Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

IFPS-3: MONTH 6

The information you are being asked to provide is authorized to be collected under Section 301 of The Public Health Service Act (42 USC 241). Providing this information is voluntary. CDC will use this information in its study, *Feeding My Baby and Me (also known as the Infant Feeding Practices Study III)*, in order to learn more about the choices mothers make in feeding their babies and toddlers in the first 2 years of life. This information will support efforts to improve the health of our nation's children. This information will be shared with a contractor, Westat, with which CDC has entered into an agreement to assist with carrying out this study.

Public reporting burden of this collection of information varies from ***2 to 24 minutes*** with an average of ***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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-***xxxx***)

DEMOGRAPHICS

A9. Are you currently {CHILD'S NAME}'s caregiver?

- Yes (GO TO A29)
- No

A10. Does {CHILD'S NAME} currently live with you?

- Yes
- No

[IF A9 AND A10 = NO, END SURVEY, MAY BE ELIGIBLE FOR FUTURE SURVEYS. SHOW SURVEY INELIGIBILITY SCREEN AND THEN END SURVEY.]

[START SURVEY INELIGIBILITY SCREEN]

We're sorry, you are not eligible to complete this survey if you are not currently the study child's caregiver and the child doesn't live with you. We will check back with you to see if you are eligible for study surveys in the future. Thank you.

[END SURVEY INELIGIBILITY SCREEN]

A29. Have you moved out of the United States?

- Yes
- No

FEEDING

Foods Your Baby Eats

[PROGRAMMER: LIST EACH REPETITION OF INSTRUCTIONS AND THE GRID THAT FOLLOWS THOSE INSTRUCTIONS ON A SEPARATE PAGE]

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Breast milk and infant formula	Feedings per day	Feedings per week
Breast milk at your breast		
Breast milk in a bottle/cup		
Infant formula		

[IF INFANT FORMULA >0] In the past week, about how many ounces of infant formula did your baby drink at each feeding?

- 1 to 2
- 3 to 4

- 5 to 6
- 7 to 8
- More than 8

In the past 7 days, how often was {CHILD'S NAME} fed each beverage listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the beverage once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the beverage less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the beverage at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Beverages	Feedings per day	Feedings per week
Water: include tap, bottled, or unflavored sparkling water		
100% pure fruit juice or 100% pure vegetable juice		
Regular soda or pop that contains sugar. Don't include diet soda or diet pop		
Sweetened fruit drinks such as Kool-Aid, lemonade, sweet tea, Hi-C, cranberry cocktail, Gatorade, or flavored milk (e.g., chocolate, strawberry, vanilla)		
Unsweetened cow's milk (includes milk added to foods such as cereals)		
Unsweetened other milk such as soy milk, rice milk, or goat milk.		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Grains	Feedings per day	Feedings per week
Baby cereal		
Infant snacks (includes baby puffs, melts, or teething biscuits)		
Hot or cold cereal (do not include baby cereal)		
Rice, pasta, breads (includes, rice, pasta, toast, rolls, bagels, cornbread, tortillas, bread in sandwiches, pancakes, waffles, crackers, etc.)		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Meats and Other Protein Foods	Feedings per day	Feedings per week
Meat (not processed): chicken, turkey, pork, beef, or lamb		
Processed meat: baby food meats, combination dinners, bacon, ham, lunch meats, hot dogs, etc.		
Fish or shellfish		
Eggs		
Beans: Refried beans, black beans,		

white beans, baked beans, beans in soup, pork and beans, or any other cooked dried beans. Don't include green beans.		
Peanut butter, other peanut foods, or nuts		
Soy foods: tofu, frozen soy desserts, etc.		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Fruits and Vegetables	Feedings per day	Feedings per week
Fruits: fresh, frozen, or canned, pureed baby food, or in squeezable pouches. Don't include juice.		
Potatoes: baked, boiled, or mashed potatoes, or sweet potatoes		
Fried potatoes including French fries, home fries, or hash browns		
Green leafy vegetables: spinach, kale, collards, lettuce, or other green leafy vegetables		
Other vegetables: fresh, frozen, or canned, or in squeezable pouches (other than green leafy or lettuce salads, potatoes, or cooked dried beans)		
Tomato sauces: Mexican-type salsa with tomato, spaghetti noodles with tomato sauce, or mixed into foods such as lasagna (do not include tomato sauce on pizza)		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Dairy	Feedings per day	Feedings per week
Cheese: all types (include cheese as a snack, on a sandwich, or in foods such as lasagna, quesadillas, or casseroles). Do not count cheese on pizza		
Other dairy products, such as pudding or yogurt. Don't include sugar free or plain kinds		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Sweets and Desserts	Feedings per day	Feedings per week
Ice cream or other frozen dairy desserts, such as frozen yogurt and sherbet. Don't include sugar free kinds		
Sugar free frozen dairy desserts or sugar free pudding, plain or sugar free		

yogurt, or other sugar free dairy products		
Sweet foods: candy, cookies, cake, doughnuts, muffins, pop-tarts, etc. Don't count frozen or sugar free desserts		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Snacks and Other Foods	Feedings per day	Feedings per week
Pizza: frozen pizza, fast food pizza, homemade pizza, or other pizza		
Snacks such as potato chips, corn chips, pretzels, or popcorn		

C13. [ASK ONLY IF BREAST MILK FROM BREAST AND BREAST MILK FROM BOTTLE/CUP ENDORSED IN FFQ] Babies might drink breast milk from the breast, a bottle, or a cup. Which of the following best describes how {CHILD'S NAME} was drinking breast milk in the past week.

- Mostly at the breast but some breast milk from a bottle or cup
- About half at the breast and half from a bottle or cup
- Some at the breast but most from a bottle or cup

Feeding Breast Milk

These next questions are about feeding your baby breast milk.

E5. [ASK IF E4 FROM PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Has {CHILD'S NAME} stopped directly feeding at your breast?

- Yes
- No (GO TO E10)

E6. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped feeding directly from your breast? Do not answer about pumped or expressed milk. You will be asked about that later. (Day 0 is the day your baby was born)

My baby completely stopped feeding at my breast at ___ days OR ___ weeks OR ___ months

E8. What were the two most important reasons for your decision to stop feeding your baby directly at your breast?

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]

	Most important reason	Second most important reason
I wanted or needed someone else to feed my baby		
Breast milk alone did not satisfy my baby		
I wanted my body back to myself		
I was sick or had to take medicine		
I could not breastfeed while working or going to school		
My baby lost interest in nursing or began to wean himself or herself		
I was pregnant		
Other reason		

These next questions are about pumped and expressed breast milk.

[PROGRAMMER: DISPLAY E10 AND E15 ON THE SAME SCREEN]

E10. [DO NOT DISPLAY IF ANSWERED WITH DATE IN PREVIOUS SURVEY] How old was {FILL: HE/SHE} when you first pumped your breast milk? (Day 0 is the day your baby was born)

I first pumped my breast milk at___ days OR ___ weeks OR ___ months

OR

- I have never pumped my breast milk

E15. [DO NOT DISPLAY IF ANSWERED WITH DATE IN PREVIOUS SURVEY] How old was {FILL: HE/SHE} when you first fed your baby pumped or hand-expressed breast milk? (Day 0 is the day your baby was born)

I first gave my baby pumped or hand-expressed breast milk at___ days OR ___ weeks OR ___ months

OR

- I have never given my baby pumped or hand-expressed breast milk

[IF E10 = NEVER PUMPED, SKIP TO E16]

C19. Are you currently pumping breast milk on a regular schedule?

- Yes
- No

C20. In the past week, how many times did you pump breast milk?

__ Times in past week

E11. [ASK IF E10 FROM PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped pumping or hand-expressing breast milk?

- Yes
- No (GO TO E16)

E12. How old was {CHILD'S NAME} when you completely stopped pumping or hand-expressing breast milk? (Day 0 is the day your baby was born). Do not answer about feeding your baby your pumped breast milk. You will be asked about that later.

I completely stopped pumping or hand-expressing my breast milk at___ days OR ___ weeks OR ___ months

E13. What were the two most important reasons for your decision to stop pumping or hand-expressing breast milk?

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]

	Most important reason	Second most important reason
Pumping milk no longer seemed worth the effort it required		
Too many challenges related to pumping at work or school		
Pumping supplies cost too much		
I was not getting enough pumped milk		
I had enough milk stored to reach my breastfeeding goal		
I was pregnant		
I was sick or had to take medicine		
Other reason		

E16. [ASK IF E15 FROM CURRENT OR PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped feeding your baby pumped or expressed breast milk?

- Yes
- No (GO TO E22)

[IF E16 = VALID SKIP, GO TO E19]

E17. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped being fed any pumped or expressed breast milk? Do not answer about feeding directly at your breast. (Day 0 is the day your baby was born)

My baby completely stopped being fed pumped or expressed breast milk at___ days OR ___ weeks OR ___ months

E19. [IF E4 OR E15 HAVE DATE IN ANY SURVEY AND E5 ≠ NO AND E16 ≠ NO, ASK E19. ONCE ANSWERED, DO NOT ASK AGAIN IN FUTURE SURVEYS] Did you feed your baby breast milk (at the breast or pumped/expressed milk) as long as you wanted?

- Yes
- No

Feeding Formula

The next two questions are about feeding your baby infant formula.

E22. [DO NOT ASK IF E22 = YES IN A PREVIOUS SURVEY; IF FORMULA ENDORSED IN FFQ CODE YES AND CONTINUE TO E23] Did you ever feed {CHILD'S NAME} infant formula?

- Yes
- No (GO TO C26)

E23. [DO NOT DISPLAY IF ANSWERED WITH DATE IN PREVIOUS SURVEY] How old was {FILL: HE/SHE} when {FILL: HE/SHE} was first fed infant formula? (Day 0 is the day your baby was born)

My baby was first fed infant formula at___ days OR ___ weeks OR ___ months

Solid Foods

These next questions are about introducing solid foods to your baby.

C26. [ONCE ANSWERED WITH ANYTHING OTHER THAN "I HAVE NOT YET FED MY BABY SOLID FOODS," DO NOT ASK AGAIN] How old was {CHILD'S NAME} when {FILL: HE/SHE} was first fed solid foods? Please include any foods such as infant cereal, fruit, vegetables, meat or other foods, even if it was just a small amount fed from a spoon, a bottle or your hands. The first solid food means the first time your baby had any food other than breast milk or infant formula.

_____ Months **[HAVE A DROP DOWN OPTION FOR LESS THAN ONE MONTH ALL OTHER RESPONSES ARE WRITE-IN]**

[NOTE TO PROGRAMMER – DO NOT ALLOW FOR OPTIONS THAT ARE OLDER THAN CHILD'S AGE AT TIME OF SURVEY]

- I have not yet fed my baby solid foods (GO TO C36)

C27. [ONCE ANSWERED, DO NOT ASK AGAIN] What was the first solid food you fed {CHILD'S NAME}? The first solid food means the first time your baby had any food other than breast milk or infant formula. This can also include anything added to the bottle.

- Infant rice cereal
- Infant cereal (not rice)
- Fruits
- Vegetables
- Meats
- Other food
- I fed my baby several different foods mixed together

C29. In the past week, how often did you give {CHILD'S NAME} infant rice cereal?

- Never
- Rarely (once a week)
- Sometimes (2 to 3 times a week)
- Most of the time (4 or 5 times a week)
- Always (every day)

C30. How old was {CHILD'S NAME} when {FILL: HE/SHE} was first fed …

Answer for each food listed. Please include any amount of food given - even if it was just a small amount fed from a spoon, a bottle or your hands.

Cow's milk, or other dairy products made with cow's milk	NEXT TO EACH ROW: **[HAVE A DROP DOWN OPTION FOR LESS THAN ONE MONTH ALL OTHER RESPONSES ARE MONTH WRITE-IN]** ____ MONTH My baby has not eaten this food yet
Soy milk or other soy food (including infant formula made with soy)	
Eggs	
Peanuts, peanut butter, or peanut butter puffs such as Bamba snacks	
Tree nuts (such as almonds, pecans, walnuts)	
Sesame seed or tahini	
Fish	
Shellfish	
Wheat (such as bread, crackers, noodles)	

MILK SHARING

Milk sharing refers to getting breast milk for your baby from another lactating woman, or providing your own breast milk to another baby besides your own son or daughter. Breast milk obtained from another lactating woman is often referred to as "donor milk"

C36. Was {CHILD'S NAME} ever fed breast milk <u>other than your own</u>, even one time? Do not include any time in the hospital following their birth.

- Yes
- No (GO TO H26a)
- Unsure (GO TO H26a)

C38. How often has {CHILD'S NAME} been fed breast milk other than your own? Do not include any time in the hospital following the birth of your baby.

- Only one time
- Several times
- My baby is (or was) regularly given another mother's breast milk

C39. When {CHILD'S NAME} was receiving breast milk other than your own, about how much of another mother's breast milk was your baby drinking?

- All of their breast milk came from another mother's breast milk
- About half of their breast milk came from another mother's breast milk
- Less than half of their breast milk came from another mother's breast milk

C40. After {CHILD'S NAME} came home from the hospital following their birth, was [CHILD'S NAME] ever fed breast milk from any of the following sources?

	Yes	No
A milk bank		
A relative		
A friend or other person you knew		
Someone you don't know personally but who is connected to you through a trusted friend or family member		
Somebody you don't know personal but who you connected with online (e.g., a parenting- or breastfeeding-related website or social media group).		

D25. Are any of the following reasons that you received breast milk from someone else?

	Yes	No
I did not produce enough breast milk		
I was on medications that prevented me from breastfeeding safely		
I had an infection I did not want to pass on to my baby		
I did not want to use formula		
I wanted my baby to get the benefits of breast milk but did not want to breastfeed or pump		

HEALTH AND LIFESTYLE

H26a. How much did {CHILD'S NAME} weigh the last time {FILL: HE/SHE} was weighed at a doctor's visit?

_____ pounds _____ ounces

H26b. What was the month, day, and year of those measurements?

_____ month _____ day_____ year

H26c. How long was {CHILD'S NAME} the last time {FILL: HE/SHE} was measured at a doctor's visit?

_____ inches

H26d. What was the month, day, and year of those measurements?

_____ month _____ day _____ year

H30. Currently, would you describe {CHILD'S NAME} as overweight, normal weight or thin?

- Overweight
- Normal weight
- Thin

H25. In the past three months, did {CHILD'S NAME} take any antibiotics?

- Yes
- No
- Don't know

H23. Which of the following problems did your baby have during the past month? (Check Yes/No for each item)

	Yes	No
Fever		
Diarrhea or vomiting		
Ear infection		
Severe respiratory infection (e.g., pneumonia, bronchiolitis)		

Wheeze		
Eczema (atopic dermatitis)		
COVID-19		

H6. What kind of birth control are you or your spouse/partner using now?

Select all that apply.

- Hormonal IUD (Mirena®, Skyla®, Kyleena®, Liletta®)
- Implant (Nexplanon®)
- Shot (Depo-Provera®)
- Progestin-only pill (e.g. mini-pill)
- Combined contraception (e.g. combined pill, patch [OrthoEvra®] or vaginal ring [NuvaRing®])
- Non hormonal method (for example permanent sterilization [e.g., tubes tied, Essure®, vasectomy], copper [non-hormonal] IUD, condoms, not having sex at certain times [rhythm method or natural family planning], withdrawal [pulling out], diaphragm, cervical cap, sponge, not having sex, no method, not applicable [e.g. hysterectomy, same-sex partner])

H10. What is your weight now?

_____ Pounds

H20. Are you currently pregnant?

- Yes
- No

[PROGRAMMER: DISPLAY CONTACT INFORMATION SECTION]