Feeding My Baby and Me: IFPS-III: MONTH 21

DEMOGRAPHICS

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

- Yes (GO TO A29)
- No

[IF A9 = 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. 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.

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.

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?

	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. [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 child breast milk (at the breast or pumped/expressed milk) as long as you wanted?**

- Yes
- No

Feeding Formula

E24. [ASK IF E23 INCLUDES DATE FROM PREVIOUS SURVEY AND R HAS NOT ALREADY ANSWERED YES] **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?

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

	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		

Feeding Milestones

[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]

CONTACT INFORMATION SCREEN

1-MONTH SURVEY AND ONWARDS:

Thank you very much for completing the survey! Please take a moment to review your information and update as needed.

We can provide you with a link for $X immediately after you complete this survey or mail you a check. Which would you prefer?

Preference for receiving the money for the survey:

O   Check [PROGRAMMER: IF CHECK IS SELECTED BUT THERE IS NO ADDRESS, DISPLAY MESSAGE "Please enter your mailing address below"]

O   Online gift card [PROGRAMMER: IF GIFT CARD IS SELECTED BUT THERE IS NO EMAIL ADDRESS, DISPLAY MESSAGE "Please enter your email address below"]

[PROGRAMMER: PRE-POPULATE ALL CONTACT INFORMATION THAT HAS BEEN PROVIDED ON PREVIOUS SURVEY(S). IF NO INFORMATION HAS BEEN PROVIDED, LEAVE BLANK]

Contact Information

Name*: _____

Cell Phone Number*: _____

Email address*: _____

*Would you **prefer** to receive study information through text or email or both?

      Text   Email   Both Text and Email

*This information is required.

[PROGRAMMER: DISPLAY IF INFORMATION HAS BEEN PRE-POPULATED]

Is this information still correct?

Yes ☐

No ☐ [PROGRAMMER: IF NO, PROVIDE BLANK CONTACT INFORMATION FOR RESPONDENT TO UPDATE]

[PROGRAMMER: MAILING ADDRESS IS ONLY DISPLAYED IF CHECK IS INDICATED ABOVE AND NO MAILING ADDRESS HAS BEEN PROVIDED PREVIOUSLY]

Address 1: _____

Address 2: _____

Zip code: _____

[PROGRAMMER: PRE-POPULATE STATE AND CITY]

Contact Information of someone the study can contact in case we lose touch with you:

Please provide the name and contact information of another person who would always know how to contact you (such as your partner, parent, or friend). We will contact them only if we cannot reach you by email or text. Please let them know they have your permission to share your contact information with the study.

Name: _____

Relationship: Spouse/Partner/Parent/Sibling/Other Relative/Friend

Phone Number: _____

Email address: _____

 [IF CHECK: Please look out for a check from Westat in 5 -7 business days IF VIRTUAL GIFT CARD: Please look out for an email or text with a link to your online gift card]. Your next survey will start [NEXT SURVEY START DATE]. We will send you a reminder on that day. Please make sure to update your

contact information at this website at any time your phone number or email address changes. Thank you for your continued participation in the Feeding My Baby and Me Study.