALL OTHERS GO TO INSTRUCTION ABOVE QUESTION 14 ON THIS PAGE.

8. How often does your baby drink all of his or her cup or 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 to 4 .... ☐ 5 to 6 ... ☐ 7 to 8 ... ☐ More than 8 .. ☐

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?

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)**

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
☐	☐	☐	☐	☐	☐

12. 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..... ☐

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 ABOVE QUESTION 21 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 .. ☐
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 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 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 ..... ☐

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 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	☐	☐	☐	☐	☐
Fruit	☐	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐	☐
Meat, chicken, combination dinners ..	☐	☐	☐	☐	☐

22. 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..... ☐
Always..... ☐
Don't know ..... ☐
Never fed any juice or never fed juice that was not sold for babies .. ☐

23. 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 ..... ☐
Whole milk..... ☐
Reduced fat (2%) milk ..... ☐
Lowfat (1%) milk..... ☐
Skim milk (nonfat) ..... ☐
Whole evaporated milk ..... ☐
Skim evaporated milk..... ☐
Lactose reduced milk ..... ☐

24. 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	☐		

25. 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 ☐

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

Yes ☐ No ☐

Section A-2 Health

27. 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	☐

28. 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	☐	☐

29. 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 32)**

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

_____

31. Why was your baby given the preparations or teas listed in Question 30? **(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 respiratory symptoms	☐
To ease digestion	☐	To stimulate the baby's immune system	☐
To ease fussiness	☐	Other (**SPECIFY**)_____	☐
To help the baby relax	☐		

32. 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

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

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

34. How much did your baby weigh the last time he or she was weighed at a doctor's visit?

_____ POUNDS _____ OUNCES Don't know ☐

35. What was the date of that weight? _____ MONTH _____ DAY Don't know ☐

36. How long was your baby the last time he or she was measured at a doctor's visit?

_____ INCHES Don't know ☐

37. What was the date of that measurement? _____ MONTH _____ DAY Don't know ☐

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

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 PAGE 4)**

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

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

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?

_____ 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	☐	☐	☐	☐
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 H ON PAGE 6)**

2. Since your baby was 9 months old, has he or she had problems caused by food, such as an allergic reaction, sensitivity, or intolerance?

Yes..... ☐ No ..... ☐➔**(GO TO SECTION H ON PAGE 6)**

3. Were these problems new since your baby was 9 months old, or a repeat occurrence of problems reported to us earlier?

New reactions only ☐
Repeat of earlier reported problems only ☐➔ **(GO TO QUESTION 6 ON THIS PAGE)**
Both ☐
Can't remember ☐

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

Yes ☐ No ☐ Not sure ☐

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.)*

9 months ☐ 11 months ☐ Older than 12 months ☐
10 months ☐ 12 months ☐

6. 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 ☐

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

Yes ☐ No ☐➔ **(GO TO QUESTION 10 ON THIS PAGE)**

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?

Yes ☐ No ☐

10. 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	☐		

11. How have these symptoms been treated since your baby was 9 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 ☐

12. Please indicate which foods caused a problem for your baby in column 12a, including food your baby reacted to through breast milk. In column 12b, 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)**

	12A. BABY HAD A PROBLEM WITH	12B. 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 H.

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 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 ..... ☐
5 to 6 hours ..... ☐
7 to 8 hours ..... ☐
8 hours or more ..... ☐

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 THIS PAGE)**

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..... ☐
Your other child or children..... ☐
Other people ..... ☐
No one else..... ☐

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 PAGE 7.

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 THIS PAGE)**

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 ..... ☐
10 to 19 hours per week ..... ☐
20 to 29 hours per week ..... ☐
30 to 34 hours per week..... ☐
35 to 40 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?

NONE				VERY MUCH
1	2	3	4	5
☐	☐	☐	☐	☐

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..... ☐
My baby is cared for by someone not in my family..... ☐
I keep my baby with me while I work at home..... ☐
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..... ☐
Not too supportive..... ☐
Somewhat supportive..... ☐
Very supportive ..... ☐

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

Yes ..... ☐ No..... ☐ ➔**(GO TO SECTION H-3 ON THIS PAGE)**

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 go to my baby and breastfeed him or her during my work day ..... ☐
My baby is brought to me to breastfeed during my work day..... ☐
I pump milk during my work day and save it for my baby to drink later..... ☐
I pump milk during my work day, but I do not save it for my baby to drink later ..... ☐
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.)*

	YES	NO
A coworker made negative comments or complained to me about breastfeeding.....	☐	☐
My employer or my supervisor made negative comments or complained to me about breastfeeding.....	☐	☐
It was hard for me to arrange break time for breastfeeding or pumping milk.....	☐	☐
It was hard for me to find a place to breastfeed or pump milk	☐	☐
It was hard for me to arrange a place to store pumped breast milk.....	☐	☐
It was hard for me to carry the equipment I needed to pump milk at work.....	☐	☐
I felt worried about keeping my job because of breastfeeding.....	☐	☐
I felt worried about continuing to breastfeed because of my job.....	☐	☐
I felt embarrassed among coworkers, my supervisor, or my employer because of breastfeeding.....	☐	☐

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..... ☐
Baby's grandparent(s) ..... ☐
Other family member(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..... ☐
Baby's home with other children or baby's brothers or sisters ..... ☐
Day care or child care center..... ☐
Other private home with no other children ..... ☐
Other private home with other children or baby's brothers or sisters..... ☐
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.

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).** If your child provider does not feed your baby, "X " here ☐ and go to Question 31.

	THE CHILD CARE PROVIDER	YOU, THE MOTHER	SOMEONE ELSE	BABY WAS NOT FED THIS ITEM
Who provided the baby's formula?	☐	☐	☐	☐
Who provided the baby's food for meals?	☐	☐	☐	☐
Who provided the baby's snacks?	☐	☐	☐	☐

31. Does your child care provider:

	YES	NO	DON'T KNOW
Feed a mother's pumped breast milk to her baby?	☐	☐	☐
Allow mothers to breastfeed at the child care place before or after work?	☐	☐	☐
Allow mothers to come in and breastfeed during their lunch or other breaks?	☐	☐	☐
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?	☐	☐	☐

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	☐	☐	☐	☐	☐
Thawed breast milk	☐	☐	☐	☐	☐

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 _____