

**Project FIRST**

R867-97P  
OMB No. 0910-0558  
Expiration date: 12/31/2007

**SECTION A: HEALTH AND HEALTH CARE**

1. Are you currently pregnant and at least 18 years old?  
Yes.....  No.....  → (THANK YOU, PLEASE RETURN QUESTIONNAIRE IN THE ENCLOSED POSTAGE PAID ENVELOPE)
2. When is your baby due? (PLEASE WRITE IN MONTH AND DAY)  
MONTH: \_\_\_\_\_ DAY: \_\_\_\_\_
3. Who provides your prenatal care? (PLEASE "X" ALL THAT APPLY)  
An obstetrician .....   
A family doctor, general practitioner, internist, or other physician .....   
A midwife or nurse midwife .....   
Another type of health care provider.....   
I am not getting prenatal care from a health professional.....  → (GO TO QUESTION 5)
4. How many weeks pregnant were you when you went for your first prenatal visit?  
4 weeks or less.....  13 to 18 weeks.....   
5 to 8 weeks .....  19 to 24 weeks.....   
9 to 12 weeks .....  25 weeks or more .....
5. Are you covered by any kind of health insurance or any kind of health care plan, such as insurance obtained through an employer or a government program like Medicaid?  
Yes .....  No.....
6. In the past month, were you enrolled in the WIC program or did you get WIC food or vouchers for yourself or for any of your children? (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 child was enrolled or got WIC food .....  No.....
7. What was your weight just before you became pregnant? \_\_\_\_\_ POUNDS
8. How tall are you? \_\_\_\_\_ FEET \_\_\_\_\_ INCHES
9. What is your age? \_\_\_\_\_ YEARS
10. On the average, how many cigarettes do you smoke a day now? (Write in 0 if you do not smoke).  
\_\_\_\_\_ CIGARETTES PER DAY
11. How many people not including yourself smoke inside your home most days? (Include family members, friends, and anyone else.)  
0.....  1.....  2.....  3.....  4 or more .....
12. Have you had gestational diabetes with this pregnancy?  
Yes.....  No.....  Don't know ....
13. As best you know, which of the following health conditions do you yourself or your baby's other relatives have? (PLEASE "X" ALL THAT APPLY)
- |  | YOU, THE<br>BABY'S<br>MOTHER | THE BABY'S<br>FATHER     | THE BABY'S<br>BROTHER OR<br>SISTER | THE BABY'S<br>GRANDPARENTS,<br>AUNTS, OR<br>UNCLES | NONE OF<br>THESE<br>RELATIVES |
|--|------------------------------|--------------------------|------------------------------------|--|-------------------------------|
| Juvenile onset diabetes (Type I).....                            | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>                           | <input type="checkbox"/>      |
| Adult onset diabetes (Type II).....                              | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>                           | <input type="checkbox"/>      |
| Asthma.....  | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>                           | <input type="checkbox"/>      |
| Eczema.....  | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>                           | <input type="checkbox"/>      |
| Food allergy.....  | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>                           | <input type="checkbox"/>      |
| Allergies to pollen, dust, animals, latex, or anything else..... | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>                           | <input type="checkbox"/>      |
| Overweight or obesity.....                                       | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>                           | <input type="checkbox"/>      |
14. Since you learned that you were pregnant, have you eaten more, less, or about the same of the following foods? If you did not eat the food before you learned that you are pregnant and you don't eat the food now, please mark "Did Not Eat Before or Now."
- |  | EAT<br>MORE              | EAT<br>LESS              | EAT ABOUT<br>THE SAME    | DID NOT EAT<br>BEFORE OR NOW |
|--|--------------------------|--------------------------|--------------------------|------------------------------|
| 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"/>     |

**IF YOU HAVE NOT EATEN LESS OF ANY FOOD LISTED IN QUESTION 14, GO TO QUESTION 16.**

15. For each food that you are eating less of, please indicate the reason. (PLEASE "X" ALL THAT APPLY)

	UPSETS MY STOMACH OR MAKES ME FEEL SICK	MAY HARM MY BABY	TO PREVENT A FOOD ALLERGY IN MY BABY	OTHER REASON
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"/>

**SECTION B: EMPLOYMENT**

16. Did you work for pay at any time from the 3 months before you became pregnant up to the present time?  
 Yes.....  No.....  →(GO TO QUESTION 23)
17. Using 1 to mean "None" and 5 to mean "Very much," how much satisfaction do you get from your paid work?  

<b><u>NONE (1)</u></b>	<b><u>(2)</u></b>	<b><u>(3)</u></b>	<b><u>(4)</u></b>	<b><u>VERY MUCH (5)</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. About how much of your family's income comes from the money you earn from work? (If you are no longer working, answer for the time you were working. If you have reduced your work hours because of your pregnancy, answer for the time before you reduced your hours.)  
 Less than half.....  About half.....  More than half.....
19. Do you work for pay now?  
 Yes, the same number of hours as before pregnancy.....   
 Yes, but with reduced hours.....   
 Yes, but on leave until after the baby's birth.....  → (GO TO QUESTION 21)  
 No.....  → (GO TO QUESTION 23)
20. How many hours per week do you usually work at this job now? (If you work at two or more jobs, answer for the total number of hours you work.)  

1 to 9 hours per week..... <input type="checkbox"/>	30 to 34 hours per week..... <input type="checkbox"/>
10 to 19 hours per week..... <input type="checkbox"/>	35 to 40 hours per week..... <input type="checkbox"/>
20 to 29 hours per week..... <input type="checkbox"/>	More than 40 hours per week..... <input type="checkbox"/>
21. Thinking of work leave that you can use for maternity leave, how many weeks are you eligible for if you have no complications? (Please write in the number of weeks of leave you are eligible for in each of the categories listed below. If you have no leave that you can use for maternity leave, write 0 in all.)  

_____ WEEKS OF FULLY PAID LEAVE	_____ WEEKS OF PARTIALLY PAID LEAVE	_____ WEEKS OF UNPAID LEAVE
---------------------------------	-------------------------------------	-----------------------------
22. In your opinion, how supportive of breastfeeding is your place of employment?  

Not at all supportive..... <input type="checkbox"/>	Somewhat supportive..... <input type="checkbox"/>
Not too supportive..... <input type="checkbox"/>	Very supportive..... <input type="checkbox"/>
23. Do you plan to work for pay during your baby's first year?  
 Yes.....  No.....  →(GO TO SECTION C)
24. How many weeks after the baby is born do you plan to return to work?  

Fewer than 4 weeks..... <input type="checkbox"/>	13 to 16 weeks..... <input type="checkbox"/>
4 to 6 weeks..... <input type="checkbox"/>	17 to 20 weeks..... <input type="checkbox"/>
7 to 9 weeks..... <input type="checkbox"/>	21 to 30 weeks..... <input type="checkbox"/>
10 to 12 weeks..... <input type="checkbox"/>	More than 30 weeks..... <input type="checkbox"/>
25. How many hours per week do you plan to work?  

1 to 9 hours per week..... <input type="checkbox"/>	30 to 34 hours per week..... <input type="checkbox"/>
10 to 19 hours per week..... <input type="checkbox"/>	35 to 40 hours per week..... <input type="checkbox"/>
20 to 29 hours per week..... <input type="checkbox"/>	More than 40 hours per week..... <input type="checkbox"/>
26. How many hours per week would you prefer to work when you return to work?  

1 to 9 hours per week..... <input type="checkbox"/>	30 to 34 hours per week..... <input type="checkbox"/>
10 to 19 hours per week..... <input type="checkbox"/>	35 to 40 hours per week..... <input type="checkbox"/>
20 to 29 hours per week..... <input type="checkbox"/>	More than 40 hours per week..... <input type="checkbox"/>
	Would prefer not to work..... <input type="checkbox"/>
27. What will you do with your baby while you are working? (PLEASE "X" ALL THAT APPLY)  

My baby will be cared for by a family member..... <input type="checkbox"/>	I will keep my baby with me while I work at home..... <input type="checkbox"/>
My baby will be cared for by someone not in my family..... <input type="checkbox"/>	I have not decided yet..... <input type="checkbox"/>
I will keep my baby with me while I work outside my home..... <input type="checkbox"/>	

**SECTION C: INFANT FEEDING**

28. What method do you plan to use to feed your new baby in the first few weeks?  
 Breastfeed only (baby will not be given formula).....   
 Formula feed only.....  →(GO TO QUESTION 34)  
 Both breast and formula feed.....  →(GO TO QUESTION 30)  
 Don't know yet.....  →(GO TO QUESTION 33)

29. How old do you think your baby will be when you first feed him or her formula or any other food besides breast milk?

- |                          |                          |                         |                          |
|--------------------------|--------------------------|-------------------------|--------------------------|
| Less than one month..... | <input type="checkbox"/> | 5 to 6 months.....      | <input type="checkbox"/> |
| 1 to 2 months.....       | <input type="checkbox"/> | 7 to 9 months.....      | <input type="checkbox"/> |
| 3 to 4 months.....       | <input type="checkbox"/> | More than 9 months..... | <input type="checkbox"/> |

30. Do you plan to continue breastfeeding after you return to work?

- Yes .....       No .....       Do not plan to work after the baby's birth .....

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

\_\_\_\_\_ MONTHS

32. 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 31?

- |                             |                          |                          |                          |                          |                       |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------|
| <b>Not At All Confident</b> |                          |                          |                          |                          | <b>Very Confident</b> |
| <b>(1)</b>                  | <b>(2)</b>               | <b>(3)</b>               | <b>(4)</b>               | <b>(5)</b>               |                       |
| <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                       |

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

- |   |                           |                          |                          |                          |                          |
|---|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|   | <b>VERY UNCOMFORTABLE</b> |                          |                          |                          | <b>VERY COMFORTABLE</b>  |
|   | <b>(1)</b>                | <b>(2)</b>               | <b>(3)</b>               | <b>(4)</b>               | <b>(5)</b>               |
| 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"/> |

34. Which of the following statements is closest to your opinion? The best way to feed a baby is:

- Breastfeeding .....
- A mix of both breast and formula feeding .....
- Formula feeding .....
- Breastfeeding and formula feeding are equally good ways to feed a baby .....

35. How strongly do you agree or disagree with the following statements?

- |   |                          |                          |                                   |                          |                          |
|---|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
|   | <b>STRONGLY DISAGREE</b> | <b>SOMEWHAT DISAGREE</b> | <b>NEITHER AGREE NOR DISAGREE</b> | <b>SOMEWHAT AGREE</b>    | <b>STRONGLY AGREE</b>    |
| Infant formula is as good as breast milk.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| If a baby is breastfed, he or she will be less likely to get ear infections.....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| If a baby is breastfed he or she will be less likely to get a respiratory illness.....    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| If a baby is breastfed he or she will be less likely to get diarrhea.....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| Babies should be exclusively breastfed (fed only breast milk) for the first 6 months..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| If a child was breastfed, he or she will be less likely to become obese.....              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |

36. How do the following people think your baby should be fed in the first few weeks? (Mark "No one in this category" if there is no one in the category, such as if you don't yet have a pediatrician for the baby.)

- |  |                          |                          |                                    |                                 |                                |
|--|--------------------------|--------------------------|------------------------------------|---------------------------------|--------------------------------|
|  | <b>ONLY BREASTFED</b>    | <b>ONLY FORMULA FED</b>  | <b>BOTH BREAST AND FORMULA FED</b> | <b>NO OPINION OR DON'T KNOW</b> | <b>NO ONE IN THIS CATEGORY</b> |
| Baby's father.....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>        | <input type="checkbox"/>       |
| Your mother.....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>        | <input type="checkbox"/>       |
| Your mother-in-law.....                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>        | <input type="checkbox"/>       |
| Your obstetrician or other doctor.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>        | <input type="checkbox"/>       |
| Baby's pediatrician or other doctor..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/>        | <input type="checkbox"/>       |

37. How important are the following people's opinions in your decision about how to feed your baby?

- |  |                             |                           |                           |                          |                                |
|--|-----------------------------|---------------------------|---------------------------|--------------------------|--------------------------------|
|  | <b>NOT AT ALL IMPORTANT</b> | <b>NOT VERY IMPORTANT</b> | <b>SOMEWHAT IMPORTANT</b> | <b>VERY IMPORTANT</b>    | <b>NO ONE IN THIS CATEGORY</b> |
| Baby's father.....                       | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>       |
| Your mother.....                         | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>       |
| Your mother-in-law.....                  | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>       |
| Your obstetrician or other doctor.....   | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>       |
| Baby's pediatrician or other doctor..... | <input type="checkbox"/>    | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>       |

38. About how many of your friends and relatives have breastfed their babies?

- |                     |                          |                          |  |
|---------------------|--------------------------|--------------------------|--|
| One or two.....     | <input type="checkbox"/> | None have breastfed..... | <input type="checkbox"/>                       |
| Three to five.....  | <input type="checkbox"/> | None have children.....  | <input type="checkbox"/> ➔ (GO TO QUESTION 40) |
| More than five..... | <input type="checkbox"/> | Don't know.....          | <input type="checkbox"/>                       |

39. About how many of your friends and relatives have never breastfed their infants at all?

- |                     |                          |  |                          |
|---------------------|--------------------------|--|--------------------------|
| One or two.....     | <input type="checkbox"/> | None – all with babies have breastfed..... | <input type="checkbox"/> |
| Three to five.....  | <input type="checkbox"/> | Don't know.....                            | <input type="checkbox"/> |
| More than five..... | <input type="checkbox"/> |  |                          |

40. When you were babies, were you and the baby's father ever breastfed?

- |                             |                          |                          |                          |
|-----------------------------|--------------------------|--------------------------|--------------------------|
|                             | <u>Yes</u>               | <u>No</u>                | <u>Don't Know</u>        |
| You, the baby's mother..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Baby's father.....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

41. How many other babies have you had or adopted when younger than 12 months old? Do not include the baby you are expecting.

\_\_\_\_\_ OTHER BABIES HAD      \_\_\_\_\_ BABIES ADOPTED

**IF YOU HAVE NOT GIVEN BIRTH TO A BABY, GO TO SECTION D.**

42. Have you ever given birth by cesarean?

Yes .....  No.....

43. Did you breastfeed, for any time at all, any of your other babies?

Yes .....  No.....  →(GO TO SECTION D)

44. How old was your baby when you stopped breastfeeding? (If you have breastfed more than one baby, answer for the youngest one.)

Less than one month .....  7 to 9 months .....   
 1 to 2 months .....  10 to 12 months .....   
 3 to 4 months .....  More than 12 months .....   
 5 to 6 months .....

**SECTION D: OTHER INFORMATION**

45. Have you heard about any problems in food related to:

	<u>YES</u>	<u>NO</u>
Listeria.....	<input type="checkbox"/>	<input type="checkbox"/>
Mercury.....	<input type="checkbox"/>	<input type="checkbox"/>
Dioxins or PCB's.....	<input type="checkbox"/>	<input type="checkbox"/>

**IF YOU HAVE NOT HEARD OF ANY OF THESE PROBLEMS, GO TO QUESTION 47.**

46. For each problem in Question 45 that you have heard of, do you remember what kind of food was related to the problem? (PLEASE "X" ALL THAT APPLY)

	<u>SOME</u> <u>TYPES OF</u> <u>FISH</u>	<u>ALL</u> <u>TYPES OF</u> <u>FISH</u>	<u>SOME TYPES OF</u> <u>SHELLFISH</u>	<u>SOME TYPES</u> <u>OF MEAT OR</u> <u>CHICKEN</u>	<u>ALL TYPES OF</u> <u>MEAT OR</u> <u>CHICKEN</u>	<u>SOME</u> <u>TYPES OF</u> <u>CHEESES</u>	<u>SOME</u> <u>TYPES OF</u> <u>LUNCHEON</u> <u>MEATS</u>	<u>ALL TYPES OF</u> <u>LUNCHEON</u> <u>MEATS</u>	<u>DON'T</u> <u>KNOW</u>
Listeria.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mercury.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dioxins or PCB's.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

47. Have you have obtained information about your diet or about feeding babies from any of the following sources for this pregnancy or a previous one? For information about feeding babies, please think of breastfeeding, formula feeding, feeding solid foods, or any other infant feeding information.

	<u>INFORMATION ABOUT MY</u> <u>DIET WHILE PREGNANT</u>	<u>INFORMATION ABOUT</u> <u>FEEDING BABIES</u>	<u>NO INFORMATION FROM THIS</u> <u>SOURCE</u>
Doctor, nurse, or other health professional .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WIC food program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relative or friend.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Books or videos.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper or magazine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Television or radio.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The web site, <a href="http://www.4woman.gov">www.4woman.gov</a> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The web site, <a href="http://www.breastfeeding.com">www.breastfeeding.com</a> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other government web site.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other non-government web site.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. Have you recently seen, heard, or read anything about breastfeeding or about infant formula from the following places?

	<u>BREASTFEEDING</u>		<u>INFANT FORMULA</u>	
	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
TV.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Magazine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newspaper.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radio.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On the internet or web.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Billboards or outdoor posters.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FOR QUESTION 49, PLEASE LOOK AT THE PICTURES ON THE AD INSERT INCLUDED WITH THIS QUESTIONNAIRE.**

49. Have you recently seen the ads shown on the Ad Insert? Have you recently seen an ad...

	<u>YES</u>	<u>NO</u>	<u>NOT SURE</u>
On TV that shows a pregnant woman riding a mechanical bull? See TV Ad 1.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On TV that shows a pregnant woman drinking soda and eating greasy food? See TV Ad 2.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On TV that shows pregnant women in a log rolling competition? See TV Ad 3.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a magazine or newspaper that shows two dandelions? See Print Ad 1.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a magazine or newspaper that shows two otoscopes, the medical tool used to examine the ear? See Print Ad 2.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a magazine or newspaper that shows two scoops of ice cream? See Print Ad 3.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a magazine or newspaper or on a billboard or the internet that has only words giving a message about breastfeeding? See Print Ad 4.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

50. Have you recently heard any ads on the radio that feature a man singing a song about breastfeeding? One ad is a song set to soul music and another ad is a song set to country western music. Have you recently heard either of these ads?

Yes, the soul music ad .....  No, have not heard either.....   
 Yes, the country western music ad .....  Not sure.....

51. Date you completed this form: MONTH \_\_\_\_ DAY \_\_\_\_ YEAR \_\_\_\_

52. As mentioned in the brochure, we need your current telephone number in order to ensure that you are involved at every step of Project FIRST.

My current telephone number is: \_\_\_\_\_  
 Area code Telephone number

53. Are you the Synovate Consumer Opinion Panel Member?

Yes.....  No.....

**THANK YOU.**

**PLEASE RETURN THIS QUESTIONNAIRE AND THE AD INSERT AS SOON AS POSSIBLE IN THE POSTAGE PAID ENVELOPE PROVIDED**