IFPS-3: MONTH 21

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 Child 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 child and include snack and night time feedings.

Fill in only one column for each item.

- o   If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- o   If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- o   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
Toddler milk (includes follow up formulas or toddler formulas)		

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

Fill in only one column for each item.

- o   If **{CHILD'S NAME}** was fed the beverage once a day or more, enter the number of feedings per day in the first column.

o   If **{CHILD'S NAME}** was fed the beverage less than once a day, enter the number of feedings per week in the second column.

o   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.

o   If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.

o   If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.

o   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
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.

- o If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- o If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- o 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.

o   If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.

o   If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.

o   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.

o   If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.

o   If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.

o   If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

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.

- o If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- o If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- o 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.

- o If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- o If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- o 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		

Feeding 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 E11)

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 child was born)

My child 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 child 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 child		
Breast milk alone did not satisfy my child		
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 child lost interest in nursing or began to wean himself or herself		
I was pregnant		
Other reason		

E11. **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 child was born). Do not answer about feeding your child 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?

	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. **Have you stopped feeding your child pumped or expressed breast milk?**

- Yes
- No (GO TO E24)

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 child was born)

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

E19. **Did you feed your child breast milk (at the breast or pumped/expressed milk) as long as you wanted?**

- Yes
- No

Feeding Formula

E24. **Has {CHILD'S NAME} stopped being fed infant formula?**

- Yes
- No (GO to E27)

E25. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped being fed infant formula? (Day 0 is the day your child was born)

My child completely stopped feeding infant formula at ___ days OR ___ weeks OR ___ months

E26. What were the two most important reasons for your decision to stop feeding {CHILD'S NAME} infant formula?

	Most important reason	Second most important

		reason
My child started drinking other milk(s) (such as cow's milk, soy milk, rice milk, or goat's milk)		
My child started drinking other drinks (such as water, juice, sweetened fruit drinks, or soda or pop)		
I fed my child my breast milk		
I fed my child breast milk from someone else		
My doctor told me to stop		
I thought it was time to be done		
Other reason		

<u>Feeding Milestones</u>

[IF E5 ≠ NO AND E16 = YES IN THE CURRENT SURVEY, GO TO E28]
[IF E5 = YES AND E16 ≠ NO IN THE CURRENT SURVEY, GO TO E28]

E27. How old was {CHILD'S NAME} when {FILL: HE/SHE} completely stopped breastfeeding or being fed breastmilk?

{CHILD'S NAME} completely stopped breastfeeding or being fed breast milk at

___ days OR ___ weeks OR ___ months

OR

- I never fed {CHILD'S NAME} breast milk
- I am still breastfeeding or feeding {CHILD'S NAME} breast milk
- Don't know

E28. How old was {CHILD'S NAME} when {FILL: HE/SHE} was first fed formula?

{CHILD'S NAME} was first fed formula at

___ days OR ___ weeks OR ___ months

OR

- I never fed {CHILD'S NAME} formula
- Don't know

E29. How old was {CHILD'S NAME} when {FILL: HE/SHE} was first fed anything other than breast milk or formula? Please include juice, cow's milk, sugar water, baby food, or anything else that {CHILD'S NAME} might have been given, even water.

{CHILD'S NAME} was first fed anything other than breast milk or formula at

___ days OR ___ weeks OR ___ months

OR

- Don't know

Solid Foods

C33. In the past week, how many times did you add salt to {CHILD'S NAME}'s food?

- More than one time per day
- One time per day
- A couple times in the past week
- Once in the past week
- Never in the past week
- Not applicable, I do not add salt to my child's food

C57a. Have you ever fed {CHILD'S NAME} food in a store bought or prepared at home squeezable pouch? This includes screw-top pouches and items like yogurt in a pouch.

- Yes
- No (GO TO C58)
- Not sure (GO TO C58)

C57b. In the past week, how often has {CHILD'S NAME} eaten food from a squeezable pouch?

- More than once a day
- Once a day
- A couple times in the past week
- Once in the past week
- Has not had a squeezable pouch in the past week

C58. What kind of snacks do you usually give {CHILD'S NAME}?

Select all that apply

- Fresh fruit or vegetables, or dried fruit
- Dried cereal, including snack puffs
- Packaged crackers, chips, or bars
- Candy, cookies, or other sweets (e.g., fruit gummies)

- String cheese, cheese chunks, or other cheese products
- Other snacks

C62. In the past week, how often did {CHILD'S NAME} eat the same dinner (or the main meal of the day) as the rest of the family?

- Every day
- 5-6 days
- 3-4 days
- 1-2 days
- No days

C63. In the past week, how many times did {CHILD'S NAME} eat food from a restaurant (includes delivery or carry-out)? Include food eaten in any type of restaurant, such as a fast food, cafeteria, or table service restaurant.

- None, my child did not eat any food from a restaurant
- 1 time
- 2 to 3 times
- 4 to 5 times
- 6 to 7 times
- 8 or more time

C64. In the past week, how many times did all or most of your family sit down for a meal together?

_____ Times

- Never

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 and year of those measurements?

_____ month _____ day

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 and year of those measurements?

_____ month _____ day

H24. Which of the following problems did {CHILD'S NAME} have during the past month?

	Yes	No
Fever		
Diarrhea or vomiting		
Ear infection		
Severe respiratory infection (e.g., pneumonia, bronchiolitis)		
Wheeze		
Eczema (atopic dermatitis)		
COVID-19		

H38. When {CHILD'S NAME} eats meals or snacks, how often is an electronic media device (e.g., TV, tablets, smart phone, etc.) on while {FILL: HE/SHE} is eating?

- Most of the time
- Much of the time
- Sometimes
- Occasionally
- Never

H36. On a typical day, how much time does {CHILD'S NAME} spend sleeping over a 24 hour period?

_____ Hours

H40a. On a typical day, how many times do you brush {CHILD'S NAME}'s teeth?

- My child does not have teeth yet (GO TO END – DISPLAY CONTACT SCREEN)
- My child has teeth, but I do not brush them (GO TO H34)
- I brush my child's teeth but not every day
- I brush my child's teeth once a day
- I brush my child's teeth twice a day or more

H40b. Do you use toothpaste when brushing {CHILD'S NAME}'s teeth?

- Yes
- No (GO TO H34)

H40c. Does the toothpaste you use on your child's teeth contain fluoride?

- Yes
- No
- Don't know

H40d. On average, how much toothpaste do you use when brushing your child's teeth?

- A full strip of toothpaste that covers a child-size toothbrush
- A pea-sized amount of toothpaste
- A smear of toothpaste or the size of a grain of rice

H34. How many cavities (teeth with decay) has {CHILD'S NAME} had in {FILL: HIS/HER} lifetime?

- None
- 1
- 2
- 3
- 4
- 5 or more
- Don't know

[PROGRAMMER: DISPLAY CONTACT INFORMATION SECTION]