

BREAST MILK STUDY INTERVIEW

Thank you for agreeing to participate in our study. I am going to begin by asking you for information on how to contact you. Your name and address information will not be included on any data files used for analysis and we will not use your name or address when you are publishing the results of the study.

[IF PARTICIPANT IS ENROLLED IN THE NCS VANGUARD STUDY, SKIP THIS SECTION]

What is your full name?

Participant Name (First, MI, Last): _____

What is your current address and phone number?

Street Address: _____ Home Phone Number: - -

City: _____ State: _____ Zip code: _____ Cell Phone Number: - -

Do you have an e-mail address?

Other Phone Number: - -

E-mail #1: _____

E-mail #2: _____

What is the best way to contact you?

In case we have difficulty reaching you, we are asking you to give us the name of an individual who would be able to help us find you if we are unable to reach you. This person will only be asked if they have current contact information for you or to relay a message to have you call us. It is best if you can tell us a friend or relative who would be likely to know how to reach you if you move.

[IF PARTICIPANT IS ENROLLED IN THE NCS VANGUARD STUDY, SKIP THIS SECTION]

Name of an individual who will know how to contact you:

(First, MI, Last): _____

Street Address: _____ Home Phone Number: - -

City: _____ State: _____ Zip code: _____ Cell Phone Number: - -

E-mail #1: _____

Other Phone Number: - -

E-mail #2: _____

Infant Name (First, MI, Last):: _____

Other Infant Names (if multiple birth): _____

Infant Birth Date: - -

Infant Birth Weight: lbs oz

Other Infant Birth Weight (if multiple birth): lbs oz

Public reporting burden for this collection of information is estimated to average 15 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 Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0593). Do not return the completed form to this address.

PARTICIPANT ID: _____

DATE: ____-____-____

Comments:

First I would like to ask you about how the breast milk sample was collected.

1. SAMPLE COLLECTION:

- a. What was the date of the collection? --
- b. What time of day did you collect the sample? : AM/PM
- c. Infant Age: days **(Calculate the infant age and fill in)**
- d. How was the sample collected, with hand expression or a breast pump?
- Hand Expression
- Manual Pump, *If yes, list brand name:* _____
- Electric Pump, *If yes, list brand name:* _____
- e. What time did you last feed your baby before collecting the sample? : AM/PM
- f. Sample Volume: cc **(Fill in the volume of the sample collected.)**
- g. How was the sample collected?
1. From both breasts
 2. From one breast while nursing with the other breast
 3. From one breast not while nursing with the other breast
- h. How long was the sample kept at room temperature? _____
- h. How long was the sample refrigerated before pick up? _____

Comments:

PARTICIPANT ID: ____

DATE: ____-____-____

We are now going to ask you some questions about your baby's breast feeding pattern.

2. INFANT FEEDING:

2-1. Are you still breastfeeding your baby?

1. Yes
2. No

2-2. What is the average number of breast feedings per day?

feedings per day

2-3. On average, how often does your baby nurse?

every hours

2-4. How long do you plan on breastfeeding your infant?

_____ (months)

PARTICIPANT ID: _____

DATE: ____-____-____

We are now going to ask you about the foods you have eaten in the last 24 hours.

3. MOTHER DIET:

Please describe what you have eaten for the following meals and snacks over the last 24 hours:

- 3-1. Breakfast: _____
- 3-2. Lunch: _____
- 3-3. Dinner: _____
- 3-4. Snacks: _____
- 3-5. Tap Water: Amount _____ glasses
- 3-6. Bottled Water:
Amount oz
Brand Name: _____

The next set of questions ask about the use of different chemicals that may have been used in your home.

4. HOUSEHOLD USE OF PESTICIDES:

Does your household use the following?

- 4-1. Herbicides such as weed killers YES NO (If no, go to 5-1)
- 4-2. What was the name of the weed killer used?

- 4-3. Who was it done/used by?
 Commercial Contractor *If so, list name/company:* _____
 Household Member
- 4-4. Where was the weed killer used? (i.e. inside/outside home)

- 4-5. How often was it used? _____
- 4-6. When was the last time the weed killer was used?
Date: --
Where: _____
- 4-8. For the most recent application, how was the weed killer used?

- 4-9. For the most recent use, did you stay in the place it was applied? YES NO
If yes, check all that apply and indicate time period:
 - During the application Hours Minutes
 - Immediately after the application Hours Minutes
 - A day after the application Hours Minutes
 - Two days after the application Hours Minutes
 - More than two days after the application Hours Minutes
- 4-10. For the most recent application, how much time did you stay/play in the placeroom the weed killer was applied? Hours Minutes

PARTICIPANT ID: _ _ _ _

DATE: _ _ - _ _ - _ _

5-1. Insecticides or pesticides used to kill insects and rodents, including chemicals used to control fleas and ticks on household pets YES NO (If no, go to 6-1)

5-2. What was the name of the chemical used? _____

5-3. Who was it done/used by?

Commercial Contractor *If so, list name/company:* _____
 Household Member

5-4. Where was the chemical used? (i.e. inside/outside home)

5-5. How often was it used? _____

5-6. When was the last time the chemical was used?

Date: - -

Where: _____

5-7. For the most recent application, how was the chemical used?

5-8. For the most recent application, did you stay in the place it was applied? YES NO

If yes, check all that apply and indicate time period:

During the application Hours Minutes
 Immediately after the application Hours Minutes
 A day after the application Hours Minutes
 Two days after the application Hours Minutes
 More than two days after the application Hours Minutes

5-9. For the most recent application, how much time did you stay/play in the place/room the chemical was applied? Hours Minutes

6-1. Fungicides (to kill fungal growth and mold) YES NO (If no, go to 7-1)

6-2. What was the name of the fungicide used?

6-3. Who was it done/used by?

Commercial Contractor *If so, list name/company:* _____
 Household Member

6-4. Where was the fungicide used? (i.e. inside/outside home)

6-5. How often was it used? _____

6-6. When was the last time the fungicide was used?

Date: - -

Where: _____

6-7. For the most recent application, how was the fungicide used?

6-8. For the most recent application, did you stay in the place it was applied? YES NO

PARTICIPANT ID: _____

DATE: ____-____-____

- | | |
|---|---|
| <input type="checkbox"/> During the application | <input type="checkbox"/> <input type="checkbox"/> Hours <input type="checkbox"/> <input type="checkbox"/> Minutes |
| <input type="checkbox"/> Immediately after the application | <input type="checkbox"/> <input type="checkbox"/> Hours <input type="checkbox"/> <input type="checkbox"/> Minutes |
| <input type="checkbox"/> A day after the application | <input type="checkbox"/> <input type="checkbox"/> Hours <input type="checkbox"/> <input type="checkbox"/> Minutes |
| <input type="checkbox"/> Two days after the application | <input type="checkbox"/> <input type="checkbox"/> Hours <input type="checkbox"/> <input type="checkbox"/> Minutes |
| <input type="checkbox"/> More than two days after the application | <input type="checkbox"/> <input type="checkbox"/> Hours <input type="checkbox"/> <input type="checkbox"/> Minutes |

6-9. For the most recent application, how much time did you stay/play in the place/room the fungicide was applied? Hours Minutes

6-10 Did anyone use any pesticides, herbicides, or fungicides inside or around the household in the past 7 days? (including use of medicated lotions or shampoos to control head lice or body lice?) YES NO DON'T KNOW
 If yes, specify: _____

6-11 Have you used insect repellent in the past 7 days? YES NO DON'T KNOW
 If yes, specify brand and type (spray, lotion): _____

7. HOUSEHOLD LOCATION:

7-1. Is your house located within a quarter mile of any major freeway, streets with heavy traffic, or industrial or incineration plants that produce lots of smoke or a strange smell? YES NO
 If yes, please specify: _____

7-2. Do you live on a farm? YES NO
 If yes, please specify: _____

7-3. Do you have contact with livestock, such as farm animals? YES NO
 If yes, please specify: _____

7-4. Do you have contact with plants? YES NO
 If yes, please specify: _____

8. MOTHER EMPLOYMENT INFORMATION:

8-1. Are you currently employed? YES NO
 If no, go to Question 9

8-2. Who do you work for? _____

PARTICIPANT ID: _____

DATE: ____-____-____

8-3. What does the person/company do? _____

8-4. What kind of work do you do? _____

8-5. What does the person/company do? _____

9. FATHER EMPLOYMENT INFORMATION:

9-1. Is the father of the baby employed? YES NO
If no, go to Question 10

9-2. Who does he work for? _____

9-3. What does the person/company do? _____

9-4. What kind of work does he (the father) do? _____

9-5. How often does the baby's father see the baby?

1. Every day, he lives in the household
2. At least once a week
3. More than once a week
4. Never

10. OTHER HOUSEHOLD MEMBER EMPLOYMENT INFORMATION:

10-1. Is anyone else living in the household currently employed? YES NO
If no, go to Question 11

10-2. If yes, who? _____

10-3. Who does he/she work for? _____

10-4. What does the person/company do? _____

10-5. What kind of work does he/she do? _____

11. WATER INFORMATION:

11-1. What are the sources of drinking water for your home? (check all that apply)

- City/County
- Well
- Bottled
- Other (specify) _____

11-2. Do you filter your drinking water?

- YES
- NO (*go to 10e*)
- DON'T KNOW (*go to 10e*)

11-3. Do you filter just the drinking water or the entire water supply (that is, for the entire house)

- Just Drinking Water
- Entire Water Supply

11-4. What kind of filter do you use?

- Particle Filter Only

PARTICIPANT ID: _____

DATE: ____-____-____

Particle Filter Plus Activated Charcoal

Don't Know

11-5. What are the sources of cooking water for your home? (check all that apply)

City/County

Well

Bottled

Other (specify) _____

PARTICIPANT ID: _ _ _ _

DATE: _ _ - _ _ - _ _

CONCLUDING STATEMENT:

Thank you very much for your time. That ends our interview for today. We really appreciate your willingness to answer our questions and to participate in the important study. You've been very helpful. (We will be in touch with you to set up an additional interview in one month.

GENERAL COMMENTS:

Overall assessment of the quality of the interview

1. Excellent, mother seemed knowledgeable and engaged in the interview
2. Good, mother seemed to understand most questions and was engaged in the interview
3. Fair, mother seemed to lack knowledge but was engaged in the interview
4. Fair, mother had knowledge but was not engaged in the interview
5. Poor, mother did not know responses and was not engaged in the interview

Please comment on any parts the mother had difficulty answering.
