



Global Opinion Panels

CHILD HEALTH & DIET SURVEY

OMB # 0910-0696

The following questions should be answered about your 6-year-old child.

Expiration Date: 11/30/2014

The Public Disclosure Burden Statement can be found in the cover letter

SECTION A

1. During the past month, what were your regular childcare arrangements for your 6-year-old?
(PLEASE "X" ALL THAT APPLY)

	BEFORE SCHOOL	AFTER SCHOOL	WEEK DAYS WHEN SCHOOL IS OUT
Parent cared for the child.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare in my home provided by someone other than a parent.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare in someone else's home.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A before- or after-school childcare program at school.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare center.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. What kind of school does your 6-year-old currently attend? (PLEASE "X" ALL THAT APPLY)

Public..... Private..... Home-schooled.....

3. What grade is your 6-year-old in?

Kindergarten..... Second grade.....
First grade..... Third grade.....

4. How many days a week is your 6-year-old in school?

Whole days: 0 days 1 day 2 days 3 days 4 days 5 days
Half days: 0 days 1 day 2 days 3 days 4 days 5 days

5. During this school year, has a special plan been developed at school to provide your 6-year-old with extra help or support such as a special needs program or an Individualized Education Program (IEP)?

EXPLANATORY NOTE: Some children have difficulty in school because of a health problem, condition, or disability. These children may receive services from a program called Special Education and have a written intervention plan called an Individualized Education Program (IEP).

Yes..... No..... Don't know.....

6. During this school year, has your 6-year-old received any of the following services? (PLEASE "X" ALL THAT APPLY)

- Speech or language therapy.....
- Occupational therapy or other type of therapy for help with handwriting or other motor skills.....
- Special instruction or help in one or more school subjects such as reading or math.....
- Special services because of a problem with vision or hearing.....
- Psychological services or counseling because of a problem with emotions, behavior, or socialization.....
- Behavioral support, such as a behavior management plan or individual support in the classroom by an assistant.....
- Other (please specify) _____
- None of these

7. How often do you read aloud to your 6-year-old?

Never..... Once a week.....
Several times a year..... At least 3 times a week.....
Several times a month..... Every day.....

8. Does your 6-year-old get special lessons or belong to any organization that encourages activities such as sports, music, art, dance, drama, etc.?

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

9. How often has a family member taken or arranged to take your 6-year-old to any type of musical or theatrical performance within the past year?

Never..... About once a month.....
Once or twice..... About once a week or more often.....
Several times.....

10. Here is a list of items that describe children. For each item, please "X" how true it has been for your 6-year-old during the past six months. He or she ...

	NOT TRUE	SOMEWHAT TRUE	CERTAINLY TRUE
a. ...is considerate of other people's feelings.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. ...is restless, overactive, cannot stay still for long.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. ...often complains of headaches, stomach aches, or sickness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. ...shares toys or treats readily with other children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. ...often loses temper.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. ...is rather solitary, prefers to play alone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. ...is generally well behaved, usually does what adults request.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. ...has many worries, or often seems worried.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. ...is helpful if someone is hurt, upset, or feeling ill.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. ...is constantly fidgeting or squirming.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. ...has at least one good friend.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. ...often fights with other children or bullies them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. ...is often unhappy, depressed, or tearful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. ...is generally liked by other children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. ...is easily distracted, concentration wanders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. ...is nervous or clingy in new situations.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. ...is kind to younger children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. ...often lies or cheats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. ...is picked on or bullied by other children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. ...often offers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. ...thinks things out before acting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. ...steals from home, school, or elsewhere.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. ...gets along better with adults than with other children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. ...has many fears, is easily scared.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y. ...has good attention span, sees chores or homework through to the end.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B

1. How tall is your 6-year-old now (without shoes)? Please use the enclosed tape measure to measure the height. Have your child back up to a wall with the back of the head, shoulder blades, buttocks, and heels touching the wall. Lay a hard-backed book or other flat item from your child's head to the wall and level with the floor. Mark the wall under the book and then measure from the floor to the mark. Please tell us the height to the nearest quarter inch.

_____ inches

2. How much does your 6-year-old weigh now (without shoes)? Please weigh your child on a scale. _____ pounds

3. How tall was your 6-year-old the last time he or she was measured at a doctor's visit? _____ inches

4. What was the date of the height measurement? Month _____ / Day _____ / 20 _____

5. How much did your 6-year-old weigh the last time he or she was weighed at a doctor's visit? _____ pounds

6. What was the date of the weight measurement? Month _____ / Day _____ / 20 _____

7. Did you check any written record from the doctor or notes that you keep after doctor's visits to answer the questions about your child's height and weight at the last doctor's visit?

Yes, for both weight and height... Yes, for weight only..... Yes, for height only.... No

8. Please indicate how you would classify your 6-year-old's weight at each of the 2 periods listed below:

	VERY UNDERWEIGHT	UNDERWEIGHT	AVERAGE	OVERWEIGHT	VERY OVERWEIGHT
Now.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First year of life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Thinking about your 6-year-old, would you like him or her to weigh:

A lot less..... A little more.....
 A little less..... A lot more.....
 About the same.....

10. How old was your 6-year-old the first time you took him or her to a dentist?

_____ years My 6-year-old has never been to a dentist..... →(GO TO QUESTION 13)

11. During the past 12 months, has your 6-year-old been to a dentist?

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

12. How many dental cavities (teeth with decay) has your 6-year-old had in his or her lifetime?

None.... 1..... 2..... 3..... 4..... 5..... 6 or more.....

13. How often does your 6-year-old usually brush his or her teeth? If someone else brushes your 6-year-old's teeth, please count this.

Never..... →(GO TO QUESTION 15) 2 times a day.....
 A few times a week..... 3 or more times a day.....
 Once a day.....

14. Does your 6-year-old usually brush his or her teeth by himself or herself, or does an older child or adult help?

(PLEASE "X" ALL THAT APPLY)

My 6-year-old brushes his or her teeth by himself or herself
 An adult or older child brushes my 6-year-old's teeth.....
 An adult or older child helps my 6-year-old brush his or her teeth.....

15. During the past 12 months, how many times did you take your 6-year-old to a doctor or other health professional for each of the following reasons?

	NONE	ONCE	2 TIMES	3 TIMES	4 TIMES	5 TIMES	6 OR MORE TIMES
Routine well child visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sick visit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow up visit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency room visit due to illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. During the past 12 months, how many times did your 6-year-old have the following infections?

	NONE	ONCE	2 TIMES	3 TIMES	4 TIMES	5 TIMES	6 OR MORE TIMES
Ear infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat infection, like strep throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia or lung infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold or upper respiratory infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. During this current school year, how many days has your 6-year-old missed school because of illness? Count part of the day as a whole day.

None.....	<input type="checkbox"/>	Three to four weeks.....	<input type="checkbox"/>
1 to 2 days.....	<input type="checkbox"/>	More than one month.....	<input type="checkbox"/>
3 to 4 days.....	<input type="checkbox"/>	Most of the year.....	<input type="checkbox"/>
One to two weeks.....	<input type="checkbox"/>		

18. Does your 6-year-old have any trouble seeing?

No.....	<input type="checkbox"/>
Yes, but he or she sees normally when wearing eyeglasses.....	<input type="checkbox"/>
Yes, and eyeglasses cannot correct his or her vision problem enough for him or her to see normally.....	<input type="checkbox"/>

19. During the past month, was your 6-year-old given any herbal or botanical remedies or supplements? (Only count things taken by mouth. Do not count anything applied to the skin or administered in any other way.)

Yes..... No →(Go To QUESTION 22A)

20. Please list all the kinds of herbal or botanical remedies or supplements your 6-year-old was given in the past month.

21. Why was your 6-year-old given an herbal or botanical remedy or supplement in the past month? (PLEASE "X" ALL THAT APPLY)

To relieve or reduce symptoms of an illness	<input type="checkbox"/>	To reduce stress or anxiety.....	<input type="checkbox"/>
To reduce congestion	<input type="checkbox"/>	To help my 6-year-old sleep.....	<input type="checkbox"/>
To strengthen or maintain health.....	<input type="checkbox"/>	Other: specify _____	<input type="checkbox"/>

22A. Has a doctor or other health professional ever told you that your 6-year-old has any of the following conditions?

If yes... If yes...

If you answer "Yes" to the first column (22A), please also answer columns 22B and 22C.

22B. How old was your 6-year-old when you were first told he or she had the condition? (Write in 0 if less than 1 year)

22C. Does your 6-year-old currently have the condition?

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>	_____ Years	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
a. Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A digestive problem like colitis, acid reflux, colic, or Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eczema or any kind of skin allergy (like contact dermatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hay fever or respiratory allergy (to pets, pollens, mold, dust mites, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, ADD, or ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Autism or developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Has your 6-year-old ever had breathing difficulties that required: (PLEASE "X" ALL THAT APPLY FOR EACH ITEM)

	YES, WITHIN THE PAST 12 MONTHS	YES, MORE THAN 12 MONTHS AGO	No
a. Use of an inhaler or nebulizer?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A visit to an emergency room or urgent care center?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Daily medicine taken seasonally or year-round?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Medicine taken occasionally or as needed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(IF "NO" TO ALL ITEMS OF QUESTION 23, GO TO QUESTION 25)

24. What are the triggers of your 6-year-old's breathing difficulties? (PLEASE "X" ALL THAT APPLY)

Exercise.....	<input type="checkbox"/>	Change of seasons.....	<input type="checkbox"/>
Infections.....	<input type="checkbox"/>	Cold, hot, or humid weather.....	<input type="checkbox"/>
Allergens (like pollen, dust, pets, food).....	<input type="checkbox"/>	Anger or emotion	<input type="checkbox"/>

Smoke or scents (like perfume, air fresheners) Other.....

25. Has your 6-year-old ever been taken to a medical doctor because of a possible food allergy? (PLEASE "X" ALL THAT APPLY)
Yes, within the past 12 months..... Yes, more than 12 months ago.... No..... → (Go To QUESTION 31)

26. What testing method was used by a doctor to check for a food allergy? (PLEASE "X" ALL THAT APPLY)
No test..... Food elimination (withdrawal of the specific food to see if symptoms disappeared).....
Description of symptoms only Food challenge (introduction of a specific food to see if symptoms reappeared).....
A skin test..... Other test
A blood test.....
An esophageal or intestinal study.....

27. Has your 6-year-old been diagnosed by a doctor as having an allergy to any food? (PLEASE "X" ALL THAT APPLY)
Yes, within the past 12 months..... Yes, more than 12 months ago..... No.....

28. What symptoms has your 6-year-old had because of a reaction to food? (PLEASE "X" ALL THAT APPLY)
Congestion..... Gassiness or stomach cramps.....
Runny nose Vomiting
Asthma or wheezing..... Diarrhea.....
Trouble breathing Constipation
Coughing..... Irritability or behavior changes.....
Swollen eyes and or lips..... Sleeplessness.....
Hives or welts..... Blood in stool.....
Flushing Loss of consciousness.....
Skin rash or eczema None of these.....
Esophagitis or severe acid reflux.....

29. Has any reaction to food been treated with epinephrine or resulted in a visit to an emergency room or urgent care center? (PLEASE "X" ALL THAT APPLY)
Yes, within the past 12 months..... Yes, more than 12 months ago..... No.....

30. Has your 6-year-old outgrown a food allergy or intolerance that he or she had when younger?
Not sure..... Yes..... No.....

31. Do you currently avoid any foods or food ingredients for your 6-year-old because of a known or suspected food allergy or intolerance?
Yes..... No..... →(Go To SECTION C)

32. Which foods or food ingredients do you currently avoid for your 6-year-old? (PLEASE "X" ALL THAT APPLY)
Cow's milk or other dairy products Beef, pork, chicken, turkey or other animal meat.....
Soy milk or other soy food Wheat, gluten, or wheat starch.....
Eggs or egg products..... Other grain or cereal (like oats, barley)
Peanuts, peanut butter, or peanut oil..... Fruit or fruit juice.....
Nuts (like almonds, pecans, walnuts)..... Vegetables.....
Sesame seed or sesame seed oil..... Artificial colors or flavors.....
Fish (like salmon, codfish, tuna)..... Sulfites.....
Crustacean shellfish (like shrimp, crab, lobster)..... None of these.....

33. Have you stopped taking your 6-year-old to restaurants, social gatherings, or parties for fear of accidental reactions to food?
Yes, always..... Yes, sometimes..... No.....

SECTION C

1. In a typical week, how many days do you or another adult in your household do any physical activities with your 6-year-old, including things like active games, sports, walks, biking, ice skating, swimming, or other physical activities? Please include only activities where both the adult and your 6-year-old are active.
0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

2. In a typical week, how many days is your 6-year-old physically active for a total of at least 60 minutes per day? Add up all the time your 6-year-old spends in any kind of physical activity that makes him or her sweat or breathe hard (for example, playing tag, running, biking, jumping rope, swimming). If your child is active during recess, please include recess time.
0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

3. Compared with other children of the same age and sex, is your 6-year-old:
A lot more physically active than most..... A little less physically active than most.....
A little more physically active than most... A lot less physically active than most.....
Average – same as most..... Don't know or not sure.....

4. On average, about how many hours per day does your 6-year-old play video games and watch TV programs or videos? (Do NOT COUNT SCHOOL OR HOMEWORK TIME)
Weekdays: _____ hours PER DAY -AND- _____ minutes PER DAY -OR- None
Weekends: _____ hours PER DAY -AND- _____ minutes PER DAY -OR- None

5. Over the past month, how many hours did your 6-year-old usually sleep each night on weekdays? _____ hours

6. Over the past month, how often has it been difficult to wake up your 6-year-old in the mornings on week days?
Less than once a week..... 1-2 times per week..... 3-5 times per week.....

	LESS THAN ONCE A WEEK	1-2 TIMES PER WEEK	3-5 TIMES PER WEEK	6-7 TIMES PER WEEK
7. Over the past month, how often has your 6-year-old slept about the same number of hours each night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Over the past month, how often has your 6-year old had trouble falling asleep after going to bed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Over the past month, how often has your 6-year-old woken up during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D

1. Do you own a pet or does your 6-year-old regularly spend time indoors where a pet lives (such as at day care or in the school classroom)? **(Please "X" ALL THAT APPLY)**

- No..... Yes, one or more hamsters, gerbils, or similar pets.....
 Yes, one or more dogs..... Yes, one or more birds
 Yes, one or more cats..... Yes, other pet.....

2. In the last 12 months, how often have the following products been used in your home?

	NOT AT ALL	LESS THAN ONCE A MONTH	1-3 TIMES A MONTH	ABOUT ONCE A WEEK	A FEW TIMES A WEEK	EVERY DAY
Air fresheners including spray, stick, aerosol, or plug-in.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scented candles (burned) or scented oil (burned).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pesticides (ant or flying insect killer, flea control, other).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. How many times a day does your 6-year-old usually eat? Please count all meals and snacks. ____ times a day

4. How many days a week does your 6-year-old usually eat breakfast? **(PLEASE "X" ONLY ONE BOX)**

- 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

5. How many days a week does your 6-year-old usually eat dinner at home with you or another adult in your household?

- 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

6. How many days a week does your 6-year-old usually eat dinner from a fast food restaurant like McDonald's, Taco Bell, Pizza Hut, etc., including take-out?

- 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

7. During the school week, how many days a week does your 6-year-old usually eat lunch at school from each of the following places?

- Food brought from home ____ days a week
 A complete school lunch from the school cafeteria ____ days a week
 Individual items from the school cafeteria ____ days a week
 Salad bar in the school cafeteria ____ days a week
 Fast food from the school cafeteria (such as McDonalds, Taco Bell, or KFC) ____ days a week
 Food from a school vending machine, school canteen, or school store ____ days a week
 Does not eat lunch at school

8. During the past month, what type of fat did you most often use to cook with at home? **(PLEASE "X" ONLY ONE BOX)**

- Butter..... Vegetable shortening.....
 Margarine..... Lard or other animal fat
 Vegetable oil (corn, canola, olive, etc.)..... Didn't use fat in cooking

9. During the past month, what kind of milk did your 6-year-old usually drink? **(PLEASE "X" ONLY ONE BOX)**

- | | | | |
|---|--|--|--|
| PLAIN COW'S MILK: | | OTHER MILK: | |
| Whole or regular milk..... <input type="checkbox"/> | | Sweetened cow's milk
(chocolate, vanilla, fruit flavored, etc.)..... <input type="checkbox"/> | |
| 2% fat or reduced-fat..... <input type="checkbox"/> | | Soy milk..... <input type="checkbox"/> | |
| 1%, ½%, or low-fat..... <input type="checkbox"/> | | Other kind of milk..... <input type="checkbox"/> | |
| Fat-free, skim, or nonfat..... <input type="checkbox"/> | | Didn't drink milk..... <input type="checkbox"/> | |

10. During the past month, what type of rice did your 6-year-old eat? **(PLEASE "X" ONLY ONE BOX)**

- Only white rice..... Mostly brown rice.....
 Only brown rice..... About half and half.....
 Mostly white rice..... Didn't eat rice.....

11. During the past month, what type of pasta did your 6-year-old eat? **(PLEASE "X" ONLY ONE BOX)**

- Only white pasta..... Mostly whole wheat pasta.....
 Only whole wheat pasta..... About half and half.....
 Mostly white pasta..... Didn't eat pasta.....

12. During the past month, what type of bread did your 6-year-old eat? **(PLEASE "X" ONLY ONE BOX)**

- Only white bread..... Mostly whole wheat bread.....
 Only whole wheat bread..... About half and half.....
 Mostly white bread..... Didn't eat bread.....

SECTION E

1. As best you know, which of the following health conditions do you yourself or your 6-year-old's other relatives have? **(PLEASE "X" ALL THAT APPLY)**

	YOUR 6-YEAR-OLD'S RELATIVES				NONE OF THESE RELATIVES
	YOU, MOTHER	FATHER	BROTHER OR SISTER	GRANDPARENT, AUNT OR UNCLE	
a. Type 1 diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Adult onset diabetes (Type II).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Eczema or any kind of skin allergy (like contact dermatitis).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Food allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Hay fever or respiratory allergy (to pets, pollens, mold, dust mites, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Overweight or obesity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, ADD, or ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Bipolar disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Depression other than bipolar disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Anxiety disorder such as generalized anxiety disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Breast cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How much do you weigh? _____ pounds

3. How tall are you? _____ feet _____ inches

4. What is your age? _____ years

5. On average, how many cigarettes do you currently smoke per day? **(WRITE IN 0 IF YOU DO NOT SMOKE)**
 _____ cigarettes per day

6. How many people not including yourself smoke inside your home most days? **(INCLUDE FAMILY MEMBERS, FRIENDS, AND ANYONE ELSE)**
 0..... 1..... 2..... 3..... 4 or more.....

The next questions are about physical activities (exercises, sports, physically active hobbies) that you may do in your LEISURE time.

7. In a usual week, how many days per week do you do VIGOROUS leisure-time physical activities for AT LEAST 10 MINUTES that cause HEAVY sweating or LARGE increases in breathing or heart rate?

0..... 1..... 2..... 3..... 4..... 5..... 6..... 7.....

8. About how long do you do these vigorous leisure-time physical activities each day? Minutes per day: _____

9. In a usual week, how many days per week do you do MODERATE leisure-time physical activities for AT LEAST 10 MINUTES that cause ONLY MEDIUM sweating or a MODERATE increase in breathing or heart rate?

0..... 1..... 2..... 3..... 4..... 5..... 6..... 7.....

10. About how long do you do these moderate leisure-time physical activities each day? Minutes per day: _____

11. For each of the following statements, please "X" the box that best describes how often you felt or behaved this way during the past week.

	RARELY OR NONE OF THE TIME (LESS THAN 1 DAY)	OCCASIONALLY OR A LITTLE OF THE TIME (1-2 DAYS)	SOME OR A MODERATE AMOUNT OF THE TIME (3-4 DAYS)	MOST OR ALL OF THE TIME (5-7 DAYS)
a. I was bothered by things that usually don't bother me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I had trouble keeping my mind on what I was doing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I felt depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I felt that everything I did was an effort.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I felt hopeful about the future.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I felt fearful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My sleep was restless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I was happy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. I felt lonely.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I could not get "going".....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Since the birth of your 6-year-old, have you had any pregnancies that ended in a miscarriage, abortion, or stillbirth?
 If so, how many? _____ **(WRITE IN 0 IF NONE)**

13. Are you pregnant now?
 Yes..... No..... Not sure.....

14. How many children have you given birth to after your 6-year-old? **(DON'T COUNT STILLBIRTHS)**
 _____ children -OR- No other children after my 6-year-old.....

15. Please answer all columns for your 6-year-old and also for each child born to you after your 6-year-old.

EXPLANATORY NOTE: Some mothers pump milk to freeze and then feed to their infant after they have stopped making milk. The third column asks how old the baby was when YOU, the mother, stopped breastfeeding and pumping milk. This may be different from how old the baby was when you stopped feeding him or her breast milk.

Sex participate in WIC?		Date of birth	How old was this child when YOU completely stopped both breastfeeding and pumping milk for him or her?	Did this child ever
Boy..... <input type="checkbox"/>	Girl..... <input type="checkbox"/>	Month___/Day___/20___	___ Weeks -OR- ___ Months Never breastfed..... <input type="checkbox"/> Still breastfeeding..... <input type="checkbox"/>	Yes..... <input type="checkbox"/> No..... <input type="checkbox"/>
Boy..... <input type="checkbox"/>	Girl..... <input type="checkbox"/>	Month___/Day___/20___	___ Weeks -OR- ___ Months Never breastfed..... <input type="checkbox"/> Still breastfeeding..... <input type="checkbox"/>	Yes..... <input type="checkbox"/> No..... <input type="checkbox"/>
Boy..... <input type="checkbox"/>	Girl..... <input type="checkbox"/>	Month___/Day___/20___	___ Weeks -OR- ___ Months Never breastfed..... <input type="checkbox"/> Still breastfeeding..... <input type="checkbox"/>	Yes..... <input type="checkbox"/> No..... <input type="checkbox"/>
Boy..... <input type="checkbox"/>	Girl..... <input type="checkbox"/>	Month___/Day___/20___	___ Weeks -OR- ___ Months Never breastfed..... <input type="checkbox"/> Still breastfeeding..... <input type="checkbox"/>	Yes..... <input type="checkbox"/> No..... <input type="checkbox"/>

16. How old was your 6-year-old when the following happened?

a. He or she stopped drinking from a bottle (include breast milk, formula, juice, water, and anything else)

___Weeks -OR- ___Months Never drank from a bottle.....

b. He or she stopped being fed breast milk, including pumped breast milk

___Weeks -OR- ___Months Never fed breast milk.....

17. When you were pregnant with your 6-year-old, did you have gestational diabetes?

Yes..... No..... Not sure.....

18. Have you worked for pay since your 6-year-old was born?

Yes..... → (Go To QUESTION 20) No.....

19. For which of the following reasons have you not worked for pay since your 6-year-old was born?
(Please X" ALL THAT APPLY)

I wanted to remain at home to raise child/children. . I could not find a suitable job.....
I could not make suitable child care arrangements. Other.....

(IF YOU ANSWERED QUESTION 19, GO TO QUESTION 26)

20. How old was your 6-year-old when you first returned to work or went to work?

___Weeks -OR- ___Months -OR- ___Years

21. Upon returning to work, did you return to a job with the employer you last worked for while pregnant with your 6-year-old?

Yes..... → (Go To QUESTION 23) No.....

22. Why did you not return to your former employer? (PLEASE "X" ALL THAT APPLY)

Employer did not make a job available..... I moved out of the area.....
Employer was no longer in business..... I didn't work while pregnant
I chose not to return to this employer..... Other.....

23. Are you currently working for pay?

Yes..... No..... →(Go To QUESTION 26)

24. During the past month, how many hours per week did you usually work?

1-9 hours per week..... 30-34 hours per week.....
10-19 hours per week..... 35-40 hours per week.....
20-29 hours per week..... More than 40 hours per week.....

25. About how much of your family's income comes from the money you earn from work?

Less than half..... About half..... More than half.....

26. Does your 6-year-old have any type of health insurance, or is your 6-year-old covered by any kind of private or governmental health or hospitalization plan or health maintenance organization (HMO) plan? (PLEASE "X" ALL THAT APPLY)

Yes, private health insurance plan or private HMO.....
Yes, government plan, like Medicaid, State Children's Health Insurance Plan (SCHIP), etc.....
No.....

27. During the past 12 months, did you or anyone in your household receive SNAP (Supplemental Nutrition Assistance Program) or Food Stamp benefits?

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

28. Date you completed this survey: Month_____ / Day_____ / 2012

THANK YOU FOR YOUR HELP