



CHILD HEALTH & DIET SURVEY

OMB # XXXX-XXXX

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

Expiration Date: zz/zz/yyyy

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 | WEEKENDS OR NON-SCHOOL DAYS |
|---|--------------------------|--------------------------|-----------------------------|
| 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..... Home-schooled
 Private..... My 6-year-old does not attend any type of school..... → (GO TO QUESTION 7)

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

Preschool or Junior Kindergarten..... First grade.....
 Kindergarten..... Second grade.....

4. How many days a week is your child 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.....
 Physical therapy.....
 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.....
 Special support because of a chronic health condition
 Other (please specify) _____
 None of these

7. About how many books does your 6-year-old have?

None..... 10 or more books.....
 1 or 2 books..... Don't know.....
 3 to 9 books.....

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

Never..... At least 3 times a week.....
 Several times a year..... Everyday.....
 Several times a month..... Don't know.....
 Once a week.....

9. Does your family encourage your 6 year-old to start and keep doing hobbies?

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

10. 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..... Don't know.....

11. 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.....

12. 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? _____ feet _____ inches

4. What was the date of the height measurement? Month____ / Day____ / Year_____

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____ / Year_____

7. 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"/> |

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

| | | | |
|---------------------|--------------------------|--------------------|--------------------------|
| A lot less..... | <input type="checkbox"/> | A little more..... | <input type="checkbox"/> |
| A little less..... | <input type="checkbox"/> | A lot more..... | <input type="checkbox"/> |
| About the same..... | <input type="checkbox"/> | | |

9. 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 12)

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

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

11. 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.....

12. 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..... | <input type="checkbox"/> | →(GO TO QUESTION 14) | 2 times a day..... | <input type="checkbox"/> |
| A few times a week..... | <input type="checkbox"/> | | 3 or more times a day..... | <input type="checkbox"/> |
| Once a day..... | <input type="checkbox"/> | | | |

13. 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 older child helps my 6-year-old brush his or her teeth.....
- An adult helps my 6-year-old brush his or her teeth.....
- An adult brushes my 6-year-old's teeth.....

14. 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"/> |

15. 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, e.g. 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"/> |

16. 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"/> | Does not go to school..... | <input type="checkbox"/> |

17. 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"/> |

18. 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 21A)

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

20. 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"/> |

21A. 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 (21A), please also answer columns 21B and 21C.

21B. 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)

21C. 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"/> | _____ | <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"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Eczema or any kind of skin allergy (e.g., contact dermatitis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <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"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Drug allergy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <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"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Autism or developmental delay | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Celiac disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

22. Has your 6-year-old ever visited an emergency room or urgent care center because of breathing difficulties?

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

23. In the past 12 months, has your 6-year-old used an inhaler or nebulizer?

Yes..... No..... →(Go To QUESTION 25) Not sure..... →(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"/> |
| Drug allergy..... <input type="checkbox"/> | Cold weather <input type="checkbox"/> |
| Infections..... <input type="checkbox"/> | Humid or hot weather..... <input type="checkbox"/> |
| Inhaled allergens (dust, pet, food, etc) <input type="checkbox"/> | Anger or emotion <input type="checkbox"/> |
| Perfume, scented candles, air freshener, etc..... <input type="checkbox"/> | Other..... <input type="checkbox"/> |
| Tobacco or other smoke..... <input type="checkbox"/> | Don't know or not sure..... <input type="checkbox"/> |

25. Has a doctor or other health professional ever told you that your 6-year-old has asthma?
 Yes..... No..... →(Go To QUESTION 27) Not sure..... → (Go To QUESTION 27)
26. Does your 6-year-old take daily medications either year-round or seasonally to manage his or her asthma?
 Yes, year-round..... Yes, seasonally..... No
27. Has your 6-year-old ever been taken to a doctor because of a possible food allergy?
 Yes..... No..... → (Go To QUESTION 30)
28. If your 6-year-old was tested by a doctor for a food allergy, what method was used?
(PLEASE "X" ALL THAT APPLY)
 Description of symptoms only (no medical testing) .. Food elimination (withdrawal of the specific food
 A skin test..... to see if symptoms disappeared).....
 A blood test..... Food challenge (introduction of a specific food to
 An esophageal or intestinal study..... see if symptoms reappeared).....
29. Has your 6-year-old ever been diagnosed by a doctor as having an allergy to any food?
 Yes..... No.....
30. 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)
31. 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 Other seafood (for example clams, mussels, squid).....
 Soy milk or other soy food Beef, pork, chicken, or other animal meat.....
 Eggs or egg products..... Wheat or gluten.....
 Peanuts, peanut butter, or peanut oil..... Non-gluten grain or cereal (for example, oats, buckwheat) . .
 Almonds, pecans, walnuts, or other tree nuts..... Fruit or fruit juice.....
 Sesame or sesame seed oil..... Artificial colors or flavors.....
 Mustard, sunflower, or other seeds Sulfites.....
 Fish (for example, salmon, codfish, tuna)..... None of these.....
 Crustacean shellfish (for example, shrimp, crab, or lobster) Other (please specify).....
32. How old was your 6-year-old the first time he or she had an allergic or intolerance reaction to any food?
 Less than 1 year ... 3 to 4 years Not sure.....
 1 to 2 years 5 years or older.....
33. Did your 6-year-old have a reaction the first time he or she ate the food?
 Yes..... No..... Not sure.....
34. Did the first reaction to food result in an emergency care visit (urgent care or emergency department)?
 Yes..... No..... Not sure.....
35. Which of the following symptoms has your 6-year-old had because of a reaction to food?
(PLEASE "X" ALL THAT APPLY)
 Congestion or runny nose..... Vomiting or spitting up.....
 Asthma, wheezing, or trouble breathing..... Abdominal pain, gassiness, or diarrhea.
 Irritability or behavior changes..... Constipation
 Swollen eyes or lips..... Unexplained weight loss or gain.....
 Hives, welts, or flushed and itchy skin..... Blood in stool.....
 Eczema or persistent skin rash..... Loss of consciousness or shock.....
 Esophagitis or severe acid reflux..... None of these.....
36. Has your 6-year-old ever been prescribed an Epi-pen or epinephrine autoinjector for management of his or her food allergy?
 Yes..... No.....
37. Have you stopped taking your 6-year-old to restaurants, social gatherings, or parties for fear of accidental reactions?
 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 -AND- _____ minutes -OR- None
 Weekends: _____ hours -AND- _____ minutes -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..... <input type="checkbox"/> | Yes, one or more hamsters, gerbils, or similar pets..... <input type="checkbox"/> |
| Yes, one or more dogs..... <input type="checkbox"/> | Yes, one or more birds <input type="checkbox"/> |
| Yes, one or more cats..... <input type="checkbox"/> | Yes, other pet..... <input type="checkbox"/> |

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. _____

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 _____
- A complete school lunch from the school cafeteria _____
- Individual items from the school cafeteria _____
- Salad bar in the school cafeteria _____
- Fast food from the school cafeteria (such as McDonalds, Taco Bell, or KFC) _____
- Food from a school vending machine, school canteen, or school store _____
- Does not go to 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..... <input type="checkbox"/> | Olive oil..... <input type="checkbox"/> |
| Margarine..... <input type="checkbox"/> | Other vegetable oil..... <input type="checkbox"/> |
| Crisco..... <input type="checkbox"/> | Lard or other animal fat..... <input type="checkbox"/> |
| Corn oil..... <input type="checkbox"/> | Cooking spray (specify type of oil)..... <input type="checkbox"/> |
| Canola oil..... <input type="checkbox"/> | Didn't use fat in cooking..... <input type="checkbox"/> |

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..... <input type="checkbox"/> | Mostly brown rice..... <input type="checkbox"/> |
| Only brown rice..... <input type="checkbox"/> | About half and half..... <input type="checkbox"/> |
| Mostly white rice..... <input type="checkbox"/> | Didn't eat rice..... <input type="checkbox"/> |

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

- | | |
|--|--|
| Only white pasta..... <input type="checkbox"/> | Mostly whole wheat pasta..... <input type="checkbox"/> |
| Only whole wheat pasta..... <input type="checkbox"/> | About half and half..... <input type="checkbox"/> |
| Mostly white pasta..... <input type="checkbox"/> | Didn't eat pasta..... <input type="checkbox"/> |

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

- | | |
|--|--|
| Only white bread..... <input type="checkbox"/> | Mostly whole wheat bread..... <input type="checkbox"/> |
| Only whole wheat bread..... <input type="checkbox"/> | About half and half..... <input type="checkbox"/> |
| Mostly white bread..... <input type="checkbox"/> | Didn't eat bread..... <input type="checkbox"/> |

13. During the past month, how often did your 6-year-old eat or drink each food listed below?

Think about all the meals and snacks your 6-year-old had at home, school, restaurants, play dates, and anywhere else. Please include food eaten on weekdays and over the weekend.

If your 6-year-old ate the food once a day or more, write the number per day in the first column. If your 6-year-old ate the food less than once a day, write the number per week in the second column. If your 6-year-old ate the food less than once a week, write the number per month in the third column. If your 6-year-old did not eat the food at all during the past month, check the box in the fourth column.

(FILL IN ONLY ONE COLUMN FOR EACH ITEM)

| | PER DAY | PER WEEK | PER MONTH | Did NOT EAT |
|--|------------|-------------|--------------|--------------------------|
| a. Hot or cold cereals..... | _____ | _____ | _____ | <input type="checkbox"/> |
| b. Milk: all types to drink or on cereal..... | _____ | _____ | _____ | <input type="checkbox"/> |
| c. Cheese: all types (include cheese as a snack, on a sandwich, and in foods such as lasagna, quesadillas, or casseroles). Do not count cheese on pizza..... | _____ | _____ | _____ | <input type="checkbox"/> |
| d. Ice cream or other frozen dairy desserts, such as frozen yogurt and sherbet. Don't include sugar free kinds..... | _____ | _____ | _____ | <input type="checkbox"/> |
| e. Other dairy products, such as pudding or yogurt. Don't include sugar free or plain kinds..... | _____ | _____ | _____ | <input type="checkbox"/> |
| f. Sugar free frozen dairy desserts or sugar free pudding, plain or sugar free yogurt, or other sugar free dairy products..... | _____ | _____ | _____ | <input type="checkbox"/> |
| g. Regular soda or pop that contains sugar. Don't include diet soda or diet pop..... | _____ | _____ | _____ | <input type="checkbox"/> |
| h. Water: include tap, bottled, and unflavored sparkling water..... | _____ | _____ | _____ | <input type="checkbox"/> |
| i. 100% pure fruit juice or 100% pure vegetable juice..... | _____ | _____ | _____ | <input type="checkbox"/> |
| j. Sweetened drinks: Kool-aid, lemonade, sweet tea, Hi-C, cranberry cocktail, Gatorade, etc. | _____ | _____ | _____ | <input type="checkbox"/> |
| k. Fruits: fresh, frozen, or canned. Don't include juice..... | _____ | _____ | _____ | <input type="checkbox"/> |
| l. Green leafy or lettuce salad, with or without other vegetables..... | _____ | _____ | _____ | <input type="checkbox"/> |
| m. Fried potatoes including French fries, home fries and hash browns... | _____ | _____ | _____ | <input type="checkbox"/> |
| n. Other kinds of potatoes such as baked, boiled, mashed, sweet potatoes and potato salad..... | _____ | _____ | _____ | <input type="checkbox"/> |
| o. Refried beans, baked beans, beans in soup, pork and beans, or any other cooked dried beans. Don't include green beans..... | _____ | _____ | _____ | <input type="checkbox"/> |
| p. Other vegetables: fresh, frozen, or canned (other than lettuce salads, potatoes, or cooked dried beans) | _____ | _____ | _____ | <input type="checkbox"/> |
| q. Rice..... | _____ | _____ | _____ | <input type="checkbox"/> |
| r. Pasta..... | _____ | _____ | _____ | <input type="checkbox"/> |
| s. Pizza: frozen pizza, fast food pizza, homemade pizza, or other pizza..... | _____ | _____ | _____ | <input type="checkbox"/> |
| t. Tomato sauces: Mexican-type salsa made with tomato, with spaghetti or noodles or mixed into foods such as lasagna..... | _____ | _____ | _____ | <input type="checkbox"/> |
| u. Processed meat: bacon, ham, lunch meats, hot dogs, etc..... | _____ | _____ | _____ | <input type="checkbox"/> |
| v. Meat (not processed): chicken, turkey, pork, beef, or lamb..... | _____ | _____ | _____ | <input type="checkbox"/> |
| w. Fish or shellfish..... | _____ | _____ | _____ | <input type="checkbox"/> |
| x. Peanut butter or peanuts..... | _____ | _____ | _____ | <input type="checkbox"/> |
| y. Bread: toast, rolls, bagels, cornbread, tortillas, in sandwiches, pancakes, waffles, etc..... | _____ | _____ | _____ | <input type="checkbox"/> |
| z. Sweet foods: candy, cookies, cake, doughnuts, muffins, pop-tarts, etc. Don't count frozen or sugar free desserts..... | _____ | _____ | _____ | <input type="checkbox"/> |
| aa. Popcorn..... | _____ | _____ | _____ | <input type="checkbox"/> |
| bb. Snacks such as potato chips, corn chips, pretzels, and crackers..... | _____ | _____ | _____ | <input type="checkbox"/> |

14. Please "X" one response for each question which best corresponds to your answer:

| | NEVER | RARELY | SOMETIMES | OFTEN | ALWAYS |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. How often are there fruits or vegetables to snack on in your home, such as apples, raisins, carrots, celery, bananas, or melon? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. How often do you encourage your 6-year-old to eat all of the food on his or her plate? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. How often does your 6-year-old eat all of the food on his or her plate? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

15. Please "X" one response for each question which best corresponds to your answer for your 6-year-old child:

| | DISAGREE | SLIGHTLY DISAGREE | NEITHER DISAGREE NOR AGREE | SLIGHTLY AGREE | AGREE |
|---|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| a. I make sure that my child does not eat too many sweets or junk foods..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If I did not guide or regulate my child's eating, he or she would eat too much of his or her favorite foods..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I am especially careful to make sure my child eats enough..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My child will lose appetite for dinner if he or she has had a snack just before..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My child is always asking for food..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If allowed to, my child would eat too much..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My child looks forward to mealtimes..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

h. My child enjoys a wide variety of foods.....

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 | GRAND-PARENT, 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 (e.g., 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 obese..... | <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. How often do you yourself do vigorous activities for at least 10 minutes that cause heavy sweating or large increases in breathing or heart rate?
 _____ times per day -OR- _____ times per week -OR- _____ times per month -OR- Less than once a month....

6. How much time do you usually spend doing these vigorous activities in one session?
 _____ minutes per session -OR- _____ hours per session -OR- None....
7. How often do you do light or moderate activities for at least 10 minutes that cause only light sweating or slight to moderate increase in breathing or heart rate?
 _____ times per day -OR- _____ times per week -OR- _____ times per month Less than once a month.....
8. How much time do you usually spend doing these light or moderate activities in one session?
 _____ minutes per session -OR- _____ hours per session None.....

9. 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) | SOME OR A LITTLE OF THE TIME (1-2 DAYS) | OCCASIONALLY 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"/> |

10. On average, how many cigarettes do you currently smoke per day? (Write in 0 if you do not smoke)
 _____ cigarettes per day
11. 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.....
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.....
14. How many children have you had after your 6-year-old?
 _____ children No other children after my 6-year-old..... →(Go To QUESTION 16)

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

| Sex | | Date of birth | How old was this child when you completely stopped breastfeeding him or her? | Did this child ever participate in WIC? |
|-----------------------------------|------------------------------------|--------------------|---|--|
| Boy..... <input type="checkbox"/> | Girl..... <input type="checkbox"/> | Month___ / Year___ | Breastfed ___ Weeks -OR- ___ Months Never breastfed..... <input type="checkbox"/> Still breastfed..... <input type="checkbox"/> | Yes..... <input type="checkbox"/> No..... <input type="checkbox"/> |
| Boy..... <input type="checkbox"/> | Girl..... <input type="checkbox"/> | Month___ / Year___ | Breastfed ___ Weeks -OR- ___ Months Never breastfed..... <input type="checkbox"/> Still breastfed..... <input type="checkbox"/> | Yes..... <input type="checkbox"/> No..... <input type="checkbox"/> |
| Boy..... <input type="checkbox"/> | Girl..... <input type="checkbox"/> | Month___ / Year___ | Breastfed ___ Weeks -OR- ___ Months Never breastfed..... <input type="checkbox"/> Still breastfed..... <input type="checkbox"/> | Yes..... <input type="checkbox"/> No..... <input type="checkbox"/> |

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

- a. I stopped breastfeeding and pumping milk for him or her
___Weeks -OR- ___Months Never breastfed or pumped milk.....
- b. He or she stopped being fed breast milk, including pumped breast milk
___Weeks -OR- ___Months Never fed breast milk.....
- c. 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.....

17. When you were pregnant with your 6-year-old, did you have gestational diabetes?
Yes..... No..... Not sure.....

18. Have you worked at a paid job or a business since your 6-year-old was born?
Yes..... → (Go To QUESTION 20) No.....

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

- I wanted to remain at home to raise child/children..
- I had medical complications related to pregnancy.....
- I could not make suitable child care arrangements.
- Other.....
- I could not find a suitable job.....

(If You Answered Question 19, Go To Question 23)

20. How old was your 6-year-old when you first returned 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?

- Employer did not make a job available.....
- I moved out of the area.....
- Employer was no longer in business.....
- Other.....
- I chose not to return to this employer.....

23. Are you currently working for pay?
Yes..... No..... →(Go To QUESTION 26)

24. During the past month, on average how many hours a week were you working?

- 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 plans or health maintenance organization (HMO) plans?

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

27. During the last 12 months, did you or anyone in your household receive SNAP (Supplemental Nutrition Assistance Program) or Food Stamp benefits?
Yes..... No.....

THANK YOU FOR YOUR HELP