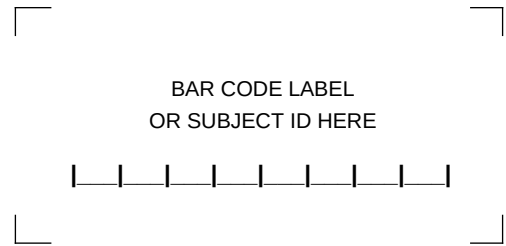


Source: FDA Infant Feeding Practices Study Neonatal Questionnaire
Visits: 6 month
Mode: Self-administered (Mail in)
Estimated Time: 10 minutes



National Children’s Study Infant Feeding Questionnaire—6 Months

PROTECTION OF PRIVACY STATEMENT INSERTED HERE

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN
Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Office, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7479, ATTN: PRA (0925-XXXX). Do not return the completed form to this address.

Please complete this questionnaire within 2 weeks and mail it in the large pre-stamped envelope to:

LABEL FOR CLINICAL CENTER RETURN ADDRESS

General Instructions



This questionnaire is about your 6-month-old infant _____. When we refer to "your baby," please respond with this 6-month old infant in mind.



This questionnaire asks you about your baby's recent diet.



Answer each question as best you can. Estimate if you are not sure. A guess is better than leaving a blank.



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 to answer the questions.



Use only a black ball-point pen. Do not use a pencil or felt-tip pen. Do not fold, staple, or tear the pages.

Put an X in the box next to your answer.



If you make any changes, cross out the incorrect answer and put an X in the box next to the correct answer. Also draw a circle around the correct answer.



BEFORE YOU BEGIN, PLEASE FILL IN TODAY'S DATE:

___/___/___
Month Day Year

1. In the **past 7 days**, how often was your baby fed each item listed below? Include feedings by everyone who feeds the baby and include snacks and night-time feedings.

If your baby was fed the item once a day or more, write the **number of feedings per day** in the first column. If your baby was fed the item 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 item at all during the past 7 days, write 0 in the second column.

	Feedings per Day	Feedings per Week
a. Breast milk (include breast fed and expressed or pumped breast milk)?	_____	_____
b. Formula?	_____	_____
c. Cow's milk?	_____	_____
d. Other milk (soy milk, rice milk, goat milk)?	_____	_____

If your baby is not drinking breast milk now, but was **ever fed breast milk** → **GO TO QUESTION 2.**

If your baby is **drinking breast milk** now → **GO TO QUESTION 3.**

If your baby was **never fed breast milk** → **GO TO QUESTION 9.**

2. How old was your baby when you completely stopped breastfeeding and pumping or expressing breast milk?

Age in weeks (if younger than 1 month) _____

Age in months (if older than 1 month) _____

3. Have you ever fed your baby pumped or expressed breast milk?

Yes..... → **GO TO QUESTION 4**

No..... → **GO TO QUESTION 9**

4. In the **past 7 days**, about how often was your baby fed pumped or expressed breast milk? Include feedings by everyone who feeds the baby and include snacks and nighttime feedings.

- 1 time per week.....
- 2 to 4 times per week.....
- Nearly every day.....
- 1 time per day.....
- 2 to 3 times per day.....
- 4 to 6 times per day.....
- More than 6 times per day.....

5. In the **past 7 days**, about how long was your breast milk usually stored in the **refrigerator** before it was fed to your baby? (Include cooler with cold source such as freezer packs).

- 1 day or less
- 2-3 days.....
- 4-5 days.....
- 6-8 days.....
- More than 8 days
- DID NOT STORE BREAST MILK IN REFRIGERATOR ...

6. In the **past 7 days**, about how long was your breast milk usually kept at **room temperature** and then fed to your baby?

- 1 hour or less
- 1-2 hours
- 3-4 hours
- 5-8 hours
- 9-11 hours
- 12-16 hours
- More than 16 hours
- DID NOT KEEP MILK AT ROOM TEMPERATURE

7. Now think about how you clean the bottle nipples used to feed pumped or expressed breast milk to your baby. In the **past 7 days**, did you never, sometimes, most of the time, or always:

	Never	Sometimes	Most of the time	Always
a. Rinse the nipples with water only before a feeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wash the nipples in an automatic dishwasher?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Wash the nipples by hand with dish detergent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Boil or sterilize the nipples?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not clean the nipples between feedings (use nipples to feed more milk without rinsing or washing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Now think about how you cleaned your breast milk collection pump kit, the container used to collect the breast milk, and the container used to store the milk. During the **past 7 days**, how often was each item oiled, sterilized in a microwave, 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
a. Pump collection kit and breast milk collection container	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Container used to store milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. How old was your baby when (he/she) was first fed **formula** on a daily basis?

Never fed formula **→GO TO QUESTION 20**

Less than 1 month old

1 to 2 months old

3 to 4 months old

5 to 6 months old

More than 6 months old

10. What kind of infant formula was your baby fed in the **past 7 days**? Infant formulas are listed alphabetically along with a group number in the chart below. Please put an X in the box next to the group number of each infant formula your baby was fed. (MARK ALL THAT APPLY)

Never fed formula **→GO TO QUESTION 20**
 Group 1 Group 4
 Group 2 Group 5
 Group 3 Group 6

FORMULA NAME	Group Number
EleCare	1
Enfamil	2
Enfamil AR LIPIL	3
Enfamil Gentlease LIPIL	3
Enfamil LactoFree LIPIL	3
Enfamil LIPIL	3
Enfamil Next Step LIPIL....	3
Enfamil Next Step ProSobee LIPIL	4
Enfamil ProSobee	5
Enfamil ProSobee LIPIL	4
Enfamil Nutramigen LIPIL	6
Enfamil Pregestimil	6
Horizon Organic	2
Isomil	5
Isomil Advance	4
Isomil 2	5
Isomil 2 Advance	4
Isomil DF	5

FORMULA NAME	Group Number
Nestle Good Start Essentials	2
Nestle Good Start 2 Essentials	2
Nestle Good Start Essentials Soy	5
Nestle Good Start 2 Essentials Soy	5
Nestle Good Start Essentials Soy DHA and ARA	4
Nestle Good Start Supreme	2
Nestle Good Start Supreme DHA and ARA	3
Nestle Good Stat Supreme 2 DHA and ARA	3
Nestle NAN DHA and ARA	3
Similac	2
Smiliac Advance	3
Similac 2	2
Similac 2 Advance	3
Similac Alimentum Advance	6
Similac Lactose Free Advance	3
Similac Neosure Advance	3
Store Brand milk based without DHA and ARA	2
Store brand milk based with DHA and ARA LIPID	3
Store brand soy based without DHA and ARA	5
Store brand soy based with DHA and ARA LIPID	4

11. Was the formula with iron or a low iron formula?

With iron.....
 Low iron.....

12. Was the formula ready-to-feed, liquid concentrate, powder from a can that makes a single serving, or powder from single serving packets? (MARK ALL THAT APPLY)

- Ready-to-feed
- Liquid concentrate
- Powder from a can that makes more than one bottle
- Powder from single serving packets

If your baby was fed ready-to-feed formula ONLY, go to question 16. If your baby was fed any liquid concentrate or powdered formula, go to question 13.

13. When the formula was mixed, was it made according to the directions on the formula label?

- Yes..... → GO TO QUESTION 14
- No..... → When the formula was mixed, how much formula and how much water were used?

	<u>Amount</u>	<u>Measurement Unit</u>
Formula _____		<input type="checkbox"/> Tablespoon <input type="checkbox"/> Teaspoon <input type="checkbox"/> Ounce <input type="checkbox"/> Cup <input type="checkbox"/> Packet <input type="checkbox"/> Formula Can
Water _____		<input type="checkbox"/> Ounces <input type="checkbox"/> Cups <input type="checkbox"/> Formula Can

14. During the **past 7 days**, what types of water have you and others who care for your baby used for mixing your baby’s formula? (MARK ALL THAT APPLY)

- Tap water from the cold faucet
- Warm tap water from the hot faucet
- Bottled water
- No water used, fed ready-to-feed formula

15. Was the water used to mix the formula **boiled**?

- Yes.....

No.....

16. In the **past 7 days**, on the average, how many ounces of formula did your baby drink at each feeding?

_____ Ounces

17. Now think about how you clean the bottle nipples used to feed formula to your baby. In the **past 7 days**, did you never, sometimes, most of the time, or always:

	Never	Sometimes	Most of the time	Always
a. Rinse the nipples with water only before a feeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wash the nipples in an automatic dishwasher?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Wash the nipples by hand with dish detergent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Boil or sterilize the nipples?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not clean the nipples between feedings (use nipples to feed more milk without rinsing or washing).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Now think about how you cleaned your hands when you were preparing formula. During the **past 7 days**, did you never, sometimes, most of the time, or always:

	Never	Sometimes	Most of the time	Always
a. Rinse hands with water only?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wipe hands only?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Wash hands with soap?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Use a hand sanitizer (such as gel or wipes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Prepare formula without cleaning your hands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. In the **past 7 days**, about how long were the bottles of prepared formula kept at **room temperature** and then fed to your baby?

1 hour or less

- 1–2 hours
- 3–4 hours
- 5–8 hours
- 9–11 hours
- 12–16 hours
- More than 16 hours
- NEVER



20. In the **past 7 days**, about how often did your baby drink from each of the following types of bottles and cups?

	Never	Sometimes	Most of the time	Always
a. Plastic baby bottle with disposable bottle liner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Plastic baby bottle without disposable liner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Other plastic bottle (for example, a water bottle)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Glass baby bottle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Plastic “no spill” cup?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Has your baby used a pacifier in the **past 7 days**?

- Yes.....
- No.....

22. Has your baby ever been fed cow’s milk that was not sold especially for babies? (This includes whole, lowfat, nonfat, or chocolate milk.)

- Yes..... **→GO TO QUESTION 23**
- No..... **→GO TO QUESTION 24**

23. How old was your baby when he/she was first fed cow’s milk that was not sold especially for babies?

Age in months _____

24. Have you ever fed your baby fruit juice that was not sold especially for babies?

- Yes..... **→GO TO QUESTION 25**

No..... → GO TO QUESTION 26

25. About how often was the fruit juice fortified with calcium?

- Always.....
- Sometimes.....
- Rarely.....
- Never.....
- Don't know.....

26. Now think about fruits, vegetables, and meats that may have been fed to your baby in the **past 7 days**. How much of each type of food your baby ate was **commercial baby food**?



(Commercial baby food is food sold for babies. Foods that are NOT commercial baby food are table foods your whole family eats, foods you made especially for your baby, fresh fruit, and fruit juices that are not sold especially for babies.)

Type of Commercial Baby Food	Always	Usually	Sometimes	Never	Not fed to my baby
a. Fruit and vegetable juice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Fruit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Meats, chicken and turkey?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Combination dinners (for example Spaghetti Dinner, Pasta and Vegetable Dinner, Turkey and Rice Dinner)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. During the **past 7 days**, were the baby foods your baby ate always, sometimes, rarely, or never **organic baby foods**?

- Always.....
- Sometimes.....
- Rarely.....
- Never.....
- Don't know.....

28. Which of the following supplements was your child given **at least three days a week** during the **past 2 weeks**? (MARK ALL THAT APPLY)

- Fluoride.....
- Iron.....
- Vitamin D.....
- Other vitamins or supplements:
Specify _____
- None.....



29. Were the supplements you gave your baby in the form of drops or pills?
[NOTE: MARK CRUSHED PILLS MIXED WITH LIQUID AS PILLS.]

- Drops.....
- Pills.....

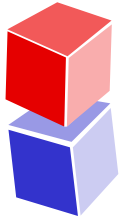
30. Was your baby given and herbal or botanical preparations or any kind of tea or home remedy in the **past 7 days**? Do not count preparations put on the baby's skin or anything the baby may have gotten from breast milk after you took an herbal or botanical preparation.

- Yes..... **→GO TO QUESTION 31**
- No..... **→GO TO LAST PAGE**

31. Please write in the name of all of the kinds of herbal or botanical preparations or teas your baby was given in the **past 7 days**.

**Thank you very much for completing this
questionnaire!
All of your answers are very important.**

Please help us by looking at each page again to make sure that you:



Did not skip any pages and

Crossed out the wrong answer and circled the right answer if you made any changes.

*Thank you for continuing to be part of
the National Children's Study.*

