



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.....	_____	_____
Other (Please specify) _____	_____	_____

- 2. What type of baby cereal was your baby fed in the past 7 days? (PLEASE "X" ALL THAT APPLY)
Baby was not fed baby cereal..... Dry cereal that you added a liquid to..... Cereal in a jar already mixed.....
- 3. Which of the following was your baby given in vitamin or mineral drops or pills at least 3 days a week during the past 2 weeks? If your baby was given drops or pills that contained more than one of the items listed, please mark each of the separate items. (PLEASE "X" ALL THAT APPLY)
Fluoride..... Vitamin D..... None of these.....
Iron..... Other vitamins.....
- 4. Has your baby used a pacifier in the past 7 days? Yes..... No.....
- 5. During the past 2 weeks, how often was your baby put to bed with a bottle of formula, breast milk, juice, juice drink, or any other kind of milk?
At most bedtimes, including naps.....
At most night bedtimes, but not naps.....
At most naps, but not night bedtimes.....
Only occasionally at bedtimes, including naps.....
Never.....
- 6. How often have you added each of the following items to your baby's bottle of formula or pumped (or expressed) breast milk in the past 2 weeks? If you have not given your baby a bottle in the past 2 weeks, "X" here and go to Question 7.

	NEVER	ONLY RARELY	EVERY FEW DAYS	ABOUT ONCE A DAY	AT MOST FEEDINGS	EVERY FEEDING
Vitamins or minerals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baby cereal.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweetener.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- 7. In the past 2 weeks, have you chewed up food and then given it to your baby, so the food was already chewed up before you fed it to your baby?
Yes..... No.....

IF YOUR BABY WAS FED FORMULA IN THE PAST 7 DAYS, PLEASE CONTINUE. ALL OTHERS GO TO INSTRUCTION ABOVE QUESTION 14 ON PAGE 2.

- 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 to 4... 5 to 6..... 7 to 8... More than 8.....
- 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)

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 [] 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 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 [] 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 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. How important was each of the following reasons for feeding your baby solid food for the very first time? Solid foods are foods such as cereal, baby foods, or table food. (PLEASE ANSWER EACH ITEM) If your baby has not been fed solid food, "X" here [] and go to Question 22.

Table with 5 columns: NOT AT ALL IMPORTANT, NOT VERY IMPORTANT, SOMEWHAT IMPORTANT, VERY IMPORTANT. Rows include reasons like 'My baby was nursing too much', 'My baby was drinking too much formula', etc.

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)

Table with 5 columns: ALL COMMERCIAL BABY FOOD, MOSTLY COMMERCIAL BABY FOOD, SOME COMMERCIAL BABY FOOD, NO COMMERCIAL BABY FOOD, NOT FED IN PAST 7 DAYS. Rows include Fruit and vegetable juice, Fruit, Vegetables, Meat, chicken, combination dinners.

23. If you fed your baby fruit juice that was not sold especially for babies, how often was the juice fortified with calcium?

Never [] Don't know []
Rarely [] Never fed any juice or never fed juice that was not sold for babies []
Sometimes []
Always []

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 []

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

Table with 5 columns: NOT AT ALL IMPORTANT, NOT VERY IMPORTANT, SOMEWHAT IMPORTANT, VERY IMPORTANT. Rows list reasons like 'My baby had trouble sucking or latching on' and '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.)

Table with 3 columns: YES, NO, DOES NOT APPLY/DON'T KNOW. Rows list people like 'The baby's father', 'Your mother', '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?

Scale from 1 (VERY UNFAVORABLE) to 5 (VERY FAVORABLE) with checkboxes.

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?

Scale from 1 (NOT AT ALL LIKELY) to 5 (VERY LIKELY) with checkboxes.

SECTION D: BREASTFEEDING
Section D-1: General Information

1. In the past 3 months, did you breastfeed this baby (or feed this baby your pumped milk)?

Yes (CONTINUE) No (GO TO SECTION E ON PAGE 7)

2. Using 1 to mean "Very Uncomfortable" and 5 to mean "Very Comfortable," how comfortable would you be in the following situations?

Table with 5 columns: VERY UNCOMFORTABLE (1) to VERY COMFORTABLE (5). Rows list nursing situations in presence of friends.

3. Have you breastfed your baby or pumped breast milk in the past 7 days?

Yes (CONTINUE) No (GO TO SECTION D-2 ON PAGE 6)

4. How old do you think your baby will be when you completely stop breastfeeding?

Table with 4 columns: 4, 7, 10, 12 months and More than 12 months, with checkboxes.

5. Using 1 to mean "Not at all Confident" and 5 to mean "Very Confident," how confident are you that you will be able to breastfeed until the baby is the age you marked in Question 4?

Scale from 1 (NOT AT ALL CONFIDENT) to 5 (VERY CONFIDENT) with checkboxes.

6. Since you have been breastfeeding, have you eaten more, less, or about the same of the following foods? If you did not eat the food before you began breastfeeding and you don't eat the food now, please mark "Did Not Eat Before or Now."

Table with 4 columns: EAT MORE, EAT LESS, EAT ABOUT THE SAME, DID NOT EAT BEFORE OR NOW. Rows include Milk or other dairy foods, Eggs, Canned tuna, Swordfish, shark, tile fish, or king mackerel, Any other type of fish, Shellfish, Luncheon meats, Nuts, peanuts, or peanut butter, Alcoholic drinks, Vitamin or mineral supplements, Any herbal or botanical supplement.

7. For each food that you are eating less of, please indicate the reason. (PLEASE "X" ALL THAT APPLY) If you are not eating less of any food, go to Question 8.

Table with 5 columns: THE FOOD IS NOT HEALTHY FOR MY BABY, TO PREVENT FOOD ALLERGY IN MY BABY, RECOMMENDED BY A HEALTH PROFESSIONAL, RECOMMENDED BY A FRIEND OR RELATIVE, OTHER. Rows include Milk or other dairy foods, Eggs, Canned tuna, Swordfish, shark, tile fish, or king mackerel, Any other type of fish, Shellfish, Luncheon meats, Nuts, peanuts, or peanut butter, Alcoholic drinks, Vitamin or mineral supplements, Any herbal or botanical supplement.

8. For each food that you are eating more of, please indicate the reason. (PLEASE "X" ALL THAT APPLY) If you are not eating more of any food, go to Question 9.

Table with 6 columns: THE FOOD IS HEALTHY FOR ME, IMPROVES THE AMOUNT OR QUALITY OF MY MILK, CRAVED THE FOOD MORE, RECOMMENDED BY A HEALTH PROFESSIONAL, RECOMMENDED BY A FRIEND OR RELATIVE, OTHER. Rows include Milk or other dairy foods, Eggs, Canned tuna, Swordfish, shark, tile fish, or king mackerel, Any other type of fish, Shellfish, Luncheon meats, Nuts, peanuts, or peanut butter, Alcoholic drinks, Vitamin or mineral supplements, Any herbal or botanical supplement.

9. Did you work for pay any time during the past 4 weeks?

Yes No (GO TO INSTRUCTION ABOVE QUESTION 11 ON THIS PAGE)

10. Which of the following circumstances describe your situation during the past 4 weeks? (If you have stopped breastfeeding or stopped working for pay, please answer for the time you were breastfeeding and working. If you have worked for less than 4 weeks, please answer for the time you have been working.) (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.....

IF YOU ANSWERED SECTION B - STOPPED BREASTFEEDING - ON THIS QUESTIONNAIRE, GO TO SECTION D-2 ON PAGE 6.

11. Was your baby fed formula to drink in the past 2 weeks, by you or by anyone else?

Yes No (GO TO SECTION D-2 ON PAGE 6)

12. How important was each of the following reasons for feeding your baby formula? (PLEASE ANSWER EACH ITEM)

Table with 4 columns: NOT AT ALL IMPORTANT, NOT VERY IMPORTANT, SOMEWHAT IMPORTANT, VERY IMPORTANT. Rows include My baby had trouble sucking or latching on, My baby became sick and could not breastfeed, 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 didn't have enough milk, My nipples were sore, cracked, or bleeding, My breasts were infected or abscessed, Breastfeeding was too painful, Breastfeeding was too tiring, I was sick or had to take medicine, Breastfeeding was too inconvenient, I wanted to be able to leave my baby for several hours at a time, 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.

Section D-2: Breast Pumps

- 13. In the past 3 months, have you pumped or tried to pump milk? (Include expressing breast milk in any way as pumping milk.)
 Yes, but I did not get any milk... Yes, and I got milk ... No..... → (GO TO SECTION E ON PAGE 7)
- 14. How old was your baby the first time you pumped or tried to pump milk?
 _____ DAYS OR _____ WEEKS OR _____ MONTHS
- 15. How have you pumped or expressed milk in the past 3 months? (PLEASE "X" ALL THAT APPLY)
 Electric breast pump..... Manual breast pump (no batteries, no cord to plug in)
 Combination electric and battery operated breast pump..... By hand (without using a pump)
 Battery operated pump

IF YOU HAVE USED A BREAST PUMP IN THE PAST 3 MONTHS, PLEASE CONTINUE. ALL OTHERS GO TO SECTION D-3 ON PAGE 7.

- 16. How many breast pumps have you used in the past 3 months? Count all the pumps you have used even if they are the same type and style.
 1..... 2 3..... 4 or more.....
- 17. What type of breast pump do you use most often?
 Electric breast pump..... Battery operated pump
 Combination electric and battery operated breast pump..... Manual breast pump
- 18. How did you get the breast pump that you use most often?
 I bought it..... I borrowed it from a friend or relative.....
 It was given to me as a gift..... I borrowed it from my place of work
 I rented it..... I use one provided by a hospital, my
 I got it from WIC..... place of work, or another place
- 19. Was the breast pump you use most often new or used when you got it or began using it?
 New Used Not sure
- 20. How did you learn to use the breast pump you use most often? (PLEASE "X" ALL THAT APPLY)
 I read the printed directions that came with the pump.....
 I got instructions for the pump from the internet.....
 I watched a video about how to use the pump
 A lactation consultant, WIC staff, nurse, or doctor showed me how to use it.....
 A friend, relative, sales clerk, or other person showed me how to use it.....
 I figured it out without directions or being shown how
- 21. Using 1 to mean "Very Dissatisfied" and 5 to mean "Very Satisfied," how satisfied are you with the performance of the breast pump that you use most often?

VERY DISSATISFIED					VERY SATISFIED
<u>1</u>		<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- 22. Have you been hurt by any breast pump that you used or tried to use to express milk in the past 3 months?
 Yes No →(GO TO QUESTION 26 ON THIS PAGE)
- 23. What type of pump hurt you? (PLEASE "X" ALL THAT APPLY)
 Electric breast pump..... Battery operated pump
 Combination electric and battery operated breast pump..... Manual breast pump
- 24. In what way were you hurt? (PLEASE "X" ALL THAT APPLY)
 Nipple injury from the pump..... Infection from a pump injury Other (SPECIFY)
 Sore nipples from the pump Pressure bruise..... _____
- 25. Did you go to a medical doctor, lactation consultant, or other health professional because of the injury?
 Yes No
- 26. Have you had any of the following problems with a breast pump that you used to express milk in the past 3 months?

	YES	NO
Pressure or suction from the pump was hard to release.....	<input type="checkbox"/>	<input type="checkbox"/>
Pump was uncomfortable or painful to use even though it did not cause injury	<input type="checkbox"/>	<input type="checkbox"/>
Pump had a bad seal or milk got into the motor or other place it should not be.....	<input type="checkbox"/>	<input type="checkbox"/>
Could not get pump to work or to express any milk.....	<input type="checkbox"/>	<input type="checkbox"/>
Pump worked, but did not get enough/much milk	<input type="checkbox"/>	<input type="checkbox"/>
Pump worked, but it took too long to get enough milk.....	<input type="checkbox"/>	<input type="checkbox"/>
Pump worked for a while but then quit working.....	<input type="checkbox"/>	<input type="checkbox"/>
Pump had another problem (SPECIFY) _____	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU HAVE NOT BEEN HURT BY A PUMP AND ANSWERED NO TO ALL PROBLEMS LISTED IN QUESTION 26, GO TO SECTION D-3 ON PAGE 7.

- 27. Did you call the pump manufacturer to get help with the problem or to report the injury or problem? Yes ... No.....
- 28. After you had a problem or injury from using the pump, did you stop breastfeeding?
 No, not at all Yes, for a short time..... Yes, I stopped breastfeeding completely
- 29. Did you stop using the pump that injured you or that you had trouble with?
 Yes, I completely stopped using the pump.....
 Yes, except I used the pump sometimes for special situations.....
 No, I continued to use the pump..... → (GO TO SECTION D-3 ON PAGE 7)
- 30. What did you do about expressing milk after you stopped using the pump?
 I changed to a different type of pump (for example, from manual to battery operated)
 I changed to a different style of pump of the same type (for example, from one brand or style of electric pump to a different electric pump)
 I changed to a new pump that was just like the one that hurt me or that I had trouble with.....
 I stopped using a pump to express milk
 I stopped expressing milk.....

Section D-3: Pumping or Expressing Milk

31. During the past 2 weeks, how many times did you pump milk? (Include expressing breast milk in any way as pumping milk.)
_____ TIMES IN PAST 2 WEEKS →(If 0, GO TO SECTION E ON THIS PAGE)

32. Are you now pumping milk on a regular schedule?
Yes No →(GO TO QUESTION 34)

33. How old was your baby when you first began pumping milk on a regular schedule?
_____ DAYS OR _____ WEEKS OR _____ MONTHS

34. On average, in the past 2 weeks, how many ounces of milk did you pump each time?
1 ounce or less 3 to 4 ounces 7 to 8 ounces
2 ounces 5 to 6 ounces More than 8 ounces

35. For what reasons have you pumped milk in the past 2 weeks? (PLEASE "X" ALL THAT APPLY)
To relieve engorgement..... To keep my milk supply up when my baby could not nurse (such as while you were away from your baby or when your baby was too sick to nurse).....
Because my nipples were too sore to nurse..... To increase my milk supply
To get milk for someone else to feed to my baby ... To mix with cereal or other food.....
For me to feed to my baby when I do not want to breastfeed or when baby cannot breastfeed To have an emergency supply of milk.....
To donate to a baby other than my own

36. How often do you collect milk from both breasts at the same time (double pumping)?
Never Rarely Sometimes Most of the time Always

37. How long is your frozen milk usually stored?
Less than 1 week 1 to 3 months I do not freeze my milk
1 to 4 weeks 4 months or more

38. How long was your milk usually stored in the refrigerator in the past 2 weeks? (Include cooler with cold source such as freezer packs.)
1 day or less 4 to 5 days More than 8 days
2 to 3 days 6 to 8 days I do not store milk in a refrigerator ...

39. How long was your milk usually kept at room temperature and then fed to your baby in the past 2 weeks?
Less than 1 hour... 5 to 8 hours More than 16 hours
1 to 2 hours 9 to 11 hours I do not keep my milk at room temperature
3 to 4 hours 12 to 16 hours

Babies are fed pumped breast milk in a lot of different situations, and bottles of milk may have to be prepared in a lot of different places. Please think of all of these situations and places as you answer the next few questions.

40. In the past 2 weeks, how often were the bottle nipples used to feed pumped breast milk cleaned in the following ways before being used again? If you don't use bottle nipples, "X" here and go to Question 41.

	RARELY OR NEVER	SOME OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
Rinsed with water only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed in an automatic dish washer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed by hand with dish detergent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boiled or sterilized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not cleaned between uses – used to feed more milk without rinsing or washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. In the past 2 weeks, how often were the following items boiled, sterilized in a microwave kit, sterilized with a chemical dip, or washed in a dishwasher?

	AFTER EACH USE	ONCE A DAY	EVERY 2 TO 6 DAYS	ABOUT ONCE A WEEK	ABOUT ONCE IN 2 WEEKS	NEVER	ITEM IS DISPOSABLE
Pump collection kit, including container used to collect the milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Container used to store the milk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. How often have you and others who feed your baby heated your baby's cup or bottle of pumped milk in a microwave oven?
Rarely or never..... Sometimes, but less than half the time About half the time Most of the time

43. In the past 2 weeks, has your baby been fed formula mixed with breast milk in the same bottle?
Yes No →(GO TO SECTION E ON THIS PAGE)

44. How were the formula and breast milk usually mixed? (PLEASE "X" ALL THAT APPLY)
Added formula powder to breast milk Added prepared (mixed up) formula or ready-to-feed formula to breast milk
Added formula concentrate to breast milk

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 J ON PAGE 8)

2. Did a doctor, health professional, or birthing class tell you how to prepare formula?
Yes No

3. Did a doctor, health professional, or birthing class tell you how to store the prepared bottles of formula?
Yes No

4. During the past 2 weeks, what type 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..... Bottled water.....
Warm tap water from the hot faucet No water used; baby is fed only ready-to-feed formula → (GO TO QUESTION 6)

5. Was the water you used to mix the formula boiled?

	<u>YES</u>	<u>NO</u>	<u>NOT USED</u>
Tap water.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bottled water.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. How often have you and others who feed your baby heated your baby's bottle of formula in a microwave oven?

Rarely or 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 of these situations and places as you answer the next few questions.

7. 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 8.

	<u>NEVER</u>	<u>SOME OF THE TIME</u>	<u>MOST OF THE TIME</u>	<u>ALL OF THE TIME</u>
Rinsed with water only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed in an automatic dish washer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed by hand with dish detergent.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boiled or sterilized.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not cleaned between uses – used to feed more formula without rinsing or washing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	<u>NEVER</u>	<u>SOME OF THE TIME</u>	<u>MOST OF THE TIME</u>	<u>ALL OF THE TIME</u>
Rinsed my hands with water only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wiped my hands only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed with soap.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used hand sanitizer (such as gel or wipes).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepared formula without cleaning my hands.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. 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..... <input type="checkbox"/>	5 to 8 hours..... <input type="checkbox"/>	More than 16 hours..... <input type="checkbox"/>
1 to 2 hours..... <input type="checkbox"/>	9 to 11 hours..... <input type="checkbox"/>	I do not keep prepared formula at room temperature..... <input type="checkbox"/>
3 to 4 hours..... <input type="checkbox"/>	12 to 16 hours..... <input type="checkbox"/>	

10. How 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..... <input type="checkbox"/>	I chose a formula labeled as useful for a problem my baby had .. <input type="checkbox"/>
I chose the same formula fed to my baby at the hospital..... <input type="checkbox"/>	I use the formula given by WIC..... <input type="checkbox"/>
I heard that the formula is better for my baby in some way .. <input type="checkbox"/>	I chose the same formula I fed an older child..... <input type="checkbox"/>
I chose the formula I received samples or coupons for..... <input type="checkbox"/>	Friends or relatives recommended the formula..... <input type="checkbox"/>
I saw an advertisement for the formula and wanted to try it .. <input type="checkbox"/>	I chose a formula based on low price..... <input type="checkbox"/>

11. Did you discuss your choice of formula with the baby's doctor?

Yes..... No.....

12. During the past 2 weeks, how many times have you switched the formula you feed your baby?

None..... ➔(GO TO SECTION J) 1..... 2..... 3..... 4..... 5 or more.....

13. 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)

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

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

Yes..... No..... ➔(GO TO SECTION J ON THIS PAGE)

15. What type of problem did your baby have with the formula(s)? (PLEASE "X" ALL THAT APPLY)

An allergic reaction or intolerance..... <input type="checkbox"/>	Too much gas..... <input type="checkbox"/>
Constipation..... <input type="checkbox"/>	Too much spit up..... <input type="checkbox"/>
Diarrhea..... <input type="checkbox"/>	Vomiting..... <input type="checkbox"/>
Too much mucus..... <input type="checkbox"/>	Other problem (Please specify _____) <input type="checkbox"/>

SECTION J: OTHER INFORMATION

1. 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.....

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

No..... Yes..... ➔(PLEASE EXPLAIN BRIEFLY) _____

3. Date you completed this form:

Month _____ Day _____ Year _____