



SECTION A: BABY'S FEEDING AND HEALTH

If your baby is regularly cared for by someone else, it is very important that you ask your child care provider to give you information for the feeding questions.

If you have older children, please think only about your youngest baby when you answer the questions.

Section A-1: Feeding

- 1. In the past 7 days, how often was your baby fed each food listed below? Include feedings by everyone who feeds the baby and include snacks and night-time feedings.

If your baby was fed the food once a day or more, write the number of feedings per day in the first column. If your baby was fed the food less than once a day, write the number of feedings per week in the second column. **Fill in only one column for each item.** If your baby was not fed the food at all during the past 7 days, write in 0 in the second column.

	FEEDINGS PER DAY	FEEDINGS PER WEEK
Breast milk.....	_____	_____
Formula.....	_____	_____
Cow's milk.....	_____	_____
Other milk: soy milk, rice milk, goat milk, etc.....	_____	_____
Other dairy foods: yogurt, cheese, ice cream, pudding, etc.....	_____	_____
Other soy foods: tofu, frozen soy desserts, etc.....	_____	_____
100% fruit or 100% vegetable juice.....	_____	_____
Sweet drinks: juice drinks, soft drinks, soda, sweet tea, Kool-Aid, etc.....	_____	_____
Baby cereal.....	_____	_____
Other cereals and starches: breakfast cereals, teething biscuits, crackers, breads, pasta, rice, etc.....	_____	_____
Fruit.....	_____	_____
Vegetables.....	_____	_____
French fries.....	_____	_____
Meat, chicken, combination dinners.....	_____	_____
Fish or shellfish.....	_____	_____
Peanut butter, other peanut foods, or nuts.....	_____	_____
Eggs.....	_____	_____
Sweet foods: candy, cookies, cake, etc.....	_____	_____
Other (Please specify) _____	_____	_____

- 2. What type of baby cereal was your baby fed in the past 7 days? (PLEASE "X" ALL THAT APPLY)
Baby was not fed baby cereal..... Dry cereal that you added a liquid to..... Cereal in a jar already mixed.....
- 3. Which of the following was your baby given in vitamin or mineral drops or pills at least 3 days a week during the past 2 weeks? If your baby was given drops or pills that contained more than one of the items listed, please mark each of the separate items. (PLEASE "X" ALL THAT APPLY)
Fluoride..... Vitamin D..... None of these.....
Iron..... Other vitamins.....
- 4. Has your baby used a pacifier in the past 7 days? Yes..... No.....
- 5. During the past 2 weeks, how often was your baby put to bed with a bottle of formula, breast milk, juice, juice drink, or any other kind of milk?
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.....
- 6. How often have you added each of the following items to your baby's bottle of formula or pumped (or expressed) breast milk in the past 2 weeks? If you have not given your baby a bottle in the past 2 weeks, "X" here and go to Instruction above Question 7.

	NEVER	ONLY RARELY	EVERY FEW DAYS	ABOUT ONCE A DAY	AT MOST FEEDINGS	EVERY FEEDING
Vitamins or minerals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baby cereal.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweetener.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF YOUR BABY WAS FED FORMULA IN THE PAST 7 DAYS, PLEASE CONTINUE. ALL OTHERS GO TO INSTRUCTION ABOVE QUESTION 13 ON PAGE 2.

- 7. How often does your baby drink all of his or her bottle of formula?
Never..... Rarely..... Sometimes..... Most of the time..... Always.....
- 8. In the past 7 days, about how many ounces of formula did your baby drink at each feeding?
1 to 2..... 3 to 4... 5 to 6..... 7 to 8.... More than 8.....
- 9. How often is your baby encouraged to finish a bottle if he or she stops drinking before the formula is all gone?
Never..... Rarely..... Sometimes..... Most of the time..... Always.....
- 10. Which formula was fed to your baby in the past 7 days? Infant formulas are listed alphabetically on the Formula List insert along with a group number. Please "X" the group number for each infant formula your baby was fed. (PLEASE "X" ALL THAT APPLY)

<u>Group 1</u>	<u>Group 2</u>	<u>Group 3</u>	<u>Group 4</u>	<u>Group 5</u>	<u>Group 6</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. What type of formula was your baby fed? **(PLEASE "X" ALL THAT APPLY)**
- Ready-to-feed..... Powder from a can that makes more than one bottle.....
 Liquid concentrate..... Powder from single serving packs.....

12. Which of the following describes the iron content of the formula you usually use?
- With iron Low iron (additional iron may be necessary)

IF YOUR BABY WAS BREASTFED OR FED BREAST MILK IN THE PAST 7 DAYS, PLEASE CONTINUE. ALL OTHERS GO TO SECTION A-2 ON THIS PAGE.

13. Does your baby usually feed from both breasts at each feeding?
- Yes No Baby is only fed pumped milk →(GO TO QUESTION 16)

14. Does your baby usually let go of the breast him or herself?
- Yes, both breasts..... Yes, first breast only Yes, second breast only No

15. About how long does an average breastfeeding last?
- Less than 10 minutes 20 to 29 minutes 40 to 49 minutes
 10 to 19 minutes 30 to 39 minutes 50 or more minutes

16. In an average 24-hour period, what is the LONGEST time for you, the mother, between breastfeedings or pumping milk? Please count the time from the start of one breastfeeding or pumping session to the start of the next. Please think of time between feedings during both night and day to find the longest time. **(WRITE IN THE NUMBER OF HOURS AND MINUTES)**

_____ HOURS AND _____ MINUTES

17. How many times in the past 7 days was your baby fed pumped breast milk to drink? Include breast milk you expressed in any way as pumped milk. *(Write in 0 if your baby was not fed pumped milk to drink.)*
- _____ TIMES → (IF 0, GO TO SECTION A-2 ON THIS PAGE)

18. How often does your baby drink all of his or her cup or bottle of pumped milk?
- Never Rarely Sometimes Most of the time Always

19. How often is your baby encouraged to finish a cup or bottle if he or she stops drinking before the pumped breast milk is all gone?
- Never Rarely Sometimes Most of the time Always

Section A-2 Health

20. Which of the following problems did your baby have during the past 2 weeks? **(PLEASE "X" ALL THAT APPLY)**

- | | |
|---|---|
| Fever..... <input type="checkbox"/> | Runny nose or cold..... <input type="checkbox"/> |
| Diarrhea..... <input type="checkbox"/> | Respiratory Syncytial Virus (RSV)..... <input type="checkbox"/> |
| Vomiting..... <input type="checkbox"/> | Cough or wheeze <input type="checkbox"/> |
| Ear infection..... <input type="checkbox"/> | Asthma..... <input type="checkbox"/> |
| Colic..... <input type="checkbox"/> | Food allergy <input type="checkbox"/> |
| Fussy or irritable <input type="checkbox"/> | Eczema (atopic dermatitis)..... <input type="checkbox"/> |
| Reflux <input type="checkbox"/> | None of these <input type="checkbox"/> |

21. Did your baby receive any of the following medicines in the past 2 weeks? *(Please do not include vitamins or minerals.)*

	<u>YES</u>	<u>NO</u>
Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Other prescription medicines.....	<input type="checkbox"/>	<input type="checkbox"/>
Non-prescription medicines.....	<input type="checkbox"/>	<input type="checkbox"/>

22. Was your baby given any herbal or botanical preparation or any kind of tea in the past 2 weeks? *(Do not count preparations applied to the baby's skin or anything the baby may have received through breastfeeding after you took an herbal or botanical preparation.)*
- Yes No →(GO TO QUESTION 25)

23. Please list all the kinds of herbal or botanical preparations or teas your baby was given in the past 2 weeks.
- _____

24. Why was your baby given the preparations or teas listed in Question 23? **(PLEASE "X" ALL THAT APPLY)**

- | | |
|--|---|
| To ease diaper rash..... <input type="checkbox"/> | To ease a cold or other respiratory symptoms <input type="checkbox"/> |
| To ease colic <input type="checkbox"/> | To ease an illness other than a cold or respiratory symptoms <input type="checkbox"/> |
| To ease digestion <input type="checkbox"/> | To stimulate the baby's immune system <input type="checkbox"/> |
| To ease fussiness..... <input type="checkbox"/> | Other (SPECIFY) _____ <input type="checkbox"/> |
| To help the baby relax..... <input type="checkbox"/> | |

25. How many stools (dirty diapers) does your baby usually have in a 24-hour period? If less than one a day, how many days usually pass between stools?
- _____ NUMBER OF STOOLS IN 24 HOURS OR ONE STOOL EVERY _____ DAYS

26. How would you describe your baby's stool in the past 7 days? **(PLEASE "X" ALL THAT APPLY)**

- Hard..... Formed..... Soft Semi-watery Watery

27. Has your baby been hospitalized for any reason or has your baby been taken to a hospital for any outpatient procedure or surgery in the past 4 weeks?
- Yes No → (GO TO QUESTION 29)

28. How many nights was your baby in the hospital for the most recent problem? *(Write in 0 if your baby did not stay overnight.)*
- _____ NIGHTS

29. It is not easy being a new mother, and it is OK to feel unhappy at times. As you have recently had a new baby, we would like to know how you are feeling. Please state the answer which comes closest to how you have felt during the past several days, not just how you are feeling today.

- 29a. I have been able to laugh and see the funny side of things:
- As much as I always could ... Not quite so much now Definitely not so much now Not at all

- 29b. I have looked forward with enjoyment to things:
 As much as I ever did Rather less than I used to Definitely less than I used to Hardly at all
- 29c. I have blamed myself unnecessarily when things went wrong:
 Yes, most of the time Yes, some of the time Not very often No, never
- 29d. I have felt worried and anxious for no real reason:
 No, not at all Hardly ever Yes, sometimes Yes, very often
- 29e. I have felt scared or panicky for no real reason:
 Yes, quite a lot Yes, sometimes No, not very much No, not at all
- 29f. Things have been too much for me:
 Yes, most of the time I haven't been able to cope at all No, most of the time I have coped quite well
 Yes, sometimes I haven't been coping as well as usual No, I have been coping as well as ever
- 29g. I have been so unhappy that I have had trouble sleeping:
 Yes, most of the time Yes, sometimes Not very often No, not at all
- 29h. I have felt sad or miserable:
 Yes, most of the time Yes, quite often Not very often No, not at all
- 29i. I have felt so unhappy I have cried:
 Yes, most of the time Yes, quite often Only occasionally No, never
- 29j. I have thought of hurting myself:
 Yes, quite often Sometimes Hardly ever Never

SECTION B: STOPPED BREASTFEEDING

1. Did you ever breastfeed this baby (or feed this baby your pumped milk)?
 Yes →(CONTINUE) No →(GO TO SECTION E ON PAGE 7)
2. Have you completely stopped breastfeeding and pumping milk for your baby?
 Yes →(CONTINUE) No →(GO TO SECTION D ON PAGE 4)
3. Did you breastfeed as long as you wanted to?
 Yes No
4. How old was your baby when you completely stopped breastfeeding and pumping milk?
 _____ DAYS (if younger than 2 weeks) OR _____ WEEKS
5. How important was each of the following reasons for your decision to stop breastfeeding your baby? (PLEASE ANSWER EACH ITEM)
- | | <u>NOT AT ALL
IMPORTANT</u> | <u>NOT VERY
IMPORTANT</u> | <u>SOMEWHAT
IMPORTANT</u> | <u>VERY
IMPORTANT</u> |
|---|---------------------------------|-------------------------------|-------------------------------|---------------------------|
| My baby had trouble sucking or latching on | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby became sick and could not breastfeed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby began to bite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby lost interest in nursing or began to wean him or herself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My baby was old enough that the difference between breast milk and formula no longer mattered | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast milk alone did not satisfy my baby | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I thought that my baby was not gaining enough weight..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A health professional said my baby was not gaining enough weight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I had trouble getting the milk flow to start | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I didn't have enough milk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My nipples were sore, cracked, or bleeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My breasts were overfull or engorged | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My breasts were infected or abscessed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My breasts leaked too much | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding was too painful | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding was too tiring | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I was sick or had to take medicine..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding was too inconvenient..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I did not like breastfeeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wanted to be able to leave my baby for several hours at a time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wanted to go on a weight loss diet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wanted to go back to my usual diet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wanted to smoke again or more than I did while breastfeeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I had too many household duties..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I could not or did not want to pump or breastfeed at work..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pumping milk no longer seemed worth the effort that it required | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I was not present to feed my baby for reasons other than work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wanted or needed someone else to feed my baby | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Someone else wanted to feed the baby | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I did not want to breastfeed in public | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I wanted my body back to myself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I became pregnant or wanted to become pregnant again..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
6. Did any of the following people want you to stop breastfeeding? (Mark "does not apply" if you do not have the person listed, such as "employer" if you do not work for pay.)
- | | <u>YES</u> | <u>NO</u> | <u>DOES NOT APPLY/
DON'T KNOW</u> |
|---|--------------------------|--------------------------|---------------------------------------|
| The baby's father..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your mother..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your mother-in-law | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your grandmother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Another family member | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A doctor or other health professional | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your employer or supervisor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

7. Using 1 to mean "Very unfavorable" and 5 to mean "Very favorable," how do you feel about the experience of having breastfed your baby?

<u>VERY UNFAVORABLE</u>						<u>VERY FAVORABLE</u>	
<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>1</u>	<u>2</u>	<u>3</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Using 1 to mean "Not at all likely" and 5 to mean "Very likely," how likely is it that you would breastfeed again if you had another child?

<u>NOT AT ALL LIKELY</u>						<u>VERY LIKELY</u>	
<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>1</u>	<u>2</u>	<u>3</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: BREASTFEEDING
Section D-1: General Information

1. Did you ever breastfeed this baby (or feed this baby your pumped milk)?

Yes → (CONTINUE) No..... → (GO TO SECTION E ON PAGE 7)

2. Have you obtained information about breastfeeding, your diet while breastfeeding, or breast pumps from any of the following sources for this baby or a previous one?

	<u>INFORMATION ABOUT BREASTFEEDING</u>	<u>INFORMATION ABOUT MY DIET WHILE BREASTFEEDING</u>	<u>INFORMATION ABOUT BREAST PUMPS</u>	<u>NO INFORMATION FROM THIS SOURCE</u>
Doctor or physician assistant.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse, nurse midwife, or nurse practitioner.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritionist or dietician.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WIC food program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactation consultant.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relatives or friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birthing or baby care class.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding support group.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone support helpline or hotline.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Books or videos.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newsletters.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspapers or magazines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Television or radio.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The web site www.4woman.gov	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The web site www.womenshealth.gov	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other web site.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Using 1 to mean "Very Uncomfortable" and 5 to mean "Very Comfortable," how comfortable would you be in the following situations?

	<u>VERY UNCOMFORTABLE</u>				<u>VERY COMFORTABLE</u>
	<u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>
Nursing your baby in the presence of close women friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing your baby in the presence of men and women who are close friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing your baby in the presence of men and women who are not close friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you breastfed your baby or pumped breast milk in the past 7 days?

Yes → (CONTINUE) No..... → (GO TO SECTION D-2 ON PAGE 5)

5. How old do you think your baby will be when you completely stop breastfeeding?

2 months..... <input type="checkbox"/>	5 months..... <input type="checkbox"/>	8 months..... <input type="checkbox"/>	11 months..... <input type="checkbox"/>
3 months..... <input type="checkbox"/>	6 months..... <input type="checkbox"/>	9 months..... <input type="checkbox"/>	12 months..... <input type="checkbox"/>
4 months..... <input type="checkbox"/>	7 months..... <input type="checkbox"/>	10 months..... <input type="checkbox"/>	More than 12 months..... <input type="checkbox"/>

6. Using 1 to mean "Not at all Confident" and 5 to mean "Very Confident," how confident are you that you will be able to breastfeed until the baby is the age you marked in Question 5?

<u>NOT AT ALL CONFIDENT (1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>VERY CONFIDENT (5)</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Since you have been breastfeeding, have you eaten more, less, or about the same of the following foods? If you did not eat the food before you began breastfeeding and you don't eat the food now, please mark "Did Not Eat Before or Now."

	<u>EAT MORE</u>	<u>EAT LESS</u>	<u>EAT ABOUT THE SAME</u>	<u>DID NOT EAT BEFORE OR NOW</u>
Milk or other dairy foods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canned tuna.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swordfish, shark, tile fish, or king mackerel.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other type of fish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shellfish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Luncheon meats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuts, peanuts, or peanut butter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic drinks.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin or mineral supplements.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any herbal or botanical supplement.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. For each food that you are eating less of, please indicate the reason. (PLEASE "X" ALL THAT APPLY) If you are not eating less of any food, go to Question 9.

	<u>THE FOOD IS NOT HEALTHY FOR MY BABY</u>	<u>TO PREVENT FOOD ALLERGY IN MY BABY</u>	<u>RECOMMENDED BY A HEALTH PROFESSIONAL</u>	<u>RECOMMENDED BY A FRIEND OR RELATIVE</u>	<u>OTHER</u>
Milk or other dairy foods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canned tuna.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swordfish, shark, tile fish, or king mackerel.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other type of fish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shellfish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Luncheon meats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuts, peanuts, or peanut butter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic drinks.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin or mineral supplements.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any herbal or botanical supplement.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. For each food that you are eating more of, please indicate the reason. (PLEASE "X" ALL THAT APPLY) If you are not eating more of any food, go to Question 10.

Table with 7 columns: THE FOOD IS HEALTHY FOR ME, IMPROVES THE AMOUNT OR QUALITY OF MY MILK, CRAVED THE FOOD MORE, RECOMMENDED BY A HEALTH PROFESSIONAL, RECOMMENDED BY A FRIEND OR RELATIVE, OTHER. Rows include Milk or other dairy foods, Eggs, Canned tuna, Swordfish, etc.

10. Did you work for pay any time during the past 4 weeks? Yes No (GO TO INSTRUCTION ABOVE QUESTION 12 ON THIS PAGE)

11. Which of the following circumstances describe your situation during the past 4 weeks? (If you have stopped breastfeeding or stopped working for pay, please answer for the time you were breastfeeding and working. If you have worked for less than 4 weeks, please answer for the time you have been working.) (PLEASE "X" ALL THAT APPLY)

- I keep my baby with me while I work and breastfeed during my work day
I go to my baby and breastfeed him or her during my work day
My baby is brought to me to breastfeed during my work day
I pump milk during my work day and save it for my baby to drink later
I pump milk during my work day, but I do not save it for my baby to drink later
I neither pump milk nor breastfeed during my work day

IF YOU ANSWERED SECTION B - STOPPED BREASTFEEDING - ON THIS QUESTIONNAIRE, GO TO SECTION D-2 ON THIS PAGE.

12. Was your baby fed formula to drink in the past 2 weeks, by you or by anyone else? Yes No (GO TO SECTION D-2 ON THIS PAGE)

13. How important was each of the following reasons for feeding your baby formula? (PLEASE ANSWER EACH ITEM)

Table with 5 columns: NOT AT ALL IMPORTANT, NOT VERY IMPORTANT, SOMEWHAT IMPORTANT, VERY IMPORTANT. Rows include My baby had trouble sucking or latching on, My baby became sick and could not breastfeed, My baby lost interest in nursing, etc.

Section D-2: Breast Pumps

14. Since your baby was born, have you ever pumped or tried to pump milk? (Include expressing breast milk in any way as pumping milk.) Yes, but I did not get any milk... Yes, and I got milk ... No..... (GO TO SECTION E ON PAGE 7)

15. How old was your baby the first time you pumped or tried to pump milk? DAYS OR WEEKS

16. How have you pumped or expressed milk since this baby was born? (PLEASE "X" ALL THAT APPLY)

- Electric breast pump
Combination electric and battery operated breast pump
Battery operated pump
Manual breast pump (no batteries, no cord to plug in)
By hand (without using a pump)

IF YOU HAVE USED A BREAST PUMP SINCE THIS BABY WAS BORN, PLEASE CONTINUE. ALL OTHERS GO TO SECTION D-3 ON PAGE 6.

17. How many breast pumps have you used since this baby was born? Count all the pumps you have used even if they are the same type and style. 1..... 2..... 3..... 4 or more.....

18. What type of breast pump do you use most often?

- Electric breast pump
Combination electric and battery operated breast pump
Battery operated pump
Manual breast pump

19. How did you get the breast pump that you use most often?

- I bought it
It was given to me as a gift
I rented it
I got it from WIC
I borrowed it from a friend or relative
I borrowed it from my place of work
I use one provided by a hospital, my place of work, or another place

20. Was the breast pump you use most often new or used when you got it or began using it?

- New
Used
Not sure

21. How did you learn to use the breast pump you use most often? (PLEASE "X" ALL THAT APPLY)

- I read the printed directions that came with the pump.....
I got instructions for the pump from the internet.....
I watched a video about how to use the pump.....
A lactation consultant, WIC staff, nurse, or doctor showed me how to use it.....
A friend, relative, sales clerk, or other person showed me how to use it.....
I figured it out without directions or being shown how.....

22. Using 1 to mean "Very Dissatisfied" and 5 to mean "Very Satisfied," how satisfied are you with the performance of the breast pump that you use most often?

VERY DISSATISFIED 1 2 3 4 5 VERY SATISFIED

23. Have you been hurt by any breast pump that you used or tried to use to express milk since this baby was born?

Yes No ->(GO TO QUESTION 27 ON THIS PAGE)

24. What type of pump hurt you? (PLEASE "X" ALL THAT APPLY)

- Electric breast pump..... Battery operated pump.....
Combination electric and battery operated breast pump..... Manual breast pump.....

25. In what way were you hurt? (PLEASE "X" ALL THAT APPLY)

- Nipple injury from the pump..... Infection from a pump injury..... Other (SPECIFY).....
Sore nipples from the pump..... Pressure bruise.....

26. Did you go to a medical doctor, lactation consultant, or other health professional because of the injury?

Yes No

27. Have you had any of the following problems with a breast pump that you used to express milk since this baby was born?

- Pressure or suction from the pump was hard to release..... YES NO
Pump was uncomfortable or painful to use even though it did not cause injury.....
Pump had a bad seal or milk got into the motor or other place it should not be.....
Could not get pump to work or to express any milk.....
Pump worked, but did not get enough/much milk.....
Pump worked, but it took too long to get enough milk.....
Pump worked for a while but then quit working.....
Pump had another problem (SPECIFY).....

IF YOU HAVE NOT BEEN HURT BY A PUMP AND ANSWERED NO TO ALL PROBLEMS LISTED IN QUESTION 27, GO TO SECTION D-3 ON THIS PAGE.

28. Did you call the pump manufacturer to get help with the problem or to report the injury or problem? Yes ... No.....

29. After you had a problem or injury from using the pump, did you stop breastfeeding?

No, not at all Yes, for a short time..... Yes, I stopped breastfeeding completely.....

30. Did you stop using the pump that injured you or that you had trouble with?

- Yes, I completely stopped using the pump.....
Yes, except I used the pump sometimes for special situations.....
No, I continued to use the pump..... -> (GO TO SECTION D-3 ON THIS PAGE)

31. What did you do about expressing milk after you stopped using the pump?

- I changed to a different type of pump (for example, from manual to battery operated).....
I changed to a different style of pump of the same type (for example, from one brand or style of electric pump to a different electric pump).....
I changed to a new pump that was just like the one that hurt me or that I had trouble with.....
I stopped using a pump to express milk.....
I stopped expressing milk.....

Section D-3: Pumping or Expressing Milk

32. During the past 2 weeks, how many times did you pump milk? (Include expressing breast milk in any way as pumping milk.)

_____ TIMES IN PAST 2 WEEKS ->(If 0, GO TO SECTION E ON PAGE 7)

33. Are you now pumping milk on a regular schedule?

Yes No ->(GO TO QUESTION 35)

34. How old was your baby when you first began pumping milk on a regular schedule?

_____ DAYS OR _____ WEEKS

35. On average, in the past 2 weeks, how many ounces of milk did you pump each time?

- 1 ounce or less..... 3 to 4 ounces..... 7 to 8 ounces.....
2 ounces..... 5 to 6 ounces..... More than 8 ounces.....

36. For what reasons have you pumped milk in the past 2 weeks? (PLEASE "X" ALL THAT APPLY)

- To relieve engorgement..... To keep my milk supply up when my baby could not nurse (such as while you were away from your baby or when your baby was too sick to nurse).....
Because my nipples were too sore to nurse..... To increase my milk supply.....
To get milk for someone else to feed to my baby..... To mix with cereal or other food.....
For me to feed to my baby when I do not want to breastfeed or when baby cannot breastfeed..... To have an emergency supply of milk.....
To donate to a baby other than my own.....

37. How often do you collect milk from both breasts at the same time (double pumping)?

Never..... Rarely..... Sometimes..... Most of the time..... Always.....

38. How long was your milk usually stored in the refrigerator in the past 2 weeks? (Include cooler with cold source such as freezer packs.)

- 1 day or less..... 4 to 5 days..... More than 8 days.....
2 to 3 days..... 6 to 8 days..... I do not store milk in a refrigerator...

39. How long was your milk usually kept at room temperature and then fed to your baby in the past 2 weeks?

- Less than 1 hour... 5 to 8 hours..... More than 16 hours.....
- 1 to 2 hours..... 9 to 11 hours..... I do not keep my milk at room
- 3 to 4 hours..... 12 to 16 hours..... temperature.....

Babies are fed pumped breast milk in a lot of different situations, and bottles of milk may have to be prepared in a lot of different places. Please think of all of these situations and places as you answer the next few questions.

40. In the past 2 weeks, how often were the bottle nipples used to feed pumped breast milk cleaned in the following ways before being used again? If you don't use bottle nipples, "X" here and go to Question 41.

	<u>RARELY OR NEVER</u>	<u>SOME OF THE TIME</u>	<u>MOST OF THE TIME</u>	<u>ALL OF THE TIME</u>
Rinsed with water only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed in an automatic dish washer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed by hand with dish detergent.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boiled or sterilized.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not cleaned between uses – used to feed more milk without rinsing or washing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. In the past 2 weeks, how often were the following items boiled, sterilized in a microwave kit, sterilized with a chemical dip, or washed in a dishwasher?

	<u>AFTER EACH USE</u>	<u>ONCE A DAY</u>	<u>EVERY 2 TO 6 DAYS</u>	<u>ABOUT ONCE A WEEK</u>	<u>ABOUT ONCE IN 2 WEEKS</u>	<u>NEVER</u>	<u>ITEM IS DISPOSABLE</u>
Pump collection kit, including container used to collect the milk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Container used to store the milk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. How often have you and others who feed your baby heated your baby's cup or bottle of pumped milk in a microwave oven?

- Rarely or never..... Sometimes, but less than half the time..... About half the time..... Most of the time.....

43. In the past 2 weeks, has your baby been fed formula mixed with breast milk in the same bottle?

- Yes..... No..... → (GO TO SECTION E ON THIS PAGE)

44. How were the formula and breast milk usually mixed? (PLEASE "X" ALL THAT APPLY)

- Added formula powder to breast milk..... Added prepared (mixed up) formula or ready-to-feed formula to breast milk.....
- Added formula concentrate to breast milk.....

SECTION E: INFANT FORMULA

1. In your opinion, how likely is it for each of the following forms of formula to contain germs?

	<u>NOT AT ALL LIKELY</u>	<u>SOMEWHAT UNLIKELY</u>	<u>SOMEWHAT LIKELY</u>	<u>VERY LIKELY</u>
Ready-to-feed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liquid concentrate.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Powder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Was your baby fed infant formula in the past 2 weeks, by you or by anyone else?

- Yes..... → (CONTINUE) No..... → (GO TO SECTION J ON PAGE 8)

3. Formula packages have several types of directions and statements. Which of these kinds of information have you read on the package of the formula you use most often? (PLEASE "X" ALL THAT APPLY)

- Written directions for preparing the formula..... What to do with formula left over in the bottle after feeding the baby.....
- How to store the package after opening it.....
- How to store formula after it is prepared..... Have not read any of this information..... → (GO TO QUESTION 9)

4. Were any of the directions and statements you read hard to understand?

- Yes..... No..... → (GO TO QUESTION 6)

5. Which were hard to understand? (PLEASE "X" ALL THAT APPLY)

- Written directions for preparing the formula..... What to do with formula left over in the bottle after feeding the baby.....
- How to store the package after opening it.....
- How to store formula after it is prepared.....

6. Was all of the information you wanted included in all of the directions and statements you read?

- No, some information I wanted was missing..... Yes, all information I wanted was on the package... → (GO TO QUESTION 8)

7. Which of the directions or statements were missing a piece of information that you wanted? (PLEASE "X" ALL THAT APPLY)

- Written directions for preparing the formula..... What to do with formula left over in the bottle after feeding the baby.....
- How to store the package after opening it.....
- How to store formula after it is prepared.....

8. Was the print size for the directions and statements too small or large enough to read easily?

- Too small to read easily..... Large enough to read easily.....

9. Have you looked at the pictures on the formula container showing how to prepare the formula?

- Yes..... No..... → (GO TO QUESTION 11)

10. How useful did you find the pictures?

- Not at all useful..... A little useful..... Somewhat useful..... Very useful.....

11. In your opinion, how important for your baby's health is it to follow the label directions that say to feed or refrigerate the prepared formula immediately or discard the formula?

- Not at all important..... Somewhat important..... Very important.....

12. Infant formula cans have a list of ingredients that tells what is in them. Have you looked at this list?

- Yes..... No..... → (GO TO QUESTION 14)

13. Did you use the ingredient list to compare brands of infant formula?

- Yes..... No.....

14. Did you look for any specific ingredients or formula characteristics (such as lactose-free or hypoallergenic) in the ingredient list or on any other part of the label?

- Yes..... No..... → (GO TO QUESTION 16)

15. In the table below, please write in what ingredient or characteristic you were looking for and "X" whether you wanted to avoid or include the ingredient or characteristic in your baby's diet.

<u>INGREDIENT OR CHARACTERISTIC</u>	<u>AVOID</u>	<u>INCLUDE</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

16. Did a doctor, health professional, or birthing class tell you how to prepare formula?
Yes No

17. Did a doctor, health professional, or birthing class tell you how to store the prepared bottles of formula?
Yes No

18. During the past 2 weeks, what type of water have you and others who feed your baby used for mixing your baby's formula? (PLEASE "X" ALL THAT APPLY)

- Tap water from the cold faucet
- Warm tap water from the hot faucet
- Bottled water.....
- No water used; baby is fed only ready-to-feed formula → (GO TO QUESTION 20)

19. Was the water you used to mix the formula boiled?

	<u>YES</u>	<u>NO</u>	<u>NOT USED</u>
Tap water.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bottled water.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. How often have you and others who feed your baby heated your baby's bottle of formula in a microwave oven?

- Rarely or never.....
- Sometimes, but less than half the time
- About half the time
- Most of the time

Babies are fed formula in a lot of different situations, and formula may have to be prepared in a lot of different places. Please think of all of these situations and places as you answer the next few questions.

21. During the past 2 weeks, how often were the bottle nipples used to feed formula cleaned in the following ways before being used again?

	<u>NEVER</u>	<u>SOME OF THE TIME</u>	<u>MOST OF THE TIME</u>	<u>ALL OF THE TIME</u>
Rinsed with water only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed in an automatic dish washer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed by hand with dish detergent.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boiled or sterilized.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not cleaned between uses – used to feed more formula without rinsing or washing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. During the past 2 weeks, how often did you clean your hands in each of the following ways before preparing formula?

	<u>NEVER</u>	<u>SOME OF THE TIME</u>	<u>MOST OF THE TIME</u>	<u>ALL OF THE TIME</u>
Rinsed my hands with water only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wiped my hands only.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed with soap.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used hand sanitizer (such as gel or wipes).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepared formula without cleaning my hands.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. How long were bottles of prepared formula usually kept at room temperature and then fed to your baby in the past 2 weeks?

- Less than 1 hour.....
- 1 to 2 hours
- 3 to 4 hours
- 5 to 8 hours
- 9 to 11 hours
- 12 to 16 hours.....
- More than 16 hours.....
- I do not keep prepared formula at room temperature

24. How did you decide to use the formula you fed your baby in the past 7 days? (PLEASE "X" ALL THAT APPLY)

- A doctor or other health professional recommended the formula
- I chose the same formula fed to my baby at the hospital.....
- I heard that the formula is better for my baby in some way
- I chose the formula I received samples or coupons for.....
- I saw an advertisement for the formula and wanted to try it.....
- I chose a formula labeled as useful for a problem my baby had ..
- I use the formula given by WIC.....
- I chose the same formula I fed an older child.....
- Friends or relatives recommended the formula.....
- I chose a formula based on low price.....

25. Did you discuss your choice of formula with the baby's doctor?

- Yes
- No

26. During the past 2 weeks, how many times have you switched the formula you feed your baby?

- None →(GO TO SECTION J)
- 1.....
- 2
- 3
- 4.....
- 5 or more

27. Which formulas did you stop using in the past 2 weeks? Infant formulas are listed alphabetically on the Formula List insert along with a group number. Please "X" the group number for each infant formula you stopped using. (PLEASE "X" ALL THAT APPLY)

<u>Group 1</u>	<u>Group 2</u>	<u>Group 3</u>	<u>Group 4</u>	<u>Group 5</u>	<u>Group 6</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Did you switch formula because your baby had a problem with the formula you were using?

- Yes
- No →(GO TO SECTION J ON THIS PAGE)

29. What type of problem did your baby have with the formula(s)? (PLEASE "X" ALL THAT APPLY)

- An allergic reaction or intolerance
- Constipation.....
- Diarrhea.....
- Too much mucus.....
- Too much gas.....
- Too much spit up.....
- Vomiting.....
- Other problem (Please specify.....)

SECTION J: OTHER INFORMATION

1. In the past month, were you or your baby enrolled in the WIC program or did you get WIC food or vouchers for yourself or for your baby? (WIC is a program that gives food to pregnant and nursing women, babies, and young children.) (PLEASE "X" ALL THAT APPLY)

- Yes, I was enrolled or got WIC food for myself.....
- Yes, my baby was enrolled or got WIC formula or food
- No.....

2. Does your baby have any serious, long-term medical problems?

- No.....
- Yes →(PLEASE EXPLAIN BRIEFLY) _____

3. Date you completed this form: Month _____ Day _____ Year _____