Form approved

OMB No. 0920-1333

Exp. Date 4/30/2024

Feeding My Baby and Me: IFPS-III: Month 24

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 provide important information to 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 (0920-1333)

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. Thank you for everything you have done to make this study a success. We wish the best to you and to your family.

[END SURVEY INELIGIBILITY SCREEN]

A29. Have you moved out of the United States?

- Yes
- No

A31. WIC is a nutrition and health program for Women, Infants, and Children. WIC benefits include food, checks or vouchers for food, health care referrals, and nutrition education. Since your child was 1 year old, did you ever get WIC food or vouchers for your child?

- Yes, my child got WIC food
- No

A22. Since your child was 1 year old, did you, or your family ever receive:

	Yes	No	Don't know
Supplemental nutrition assistance benefits, sometimes called SNAP or Food Stamps?			
Temporary assistance to needy families, sometimes called TANF or welfare?			
Free or reduced price meals from the National School Lunch or School Breakfast Program, or the Summer Foods Program?			
Are you receiving any food or free meals from another source such as a food bank, church, or community center?			

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.

- 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
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.

- 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
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		

C55. How many times does {CHILD'S NAME} eat (such as breakfast, lunch, dinner, or snacks) on a normal day?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8 or more

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. [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)

[IF E11 = VALID SKIP, SKIP 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?

[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 PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped feeding your child pumped or expressed breast milk?

- Yes
- No (GO TO E24)

[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 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 C51a)

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 your child 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		

[PROGRAMMER: IF C51a AT MONTH 15 = YES, GO TO C95]

C51a. Has {CHILD'S NAME} stopped drinking anything from a bottle?

- Yes
- No, my child is still drinking from a bottle (GO TO C95)

- My child never drank anything from a bottle (GO TO C95)

C51b. How old was {CHILD'S NAME} when {FILL: HE/SHE} stopped using a bottle?

Weeks____ Months _____ Years _____

C95. During the past week, how often was {CHILD'S NAME} put to bed with a bottle, or a sippy cup, with anything other than water?

- At most bedtimes, including naps
- At most night bedtimes, but not naps
- At most naps, but not night bedtimes
- Only occasionally at bedtimes, including naps
- Never

Solid Foods

The next questions are about food you feed your child.

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.
[DO NOT DISPLAY FOODS ENDORSED IN MONTH 6 OR MONTH 12]

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 a Bamba snacks	
Tree nuts (such as, almonds, pecans, walnuts)	
Sesame seed or tahini	
Fish	
Shellfish	
Wheat (such as bread, crackers, noodles)	

These next questions are about the food eaten in your household in the last month, and whether you were able to afford the food you need.

A24a. The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more. Was that often, sometimes, or never true for (you/your household) in the last month?

- Often true;
- Sometime true;
- Never true

A24b. (I/we) couldn't afford to eat balanced meals

- Often true;
- Sometime true
- Never true

A24c. In the last month, did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

- Yes
- No (GO TO A24E)

A24d. How often did this happen?

- Every week
- Some weeks but not every week
- Only 1 or 2 weeks

A24e. In the last month, did you ever eat less than you felt you should because there wasn't enough money for food?

- Yes
- No

A24f. In the last month, were you ever hungry but didn't eat because there wasn't enough money for food?

- Yes
- No

FOOD ALLERGIES

These next questions are about problems with food {CHILD'S NAME} has had, either through breast milk or from eating directly.

F3. [ASK ONLY IF NOT YES IN PREVIOUS MONTHS] Has your child ever had problems caused by food, such as an allergic reaction, sensitivity, or intolerance?

- Yes
- No (GO TO H26a)

F4. [ASK IF F3 = YES] In the table below, please indicate which foods {CHILD'S NAME} had a problem with such as an allergic reaction, sensitivity, or intolerance. Include foods {CHILD'S NAME} reacted to through breast milk as well as foods {FILL: HE/SHE} ate directly.

{CHILD'S NAME} had a problem with...

	Yes	No
Cow's milk or other dairy products (not including infant formula made with cow's milk)		
Infant formula made with cow's milk		
Soy milk or other soy food (including infant formula made with soy)		
Eggs		
Peanuts, peanut butter, or peanut oil		
Tree nuts (such as, almonds, pecans, walnuts)		
Sesame seed, tahini, or sesame seed oil		
Fish		
Shellfish		
Wheat, gluten, or wheat starch		
Other food or ingredient (Please specify)		

F5. [ASK IF YES TO ANY ITEM IN F4] Was {CHILD'S NAME} diagnosed as allergic to [INSERT EACH ITEM IN F4 THAT IS A YES RESPONSE] by a health care provider.

	Yes	No
Cow's milk or other dairy products (not including infant formula made with cow's milk)		
Infant formula made with cow's milk		
Soy milk or other soy food (including infant formula made with soy)		
Eggs		
Peanuts, peanut butter, or peanut oil		
Tree nuts (such as, almonds, pecans, walnuts)		
Sesame seed, tahini, or sesame seed oil		
Fish		
Shellfish		
Wheat, gluten, or wheat starch		
Other food or ingredient (Please specify)		

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

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

- Overweight
- Normal weight
- Thin

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		

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

- Yes
- No
- Don't know

H29. Has {CHILD'S NAME} ever been referred to a developmental specialist or program for developmental concerns or follow up (such as speech therapist, occupational therapist, Early Intervention program)?

- Yes
- No
- Don't know

H10. What is your weight now?

_____ POUNDS

H20. Are you currently pregnant?

- Yes
- No

END SCREEN:

Thank you for everything you have done to make this study a success. We wish the best to you and to your family.