B-WELL-Mom Study
Breathe - Wellbeing, Environment, Lifestyle, and Lung Function

Post-partum questionnaire

Study ID: ☐☐☐-☐☐☐-☐☐☐
Site ID Group

Changes To Your Address

First, we would like to ask you if anything has changed about your living situation since your last study visit:

1. Have you moved from this address? _____ (autofill address)
   a. Yes (SKIP to next section)
   b. No

2. Has there been any change in the number or type of your household pets since your last visit?
   a. No
   b. Yes → (SKIP TO Q2a.)
   2a. Please indicate how many of each kind of pet you have:
      i. Cat: □No □Yes → Number:_____
      ii. Dog: □No □Yes → Number:_____
      iii. Rabbit: □No □Yes → Number:_____
      iv. Other: □No □Yes → Specify:_____ Number:____
      v. Other: □No □Yes → Specify:_____ Number:____

3. Any change in your marital status?
   a. Yes
   b. No (SKIP TO NEXT SECTION ON JOB STATUS)

4. What is your current marital status? Are you:
   a. Married and/or living with partner
   b. Divorced
   c. Widowed
   d. Separated
   e. Single

Details About Your New Home

1. What is your current address?

   Street_____

City:_____
State:____ Zipcode:_____

State options: 1=Alabama – AL
2=Illinois – IL
3=Indiana – IN
4=Michigan – MI
5= \Wisconsin - WI

2. When did you move to your current address?
    a. MM/YYYY: _____

3. What type of residence are you currently living in?
    a. Single house
    b. House attached to one or more other houses (duplex/triplex/4-plex)
    c. Building with 2-4 apartments
    d. Building with 5-19 apartments
    e. Building with 20 or more apartments
    f. Condominium
    g. Mobile home, RV, van.
    h. Dormitory or residence hall
    i. Don't know
    j. Other (Please specify _____)

4. About how old was the building when you moved in (your best estimate)?
    a. More than 50 years old
    b. 25-50 years old
    c. 10-25 years old
    d. Less than 10 years old
    e. Don't Know

5. Does the tap water in your current home come from a private well? This is not common.
    a. Yes
    b. No
    c. Don't Know

6. Do you use a gas range or stovetop for cooking in your current home?
    a. Yes
    b. No (SKIP TO Q10)

7. Do you have a hood or vent fan over the stove?
    a. Yes
    b. No (SKIP to 10)

8. Does the hood or vent fan exhaust air to the outside?
    a. Yes
    b. No
    c. Don't know

9. How often do you use the hood or vent fan over the stove when cooking?
    a. Always
    b. Usually
    c. Sometimes
    d. Rarely
    e. Never

10. Is your current home within ¼ mile of agricultural fields or golf course?
    a. Yes
    b. No
    c. Don't Know

11. Is your current home within 3 blocks of a gas station?
    a. Yes
    b. No
    c. Don't Know

12. Do you use an ozone air ionizer or purifier in your current home?
    a. Yes
    b. No

13. What type of air conditioning do you use in your current house? (check all that apply)
    a. None
    b. Central air conditioning
    c. Room air conditioning (a window unit, for example)
    d. Other. Specify:_____

14. What is the fuel source used for the heating system in your house? (check all that apply)
    a. None
    b. Natural gas
    c. Oil
    d. Propane
    e. Wood or pellet stove
    f. Fireplace
    g. Coal stove
    h. Electric
    i. Other. Specify:_____

15. *Below is a chart with each season listed. Thinking about the past year, you should fill in the number of hours in a typical day that your home has "no ventilation", "low", "medium" or "high" ventilation for each season using the definitions below to help you. The totals should add up to 24 hours. If you are not sure, give us your best guess.*

    No ventilation: All windows and doors closed.

    Low: One or two windows or doors open just a crack (up to 1 inch).

    Medium: Several windows or doors open at least a crack, or one or two windows open part-way (at least several inches).

High: Some windows or doors fully open, or several windows or doors open part-way, or almost all windows or doors open at least a crack.

(**NOTE**: The number of hours for no ventilation, low, medium, and high **SHOULD TOTAL 24** for each season)

	No ventilation		Low		Medium		High		Total hours per day
a. Summer	__(hours)	+	___(hours)	+	__(hours)	+	__(hours)	=	24 (hours)
b. Fall	__(hours)	+	___(hours)	+	__(hours)	+	__(hours)	=	24 (hours)
c. Winter	__(hours)	+	___(hours)	+	__(hours)	+	__(hours)	=	24 (hours)
d .Spring	__(hours)	+	___(hours)	+	__(hours)	+	__(hours)	=	24 (hours)

16. Has there been any change in the number or type of your household pets since your last study visit?
    a. No
    b. Yes → (SKIP TO Q16a.)

    16a. Please indicate how many of each kind of pet you have:

Cat:	□No	□Yes →	Number:___
Dog:	□No	□Yes →	Number:___
Rabbit:	□No	□Yes →	Number:___
Other:	□No	□Yes →	Specify:_____ Number:__
Other:	□No	□Yes →	Specify:_____ Number:__

17. Has there ever been mold in your current house?
    a. Yes
    b. No (SKIP TO Q18)
    c. Don't Know (SKIP TO Q18)

    17a. Was the mold in the shower area?
        a. Yes
        b. No
        c. Don't know

    17b. Was the mold in other parts of the house (walls, ceilings, etc.)?
        a. Yes
        b. No
        c. Don't know

18. Has your current house ever had a sustained water problem (leaks, flooding, etc.)?
    a. Yes
    b. No
    c. Don't know

19. Has your current house had a problem with roaches or other pests?
    a. No
    b. Yes, occasionally
    c. Yes, most of the time
    d. Don't know

20. Any change in your marital status?
    a. Yes
    b. No (SKIP TO NEXT SECTION)

21. What is your current marital status? Are you:
    a. Married and/or living with partner
    b. Divorced
    c. Widowed
    d. Separated
    e. Single

Changes To Your Job Status

Now we would like to ask you if anything has changed about your work situation since your last study visit:

Your previous employment status was: _____ (auto-populated from previous visit)

(1=Employed full-time; 2=Employed part-time; 3=On leave from employment, such as disability leave; 4=Unemployed)

1. Any change to your occupation since your last study visit?
    a. Yes
    b. No (see skip options below)
    [If previously working, full or part-time, and no change then skip to Q3]
    [If previously unemployed and no change then skip to Q19]
    [If previously on leave and no change then skip to Q19]

2. Are you currently
    a. Employed full-time
    b. Employed part-time
    c. On leave from employment, such as disability leave (SKIP TO Q5)
    d. Unemployed (SKIP TO Q7)
    e. Same job location but working more hours (e.g., from part-time to full-time)
    f. Same job location but working fewer hours (e.g., from full-time to part-time)

3. What do you do with your baby while you are working?
    a. My baby is cared for by a family member
    b. My baby is cared for by someone not in my family
    c. I keep my baby with me while I work at home
    d. I keep my baby with me while I work outside my home

4. Were you able to stay home with your baby as long as you wanted before returning to work?
    a. Yes
    b. No

5. Did your employer provide a maternity leave benefit?
    a. Yes

b. No

6. Is your place of employment the same as before you gave birth?
    a. Yes (SKIP TO Q19)
    b. No (SKIP TO Q8)

7. How many months have you been unemployed? (<1,1-6,>6) months (SKIP TO Q19)

These next few questions are about your new job since your last study visit:

8. What is your new occupation? (DROP DOWN LIST)
    a. Management
    b. Business or financial operations
    c. Computer and Mathematical
    d. Architecture and engineering
    e. Life, physical, and social science
    f. Community and social services
    g. Legal
    h. Education, training, library
    i. Art, design, entertainment
    j. Healthcare practitioner
    k. Healthcare support
    l. Protective service
    m. Food preparation and serving
    n. Building and grounds cleaning and maintenance
    o. Personal care and service
    p. Sales and related
    q. Office and administrative support
    r. Farming, fishing, forestry
    s. Construction
    t. Installation, maintenance and repair
    u. Production
    v. Transportation and material moving
    w. Military
    x. Student
    y. Other (please specify):_____

9. How long have you worked at that type of job? (<1,1-6,>6) # of months

10. Which of the following best describes your usual work schedule?
    a. Day shift
    b. Afternoon shift
    c. Night shift
    d. Split shift
    e. Irregular shift/on-call
    f. Rotating shifts

Now we would like to collect some information about your new workplace environment where you spend the majority of your working day:

11. Is your work environment:
    a. Mostly carpeted
    b. Mostly tiled
    c. Mostly hardwood
    d. Mostly outside
    e. None of the above

12. Is it air-conditioned?
    a. Yes
    b. No

13. Is smoking permitted?
    a. Yes
    b. No

14. Are you exposed to chemicals or strong odors?
    a. Yes → Please tell us more about it: _____
    b. No

15. Is your work environment moldy or musty?
    a. Yes
    b. No

(NOTE: IF NO ASTHMA, SKIP TO Q17. QUESTION 16 IS FOR WOMEN WITH ASTHMA ONLY)

16. Are your asthma symptoms worse at work?
    a. Yes
    b. No (SKIP TO Q17)

    16a. Which symptoms are worse at work?

    i. Wheezing: □No □Yes

    ii. Coughing: □No □Yes

    iii. Tightness in chest/shortness of breath: □No □Yes

    iv. Other : □No □Yes, please specify:_____

17. Have you missed any time from work because of asthma or allergies since your last study visit?
    a. Yes
    b. No (SKIP TO 18)

    17a. How many days since your last study visit have you missed work because of asthma or allergies? _____days

18. Since your last study visit, have you worked or been trained in any of the following workplaces or jobs, including part-time or temporary summer employment for at least a month? For each YES, answer for how many weeks.

ON THE JOB:

a.	Gas station or auto repair shop	NO	YES→How many weeks (<1,1-12,>12)
b.	Dry cleaning shop	NO	YES→How many weeks (<1,1-12,>12)
c.	Farmer, farmworker or forestry worker	NO	YES→How many weeks (<1,1-12,>12)
d.	Laboratory worker	NO	YES→How many weeks (<1,1-12,>12)
e.	Housekeeper, maid, janitor or cleaning worker	NO	YES→How many weeks (<1,1-12,>12)
f.	Hair stylist or manicurist	NO	YES→How many weeks (<1,1-12,>12)
g.	Exterminator or pest control worker	NO	YES→How many weeks (<1,1-12,>12)
h.	Taxi or bus driver or other motor vehicle operator	NO	YES→How many weeks (<1,1-12,>12)
i.	Parking lot attendant or toll booth operator	NO	YES→How many weeks (<1,1-12,>12)
j.	Veterinarian, animal care worker or poultry or livestock farmer	NO	YES→How many weeks (<1,1-12,>12)
k.	Nurse	NO	YES→How many weeks (<1,1-12,>12)
l.	Dental assistant	NO	YES→How many weeks (<1,1-12,>12)
m.	Flight attendant or pilot	NO	YES→How many weeks (<1,1-12,>12)

This next question asks you about things you may have been in contact with either at your job, at home, when doing your favorite hobby or other activity:

19. Since your last study visit, have you had any exposure to or had contact with any of the following at least once a week for at least one month? Check NO or YES for each substance. For each YES, answer for how many weeks.

a.	Metal or metal compounds, such as lead, mercury, arsenic, boron, chromium, cadmium, and selenium (as filings, dust or fumes)	NO	YES→How many weeks (<1,1-12,>12)
b.	Drugs or pharmaceuticals (not for personal use)	NO	YES→How many weeks (<1,1-12,>12)
c.	Chemicals used to develop or process photographic film	NO	YES→How many weeks (<1,1-12,>12)
d.	Dyes, other than hair dyes	NO	YES→How many weeks (<1,1-12,>12)
e.	Grease or oils, such as cutting oil or creosote	NO	YES→How many weeks (<1,1-12,>12)
f.	Welding fumes	NO	YES→How many weeks (<1,1-12,>12)
g.	Solvents, (chemicals that lubricate, soften or dissolve grease, oil, paints or other materials)	NO	YES→How many weeks (<1,1-12,>12)
h.	Chemical fixatives (such as embalming fluids, tissue preservation materials)	NO	YES→How many weeks (<1,1-12,>12)
i.	Chemicals to make rubber or plastic	NO	YES→How many weeks (<1,1-12,>12)
j.	Pesticides to control insect pests	NO	YES→How many weeks (<1,1-12,>12)
k.	Herbicides to control weeds	NO	YES→How many weeks (<1,1-12,>12)
l.	Fumigants	NO	YES→How many weeks (<1,1-12,>12)
m.	Chemical fertilizers	NO	YES→How many weeks (<1,1-12,>12)
n.	Stains, varnish or other wood finishes	NO	YES→How many weeks (<1,1-12,>12)
o.	Paints or paint products, or paint thinner or remover	NO	YES→How many weeks (<1,1-12,>12)
p.	Natural gas, gasoline or fuel products	NO	YES→How many weeks (<1,1-12,>12)
q.	Chemicals to sterilize medical or dental instruments	NO	YES→How many weeks (<1,1-12,>12)
r.	Laboratory animals	NO	YES→How many weeks (<1,1-12,>12)
s.	Farm animals	NO	YES→How many weeks (<1,1-12,>12)

Changes To Your Travel Patterns

In this next series of questions we would like to update the information you told us about how you get around town every day, either to go to work, or to school, or to do your usual daily activities now that you've had your baby:

1. Thinking about your typical daily commute, which of the following BEST describes your usual means of commuting to work/school/other activity each day? If you use more than one mode of transportation on your usual daily commute, please check all that apply.
    a. I drive alone
    b. I carpool/drive with others
    c. I ride a motorcycle/scooter
    d. I take a bus
    e. I take a train
    f. I walk
    g. I ride a bicycle
    h. Other, please specify: _____

2. On average, approximately how many minutes does it take you to get to work/school/other activity on a normal day?
    a. <15 min
    b. 15-30 min
    c. 31-45 min
    d. 46-60 min
    e. 61-75 min
    f. 76-90 min
    g. >90 min

3. On average, approximately how far is your commute?
    a. <1 mile
    b. 1-5 miles
    c. 6-10 miles
    d. >10 miles

Changes To Your Health And Lifestyle

Now we would like to ask you some general questions about your health and lifestyle since your baby was born:

1. How is your health, in general?
    a. Excellent
    b. Very Good
    c. Good
    d. Fair
    e. Poor

2. How many cigarettes do you smoke on an average day now?
    a. None

b. 1-5
c. 6-15
d. 16-20
e. More than 20

3. Since your baby was born, does anyone smoke in your home?
    a. Yes
    b. No

4. How many alcoholic drinks do you have during an average week now?
    a. None
    b. 1-2
    c. 3-4
    d. 5-6
    e. 7 or more

5. Since your baby was born, did you ever drink more than 5 drinks in one occasion?
    a. Yes
    b. No (SKIP TO Q7)

6. How many times since your baby was born did you drink more than 5 drinks in one occasion?
    a. 1-2
    b. 3-4
    c. 5-6
    d. 7 or more

7. Since your baby was born, did you ever drink any caffeinated beverages? (Do not include decaf coffee)
    a. Yes
    b. No (SKIP TO NEXT SECTION)

8. On average, how often did you drink them?
    a. Daily
    b. Weekly
    c. Occasionally

9. On a typical occasion when you drank caffeinated beverages since your baby was born, how many drinks did you consume (if you drank some every day, answer for a typical day):
    a. Caffeinated coffee: number of 8 ounce cups (about the size of a mug): ____(0-10,More than 10)
    b. Caffeinated tea: number of 8 ounce cups (about the size of a mug):___(0-10,More than 10)
    c. Cans (12 oz) or bottles (16 oz) of soda with caffeine (for example, Coke, Pepsi, Dr. Pepper, Mountain Dew. Count diet and regular together): ____(0-10,More than 10)
    d. Cans (12 oz) or bottles (16 oz) of energy drinks with caffeine (for example, Red Bull, Amp): __(0-10,More than 10)

Changes In Your Asthma (women with asthma only)

Now we would like to get some information about how your asthma has been since your baby was born:

1. During the past 30 days, on how many nights did symptoms of asthma make it difficult for you to stay asleep?
    a. None
    b. Less than every night
        i. How many: ____ nights (response should be <30 nights)
    c. Every night
    d. Don't know

2. Since your baby was born, have you had an episode of asthma or an asthma attack?
    a. Yes
    b. No (SKIP TO Q6)
    c. Don't know (SKIP to Q6)

3. Since your baby was born, how many asthma episodes or attacks have you had? (If you don't know the exact number, just give us your best guess)
    a. ____episodes

4. How long did your MOST RECENT asthma episode or attack last?
    a. __ __ # of minutes
    b. __ __ # of hours
    c. __ __# of days
    d. Don't know/Not sure

5. Compared with other episodes or attacks, was this most recent attack shorter, longer, or about the same?
    a. Shorter
    b. Longer
    c. About the same
    d. The most recent attack was actually the first attack
    e. Don't know

Now we would like to ask you about times when you seek treatment for your asthma:

6. Since your baby was born, how many times did you see a doctor or other health professional for a routine checkup for your asthma?
    a. None
    b. 1 time
    c. >1 time
        i. How many: _____
    d. Don't know

7. An urgent care center treats people with illnesses or injuries that must be addressed immediately and cannot wait for a regular medical appointment. Since your baby was born, have you had to visit an emergency room at a hospital or urgent care center because of your asthma?

a. Yes
b. No (SKIP TO Q9)
c. Don't know (SKIP TO Q9)

8. Since your baby was born, how many times did you visit an emergency room or urgent care center because of your asthma?
    a. 1 time
    b. >1 time
        i. How many: _____
    c. Don't know

9. Since your baby was born, other than urgent care, how many times did you see a doctor or other health professional because of worsening asthma symptoms or for an asthma episode or attack?
    a. None
    b. 1 time
    c. >1 time
        i. How many: _____
    d. Don't know

10. Since your baby was born, have you had to stay overnight in a hospital because of your asthma? Do not include an overnight stay in the emergency room?
    a. Yes
    b. No (SKIP TO NEXT SECTION)
    c. Don't know (SKIP TO NEXT SECTION)

11. Since your baby was born, how many different times did you stay in any hospital overnight or longer because of your asthma? (If you do not know exactly how many, just give us your best guess)
    a. _____ (response should be >0)

Changes To Physical Activity

1. SINCE your baby was born, when you are NOT at work, how much time do you usually spend:

		None	Less than ½ hour per day	½ to almost 1 hour per day	1 to almost 2 hours per day	2 to almost 3 hours per day	3 or more hours per day
a.	Preparing meals (cook, set table, wash dishes)	①	②	③	④	⑤	⑥
b.	Dressing, bathing, feeding children while you are sitting	①	②	③	④	⑤	⑥
c.	Dressing, bathing, feeding children while you are standing	①	②	③	④	⑤	⑥

d.	Playing with children while you are sitting or standing	①	②	③	④	⑤	⑥
e.	Playing with children while you are walking or running	①	②	③	④	⑤	⑥
f.	Carrying children	①	②	③	④	⑤	⑥
g.	Taking care of an older adult	①	②	③	④	⑤	⑥
h.	Sitting and using a computer or tablet or writing, while not at work	①	②	③	④	⑤	⑥
i.	Sitting and playing a video game while not at work	①	②	③	④	⑤	⑥
j.	Playing with pets	①	②	③	④	⑤	⑥
k.	Light cleaning (make beds, laundry, iron, put things away)	①	②	③	④	⑤	⑥
l.	Shopping (for food, clothes, or other items)	①	②	③	④	⑤	⑥
m.	Heavier cleaning (vacuum, mop, sweep, wash windows)	①	②	③	④	⑤	⑥
n.	Mowing lawn while on a riding mower	①	②	③	④	⑤	⑥
o.	Mowing lawn while using a walking mower, raking, gardening	①	②	③	④	⑤	⑥
p.	Walking slowly to go places (such as to the bus, work, visiting) *Not for fun or exercise*	①	②	③	④	⑤	⑥
q.	Walking more quickly to go places (such as to the bus, work, visiting) *Not for fun or exercise*	①	②	③	④	⑤	⑥
r.	Driving or riding in a car or bus	①	②	③	④	⑤	⑥
s.	Walking slowly for fun or exercise	①	②	③	④	⑤	⑥

t.	Walking more <u>quickly</u> for fun or exercise	①	②	③	④	⑤	⑥
u.	Walking <u>quickly up hills</u> for fun or exercise	①	②	③	④	⑤	⑥
v.	Jogging	①	②	③	④	⑤	⑥
w.	Swimming	①	②	③	④	⑤	⑥
x.	Dancing	①	②	③	④	⑤	⑥
y.	Doing other things for fun or exercise? Please tell us what they are (or leave this blank if you have none to report). — — —	①	②	③	④	⑤	⑥
z.	Doing other things for fun or exercise? Please tell us up to three activities (or leave this blank if you have none to report). i_____ ii_____ iii_____	①	②	③	④	⑤	⑥

2. SINCE your baby was born, how much time do you usually spend:

	None	Less than ½ hour per day	½ to almost 2 hours per day	2 to almost 4 hours per day	4 to almost 6 hours per day	6 or more hours per day
a. Watching TV or a video	①	②	③	④	⑤	⑥
b. Sitting and reading, talking or on the phone, **while <u>not</u> at work**	①	②	③	④	⑤	⑥
c. Sitting **at work** or in class (If you were						

	not working, please record “None”)	①	②	③	④	⑤	⑥
d.	Standing or slowly walking **at work** while carrying things (If you were not working, please record “None”)	①	②	③	④	⑤	⑥
e.	Standing or slowly walking **at work** not carrying anything (If you were not working, please record “None”)	①	②	③	④	⑤	⑥
f.	Walking quickly **at work** while carrying things (heavier than a 1 gallon milk jug) (If you were not working, please record “None”)	①	②	③	④	⑤	⑥
g.	Walking quickly **at work** not carrying anything (If you were not working, please record “None”)	①	②	③	④	⑤	⑥

Changes To Sleep

Now we would like to get some information about things that may have changed about your general sleep patterns since your baby was born:

1. How many hours of sleep did you usually get per night in the past two months:
    a. On weekdays or workdays? (4-10,>10) hours
    b. On weekends? (4-10,>10) hours

2. How many minutes did it usually take for you to fall asleep at bedtime? ____minutes

3. How many minutes of wake time (waking up in the middle of the night) did you have during a typical night’s sleep? ____minutes

The next two questions below refer to the times you got in and out of bed to sleep, not including naps.

4. Not including naps, what time did you usually go to bed?

a. On weekdays or workdays? ____ hh:mm AM/PM
b. On weekends? ____ hh:mm AM/PM

5. Not including naps, what time did you usually wake up?
   a. On weekdays or workdays? ____ hh:minutes AM/PM
   b. On weekends? ____ hh:mm AM/PM

6. During a usual week, how many times did you nap for 5 minutes or more?
   a. None
   b. 1 or 2 times
   c. 3 or more times

The following questions ask about your sleep habits. Please check one of the following for each of the questions. Pick the answer that best describes how often you experienced the situation

1. In the past month

		No	**Yes, Less than once a week**	**Yes, 1 or 2 times a week**	**Yes, 3 or 4 times a week**	**Yes, 5 or more times a week**
a.	Did you have trouble falling asleep?	☐	☐	☐	☐	☐
b.	Did you wake up several times at night?	☐	☐	☐	☐	☐
c.	Did you wake up earlier than you planned to?	☐	☐	☐	☐	☐
d.	Did you have trouble getting back to sleep after you woke up too early?	☐	☐	☐	☐	☐
e.	Did you take sleeping pills to help you sleep?	☐	☐	☐	☐	☐

2. Overall, your typical night's sleep during the last 4 weeks was?
   a. Very sound or restful
   b. Sound of restful
   c. Average quality
   d. Restless
   e. Very restless

3. What position did you usually wake up in?

On my left side mostly	**On my right side mostly**	**Both sides just as much**	**On my back mostly**	**On my front mostly**	**Just as much on my**	**Sitting up/propped up**	**Don't remember/don't**

						side as on my front or back		know
a. During the last week?	□	□	□	□	□	□	□	□
b. Last night?	□	□	□	□	□	□	□	□

4. How often did you usually wake up during the night?
    a. On average, during the last week? ____times per night
    b. Last night? ___times per night

5. During the night, how often did you have to get out of bed (for example, to use the toilet)?
    a. On average, during the last week? ____times per night
    b. Last night? ___times per night

6. Based on your experience in the last 4 weeks, what is the chance that you would doze off or fall asleep (not just "feel tired") in the following situations? (Check one box for each situation. If you are never or rarely in the situation, please give your best guess for what would happen.)

		No chance	**Slight chance**	**Moderate chance**	**High chance**
a.	Sitting and reading?	□	□	□	□
b.	Watching TV?	□	□	□	□
c.	Sitting inactive in a public place (such as a theater or meeting)?	□	□	□	□
d.	Riding as a passenger in a car for an hour without a break?	□	□	□	□
e.	Lying down to rest in the afternoon when circumstances permit?	□	□	□	□
f.	Sitting and talking to someone?	□	□	□	□
g.	Sitting quietly after a lunch without alcohol?	□	□	□	□
h.	In a car while stopped for a few minutes in traffic?	□	□	□	□
i.	While driving?	□	□	□	□

The next set of questions ask about snoring and sleep apnea in the last 4 weeks.

7. In the last 4 weeks, have you snored?
    a. Yes
    b. No (SKIP TO Q11)
    c. Don't know (SKIP TO Q11)

8. In the last 4 weeks, your snoring has been?
    a. Slightly louder than breathing
    b. As loud as talking
    c. Louder than talking
    d. Very loud - could be heard in adjacent rooms

9. In the last 4 weeks how often have you snored?
    a. Nearly every day
    b. 3-4 times a week
    c. 1-2 times a week
    d. 1-2 times a month
    e. Nearly never

10. In the last 4 weeks, has your snoring ever bothered other people?
    a. Yes
    b. No
    c. Don't know

11. In the last 4 weeks, has anyone noticed that you quit breathing during your sleep?
    a. Nearly every day
    b. 3-4 times a week
    c. 1-2 times a week
    d. 1-2 times a month
    e. Nearly never
    f. Never

12. In the last 4 weeks, how often did you feel tired or fatigued after your sleep?
    a. Nearly every day
    b. 3-4 times a week
    c. 1-2 times a week
    d. 1-2 times a month
    e. Nearly never
    f. Never

13. During your waking time in the last 4 weeks, did you feel tired, fatigued or not up to par?
    a. Nearly every day
    b. 3-4 times a week
    c. 1-2 times a week
    d. 1-2 times a month
    e. Nearly never
    f. Never

14. In the last 4 weeks, did you ever nod off or fall asleep while driving a vehicle?
    a. Yes
    b. No (SKIP TO NEXT SECTION ON FATIGUE)
    c. Don't drive a vehicle (SKIP TO NEXT SECTION ON FATIGUE)

    14a. How often did this occur?
    a. Nearly every day
    b. 3-4 times a week
    c. 1-2 times a week
    d. 1-2 times a month
    e. Nearly never

Now we would like to ask you some questions about fatigue since your baby was born. Fatigue is when you feel weary, tired, or have a lack of energy.

For each of the following questions, indicate the number that most closely indicates how you have been feeling <u>during the past week</u>.

1. To what degree have you experienced fatigue?

1	2	3	4	5	6	7	8	9	10
Not at all									**A great deal**

If no fatigue (answer choice 1), skip to next section

2. How severe is the fatigue which you have been experiencing?

1	2	3	4	5	6	7	8	9	10
Mild									**Severe**

3. To what degree has fatigue caused you distress?

1	2	3	4	5	6	7	8	9	10
No distress									**A great deal of distress**

In the past week, rate on a scale from 1-10 (1=Not at all, 10=A great deal) the degree fatigue has interfered with your ability to:

(NOTE: Check the box to the right of each activity if you don't do the activity)

Fatigue interfered with your ability to:

4. **Do household chores:** Don't do activity ☐

1	2	3	4	5	6	7	8	9	10
Not at all									**A great deal**

5. **Cook:** Don't do activity ☐

1	2	3	4	5	6	7	8	9	10
Not at all									**A great deal**

6. **Bathe or wash:** Don't do activity ☐

1	2	3	4	5	6	7	8	9	10
Not at all									**A great deal**

7. **Dress:** Don't do activity ☐

1 2 3 4 5 6 7 8 9 10

Not at all **A great deal**

8. **Work:** Don't do activity ☐

1 2 3 4 5 6 7 8 9 10

Not at all **A great deal**

9. **Visit or socialize with friends or family**: Don't do activity ☐

1 2 3 4 5 6 7 8 9 10

Not at all **A great deal**

10. **Engage in sexual activity:** Don't do activity ☐

1 2 3 4 5 6 7 8 9 10

Not at all **A great deal**

11. **Engage in leisure and recreational activities**: Don't do activity ☐

1 2 3 4 5 6 7 8 9 10

Not at all **A great deal**

12. **Shop and do errands**: Don't do activity ☐

1 2 3 4 5 6 7 8 9 10

Not at all **A great deal**

13. **Walk:** Don't do activity ☐

1 2 3 4 5 6 7 8 9 10

Not at all **A great deal**

14. **Exercise, other than walking:** Don't do activity ☐

1	2	3	4	5	6	7	8	9	10
Not at all									**A great deal**

15. Over the past week, how often have you been fatigued?
    a. Every day
    b. Most, but not all days
    c. Occasionally, but not most days
    d. Hardly any days

16. To what degree has your fatigue changed during the past week?
    a. Increased
    b. Fatigue has gone up and down
    c. Stayed the same
    d. Decreased

Health

Now we would like to ask you some questions about your emotions and how you've been feeling lately. There are no "right" or "wrong" answers to any of these questions.

For the following 20 items, please select the choice that best describes how you have felt ***over the past week***:

		Rarely (< 1 day) or never	**Some or a little of the time (1-2 days)**	**Occasionally or a moderate amount of the time (3-4 days)**	**Most or all of the time (5-7 days)**
1	I was bothered by things that don't usually bother me.	①	②	③	④
2	I did not feel like eating; my appetite was poor.	①	②	③	④
3	I felt that I could not shake off the blues even with the help from my family and friends.	①	②	③	④
4	I felt that I was not as good as other people.	①	②	③	④
5	I had trouble keeping my mind on what I was doing.	①	②	③	④
6	I felt depressed.	①	②	③	④

7	I felt that everything I did was an effort.	①	②	③	④
8	I felt hopeless about the future.	①	②	③	④
9	I thought my life had been a failure.	①	②	③	④
10	I felt fearful.	①	②	③	④
11	My sleep was restless.	①	②	③	④
12	I was unhappy.	①	②	③	④
13	I talked less than usual.	①	②	③	④
14	I felt lonely.	①	②	③	④
15	People were unfriendly.	①	②	③	④
16	I did not enjoy life.	①	②	③	④
17	I had crying spells.	①	②	③	④
18	I felt sad.	①	②	③	④
19	I felt that people disliked me.	①	②	③	④
20	I could not get “going”.	①	②	③	④

With this next set of questions we want to know about your level of anxiety over the last two weeks:

1. Over the last 2 weeks, how many days have you been nervous, anxious, or on edge?
    a. 0
    b. 1-2
    c. 3-4
    d. >4
    e. Don't know

2. Over the last 2 weeks, how many days have you not been able to stop or control worrying?
    a. 0
    b. 1-2
    c. 3-4
    d. >4
    e. Don't know

3. Over the last 2 weeks, how many days have you worried too much about different things?
    a. 0
    b. 1-2
    c. 3-4
    d. >4
    e. Don't know

4. Over the last 2 weeks, how many days have you had trouble relaxing?
   a. 0
   b. 1-2
   c. 3-4
   d. >4
   e. Don't know

5. Over the last 2 weeks, how many days have you been so restless that it was hard to sit still?
   a. 0
   b. 1-2
   c. 3-4
   d. >4
   e. Don't know

6. Over the last 2 weeks, how many days have you been easily annoyed or irritable?
   a. 0
   b. 1-2
   c. 3-4
   d. >4
   e. Don't know

7. Over the last 2 weeks, how many days have you felt afraid as if something awful might happen?
   a. 0
   b. 1-2
   c. 3-4
   d. >4
   e. Don't know

Now we would like to know about stress in your life <u>in the last month</u>.

For each question, please check the answer that is most true for you. There are no "right" or "wrong" answers.

		Never (1)	**Almost Never (2)**	**Some-times (3)**	**Fairly Often (4)**	**Often (5)**
1	In the last month, how often have you been upset because of something that happened unexpectedly?	①	②	③	④	⑤
2	In the last month, how often have you felt that you were unable to control the important things in your life?	①	②	③	④	⑤
3	In the last month, how often have you felt nervous and “stressed’?	①	②	③	④	⑤
4	In the last month, how often have you felt confident about your ability to handle your					

	personal problems?	①	②	③	④	⑤
5	In the last month, how often have you felt that things were going your way?	①	②	③	④	⑤
6	In the last month, how often have you found you could not cope with all the things that you had to do?	①	②	③	④	⑤
7	In the last month, how often have you been able to control irritations in your life?	①	②	③	④	⑤
8	In the last month, how often have you felt that you were on top of things?	①	②	③	④	⑤
9	In the last month, how often have you been angered because of things that happened that were outside of your control?	①	②	③	④	⑤
10	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	①	②	③	④	⑤

Infant Feeding

Now we would like to ask you some questions about your new baby!

These questions are about your baby's diet and it is important that you include information from anyone who feeds your baby, including other family members and baby-sitters/daycare.

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. Indicate your answer to this in the first answer column.

   If your baby was fed the food once a day or more, write the number of feedings per day in the second answer column.

   Or, if your baby was fed the food less than once a day, write the number of feedings per week in the third answer column.

	Food Description	**Was your baby fed this food in the past 7 days?**	**Feedings Per Day** *(x)*	**Feedings Per Week** *(x)*

a.	Breast milk	*		
b.	Formula	*		
c.	Cow's milk	*		
d.	Other milk: soy milk, rice milk, goat milk, etc.	*		
e.	Other dairy foods: yogurt, cheese, ice cream, pudding, etc.	*		
f.	Other soy foods: tofu, frozen soy desserts, etc.	*		
g.	100% fruit juice or 100% vegetable juice	*		
h.	Sweet drinks: juice drinks, soft drinks, soda, sweet tea, Kool-Aid, etc.	*		
i.	Baby cereal	*		
j.	Other cereal & starches: breakfast cereal, teething biscuits, crackers, breads, pasta, rice, etc.	*		
k.	Fruit	*		
l.	Vegetables	*		
m.	French fries	*		
n.	Meat, chicken, combination dinners	*		
o.	Fish or shellfish	*		
p.	Peanut butter, other peanut foods, or nuts	*		
q.	Eggs	*		
r.	Sweet foods: candy, cookies, cake, etc.	*		
s.	Other, describe: _____	*		

*** Not fed this food at all in the past 7 days, Fed this food once or more per day in the past 7 days, Fed this food less than once per day in the past 7 days**

2. Have you obtained information about feeding babies from any of the following sources for this baby or a previous one? Think of information you have received about breastfeeding, formula feeding, feeding solid foods, or any other infant feeding information. (select all that apply)

Yes **No**

Doctor, nurse, or other health professional	□	□
WIC food program	□	□
Baby care class or support group	□	□
Relative or friend	□	□
Books or videos	□	□
Newsletters	□	□
Newspapers or magazines	□	□
Television or radio	□	□
Website		

3. What type of baby cereal was your baby fed in the past 7 days? (select one)
   - Dry cereal that you added a liquid to □
   - Cereal in a jar already mixed □
   - Both dry and pre-mixed □

4. Was your baby given any of the following vitamin or mineral drops or pills at least 3 days a week during the <u>past 2 weeks</u>?
   a. Yes
   b. No (SKIP to Q5)

   If "Yes," please indicate which vitamins or minerals were given to your baby. If your baby was given drops or pills that contained more than one of the items listed, please mark each of the separate items.

	Yes	No
Fluoride	□	□
Vitamin D	□	□
Iron	□	□
Other vitamins	□	□

5. Has your baby used a pacifier in the <u>past 7 days</u>?
   a. Yes
   b. No

6. Has your baby been given a bottle in the <u>past 2 weeks</u>?
   a. Yes
   b. No (SKIP to Q9)

7. During the <u>past 2 weeks</u>, how often was your baby put to bed with a bottle of formula, breast milk, juice, juice drink, or any other kind of milk?
   a. At most bedtimes, including naps
   b. At most night bedtimes, but not naps

c. At most naps, but not night bedtimes
d. Only occasionally at bedtimes, including naps
e. Never

8. 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? (SKIP to Q9 if not fed a bottle in past 2 weeks) (SKIP to Q14 if not fed formula in past 7 days (see Q1))

	Never	Only Rarely	Every Few Days	About Once A Day	At Most Feedings	Every Feeding
Vitamins or minerals	□	□	□	□	□	□
Baby cereal	□	□	□	□	□	□
Sweetener	□	□	□	□	□	□
Medicine	□	□	□	□	□	□
Other, specify:_____	□	□	□	□	□	□

9. How often does your baby drink all of his or her bottle of formula?
   a. Never
   b. Rarely
   c. Sometimes
   d. Most of the time
   e. Always

10. In the past 7 days, about how many ounces of formula did your baby drink at each feeding?
   a. 1 to 2
   b. 3 to 4
   c. 5 to 6
   d. 7 to 8
   e. More than 8

11. How often is your baby encouraged to finish a bottle if he or she stops drinking before the formula is all gone?
   a. Never
   b. Rarely
   c. Sometimes
   d. Most of the time
   e. Always

12. 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 check the group number for each infant formula your baby was fed. (check "Yes" or "No" for each group)
   Yes □ No □ Group 1
   Yes □ No □ Group 2
   Yes □ No □ Group 3
   Yes □ No □ Group 4
   Yes □ No □ Group 5
   Yes □ No □ Group 6

(NOTE: FORMULAS AND GROUP NUMBER ARE LISTED IN THE TABLE BELOW)

13. Which of the following describes the iron content of the formula you usually use?
    a. With iron
    b. Low iron (additional iron may be necessary)
    c. No iron

14. Does your baby usually feed from both breasts at each feeding?
    a. Yes
    b. No
    c. Baby is only fed pumped milk (SKIP TO Q17)

15. Does your baby usually let go of the breast him or herself?
    a. Yes, both breasts
    b. Yes, first breast only
    c. Yes, second breast only
    d. No

16. About how long does an average breastfeeding last?
    a. Less than 10 minutes
    b. 10 to 19 minutes
    c. 20 to 29 minutes
    d. 30 to 39 minutes
    e. 40 to 49 minutes50 or more minutes

17. In an average 24-hour period, what is the LONGEST time for you, the mother, between breast feedings 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. **(ENTER IN THE NUMBER OF HOURS AND MINUTES)** __ HH __ MM

18. Was your baby fed pumped breast milk in the <u>past 7 days</u>?
    a. Yes
    b. No (SKIP TO NEXT SECTION)

    18a. If "Yes," how many times in the <u>past 7 days</u> was your baby fed pumped breast milk to drink? Include breast milk you expressed in any way as pumped milk.

    _____ TIMES

19. How often does your baby drink all of his or her cup or bottle of pumped milk?
    a. Never
    b. Rarely
    c. Sometimes
    d. Most of the time
    e. Always

20. 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?
    a. Never
    b. Rarely
    c. Sometimes
    d. Most of the time
    e. Always

Breastfeeding

1. Did you ever breastfeed this baby (or feed this baby your pumped milk)?
    a. Yes
    b. No (SKIP TO NEXT SECTION)

2. Have you completely stopped breastfeeding and pumping milk for your baby?
    a. Yes
    b. No (SKIP TO NEXT SECTION)

3. Did you breastfeed as long as you wanted to?
    a. Yes
    b. No

4. How old was your baby when you completely stopped breastfeeding and pumping milk?
    a. <7 days
        i. (1-6) # of days
    b. 1 week of more
        i. (1-20) # of weeks

5. How important was each of the following reasons for your decision to stop breastfeeding your baby? **(PLEASE ANSWER EACH ITEM)**

	Not at all important	**Not very important**	**Somewhat important**	**Very important**
My baby had trouble sucking or latching on	□	□	□	□
My baby became sick and could not breastfeed	□	□	□	□
My baby began to bite	□	□	□	□
My baby lost interest in nursing or began to wean him or herself	□	□	□	□
My baby was old enough that the difference between breast milk and formula no longer mattered	□	□	□	□
Breast milk alone did not satisfy my baby	□	□	□	□
I thought that my baby was not gaining enough weight	□	□	□	□
A health professional said my baby was not gaining enough weight	□	□	□	□
I had trouble getting the milk flow to start	□	□	□	□
I didn't have enough milk	□	□	□	□
My nipples were sore, cracked, or bleeding	□	□	□	□
My breasts were overfull or engorged	□	□	□	□
My breasts were infected or abscessed	□	□	□	□
My breasts leaked too much				
Breastfeeding was too painful	□	□	□	□
Breastfeeding was too tiring	□	□	□	□
I was sick or had to take medicine	□	□	□	□
Breastfeeding was too inconvenient	□	□	□	□
I did not like breastfeeding	□	□	□	□
I wanted to be able to leave my baby for several hours at a time	□ □	□ □	□ □	□ □
I wanted to go on a weight loss diet	□	□	□	□
I wanted to go back to my usual diet	□	□	□	□
I wanted to smoke again or more than I did while breastfeeding	□ □	□ □	□ □	□ □
I had too many household duties	□	□	□	□
I could not or did not want to pump or breastfeed at work	□	□ □	□ □	□ □
Pumping milk no longer seemed worth the effort that it required	□ □	□ □	□ □	□ □
I was not present to feed my baby for reasons other than work	□	□	□	□
I wanted or needed someone else to feed my baby	□	□	□	□
Someone else wanted to feed the baby	□	□	□	□
I did not want to breastfeed in public	□	□	□	□
I wanted my body back to myself	□	□	□	□
I became pregnant or wanted to become pregnant again	□	□	□	□

Infant Health

1. Has your baby ever had any of the following problems? **(PLEASE MARK ALL THAT APPLY)**

Fever	□
Runny nose or cold	□
Diarrhea	□
Respiratory Syncytial Virus (RSV)	□
Vomiting	□
Cough or wheeze	□
Ear infection	□
Asthma	□
Colic	□
Food allergy	□
Fussy or irritable	□
Eczema (atopic dermatitis)	□
Reflux	□
None of these	□

2. Has your baby ever received any of the following medicines? (Please do not include vitamins or minerals.)

	Yes	No
Antibiotics	□	□
Other prescription medicines	□	□
Non-prescription medicines	□	□

3. Has your baby ever been hospitalized for any reason or has your baby been taken to a hospital for any outpatient procedure or surgery?
   a. Yes
   b. No (SKIP TO Q5)

4. How many nights was your baby in the hospital?_____(nights)

5. How many teeth does your baby have now? (Write in 0 if none) _____(number)

Sleeping Arrangements

1. Please complete the information below for the times your baby was 2 weeks old, 1 month old, 2 months old, and now. Some of the questions ask you to think about "night." If your major time for sleeping is some time other than at night (for example, if you work at night and sleep during the day), please think of your major sleep period when the question asks about "night."

	Baby's age:			
	2 weeks	**1 month**	**2 months**	**Now**
a. What was the longest time your baby usually slept at night without waking?				
i. 2 hours or less	□	□	□	□

ii.	3 to 4 hours	□	□	□	□
iii.	5 to 6 hours	□	□	□	□
iv.	7 to 8 hours	□	□	□	□
v.	8 hours or more	□	□	□	□

b. In what position did you most often lay your baby down for naps at each age?

i.	Side	□	□	□	□
ii.	Stomach	□	□	□	□
iii.	Back	□	□	□	□

c. Where did your baby <u>usually</u> sleep at night?

i.	In your room	□	□	□	□
ii.	In a different room	□	□	□	□

d. What did your baby <u>usually</u> sleep in at night?

i.	Bassinet	□	□	□	□
ii.	Crib	□	□	□	□
iii.	Co-sleeper	□	□	□	□
iv.	In bed or other place with you	□	□	□	□
v.	In something else	□	□	□	□

e. In what position did you most often lay your baby down to sleep at night at each age?

i.	Side	□	□	□	□
ii.	Stomach	□	□	□	□
iii.	Back	□	□	□	□

f. Did you ever lie down with or sleep with your baby at night? (Please check all that apply)

i.	Yes, with the baby in a co-sleeper	□	□	□	□
ii.	Yes, in a bed (standard mattress)	□	□	□	□

iii.	Yes, in a water bed	□	□	□	□
iv.	Yes, on a mattress on the floor	□	□	□	□
v.	Yes, on a couch or other place that is not a bed	□	□	□	□
vi.	No **(IF NO FOR ALL AGES, SKIP TO LAST QUESTION)**	□	□	□	□

g. On the nights you lay down with or slept with your baby, did you usually have the baby with you all night or part of the night? (Include time the baby was in a co-sleeper.)

i.	All night	□	□	□	□
ii.	The first part of the night only	□	□	□	□
iii.	The last part of the night only	□	□	□	□
iv.	Several short times throughout the night	□	□	□	□

h. How many nights per week did you and your baby usually lie down together or sleep together?

i.	Baby did not usually lie down or sleep with me	□	□	□	□
ii.	Less than 1 night a week	□	□	□	□
iii.	1 to 2 nights	□	□	□	□
iv.	3 to 4 nights	□	□	□	□
v.	5 to 6 nights	□	□	□	□
vi.	7 nights per week	□	□	□	□

i. When you and your baby lay down together or slept together, you usually:

i.	Stay with the baby and also sleep	□	□	□	□
ii.	Move baby after he/she is asleep before you go to bed	□	□	□	□

j. On the nights when you and your baby lay down together or slept together, who else usually lay down

with or slept with you?

i.	Your husband or partner	□	□	□	□
ii.	Your other child or children	□	□	□	□
iii.	Other people	□	□	□	□
iv.	No one else	□	□	□	□

2. Do you bring your baby to bed with you?
    a. Yes
    b. No (SKIP to Q4)

3. What are your reasons for bringing your baby to bed with you? (Please check all that apply)

It is commonly done in my family	□
To bottle feed	□
Sleeping with my baby helps the baby or me to sleep better	□
To help with a blocked milk duct or other breastfeeding problem	□
I think it is safer if my baby sleeps with me or us	□
To be close or bond	□
A doctor or nurse advised sleeping with my baby	□
To comfort when fussy breastfeed	□
To comfort when sick	□

4. What are your reasons for not bringing your baby to bed with you? (Please check all that apply)

It is not commonly done in my family	□
We wake each other up, or baby wakes me or others in the bed	□
I think it is safer if my baby does not sleep with me or us	□
I do not think the baby should sleep with me	□
Because I smoke, take sedative medicine, or other reason	□
A doctor or nurse advised not sleeping with my baby	□
I think it will be too hard to get my baby to sleep in a crib when he or she is older	□

Food Allergies

1. Has your baby ever had problems caused by food, such as an allergic reaction, sensitivity, or intolerance?
    a. Yes
    b. No (SKIP TO NEXT SECTION)

2. Did your baby have a reaction the first time he or she ate the food?
    a. Yes
    b. No

3. Were the problems caused by (Please check all that apply)

    o Food your baby ate (including infant formula)
    o Food your baby was exposed to through breast milk because of something you ate

4. How old was your baby the first time he or she had a problem with food? (include food your baby reacted to through breast milk.)
    a. 1 month or less
    b. 2 months
    c. 3 months
    d. 4 months

5. Did you take your baby to a medical doctor because of these problems with food?
    a. Yes
    b. No

6. If your baby was tested or examined for food allergy, what method was used? (Please check all that apply). If your baby was not tested for food allergies, mark "None" and go to the next question.
    □None
    □Parents' description of symptoms
    □A skin test
    □A blood test such as RAST, or CAP-RAST
    □An esophageal or intestinal study
    □Food elimination (withdrawal of the specific food to see if symptoms disappeared)
    □Food challenge (introduction of a specific food to see if symptoms reappeared)
    □Other(Please specify:)_____

7. Was your baby diagnosed by a medical doctor as having an allergy to any food?
    a. Yes
    b. No

8. What symptoms of a problem with food has your baby had? **(**Please check all that apply**)**

□Congestion
□Runny nose
□Asthma or wheezing
□Trouble breathing
□Coughing
□Swollen eyes and or lips
□Hives or welts
□Flushing
□Skin rash or eczema
□Spitting up
□Diarrhea
□Gassiness or stomach cramps
□Vomiting
□Constipation
□Colic
□Irritability
□Sleeplessness
□Blood in stool
□Loss of consciousness

9. How have these symptoms been treated? (Please check all that apply)
    □Treated in a doctor's office or emergency room
    □Treated by emergency medical technician
    □Admitted to a hospital
    □Given epinephrine, such as with an EpiPen
    □Given benedryl or other anti-histamine
    □Prescribed an EpiPen or other epinephrine
    □ Other (Please specify):_____

10. Please indicate which foods caused a problem for your baby in "Baby had a problem with" column, including food your baby reacted to through breast milk. In "Baby diagnosed as allergic to" column, indicate the foods that your baby has been diagnosed as allergic to (If your baby has had a problem with a food and has been diagnosed as allergic to the food, mark both columns for that food.) (Please check all that apply)

	10a. Baby had a problem with	10b. Baby diagnosed as allergic to
Cow's milk or other dairy products (including infant formula made with cow milk)	□	□
Soy milk or other soy food (including infant formula made with soy)	□	□
Eggs	□	□
Peanuts, peanut butter, or peanut oil	□	□
Nuts (such as, almonds, pecans, walnuts)	□	□
Sesame seed, tahini, or sesame seed oil	□	□
Fish, shellfish, or other seafood	□	□
Beef, chicken or turkey	□	□
Wheat, gluten, or wheat starch	□	□
Other grain or cereal (such as oats, barley)	□	□
Fruit or fruit juice	□	□
Vegetable	□	□
Other food (Please specify:) _____	□	□

11. Has your baby had a problem with infant formula?
    a. Yes
    b. No (SKIP to NEXT SECTION)

12. Which infant formula has your baby had a problem with? Infant formulas are listed alphabetically on the insert along with a group number. Please mark the group number for each formula your baby had a problem with. (Please check all that apply)
    □Group 1
    □Group 2
    □Group 3
    □Group 4
    □Group 5
    □Group 6

(NOTE: FORMULAS AND GROUP NUMBER ARE LISTED IN TABLE BELOW)

13. How many of the different formulas listed on the insert has your baby had a problem with?
    □ 1
    □ 2
    □ 3
    □ 4
    □ 5 or more

Many of these formulas are represented by the same number. To make it easy for you to find your formula, they are listed alphabetically by brand instead of by number.

EleCare ..... Group 1
Enfamil ..... Group 2
Enfamil AR LIPIL ..... Group 3
Enfamil Gentlease LIPIL..... Group 3
Enfamil LactoFree LIPIL ..... Group 3
Enfamil LIPIL ..... Group 3

Enfamil Next Step LIPIL ..... Group 3
Enfamil Next Step ProSobee LIPIL ..... Group 4
Enfamil ProSobee..... Group 5
Enfamil ProSobee LIPIL ..... Group 4
Enfamil Nutramigen LIPIL..... Group 6
Enfamil Pregestimil..... Group 6
Horizon Organic..... Group 2
Isomil ..... Group 5
Isomil Advance ..... Group 4
Isomil 2 ..... Group 5
Isomil 2 Advance ..... Group 4
Isomil DF..... Group 5
Neocate ..... Group 1
Nestlé Good Start Essentials..... Group 2
Nestlé Good Start 2 Essentials..... Group 2
Nestlé Good Start Essentials Soy ..... Group 5
Nestlé Good Start 2 Essentials Soy ..... Group 5
Nestlé Good Start Essentials Soy DHA and ARA ..... Group 4
Nestlé Good Start Supreme ..... Group 2
Nestlé Good Start Supreme DHA and ARA ..... Group 3
Nestlé Good Start Supreme 2 DHA and ARA ..... Group 3
Nestlé NAN DHA and ARA..... Group 3
Similac ..... Group 2
Similac Advance ..... Group 3
Similac 2 ..... Group 2
Similac 2 Advance ..... Group 3
Similac Alimentum Advance ..... Group 6
Similac Lactose Free Advance ..... Group 3
Similac Neosure Advance ..... Group 3
Store brand milk based without DHA and ARA ..... Group 2
Store brand milk based with DHA and ARA ..... Group 3
Store brand soy based without DHA and ARA..... Group 5
Store brand soy based with DHA and ARA..... Group 4

Child Care

1. Was your baby cared for by someone other than you on a regular schedule during the past month? That is, did someone else usually keep your baby at least once a week for three or more hours at a time? (Include arrangements in which the exact day or time may change if the child care usually occurred at least once a week.) **Please mark "yes" if your baby is regularly cared for by anyone other than you, including the baby's father or other close relative.**
    a. Yes
    b. No (SKIP TO NEXT SECTION)

2. Who usually kept your baby regularly during the past 4 weeks? **(PLEASE MARK ALL THAT APPLY)**

   □Baby's father

   □Other family member(s)

   □Baby's grandparent(s)

   □Other relative

   □Someone not in your family

3. Where did the child care usually occur? **(PLEASE MARK ALL THAT APPLY)**

   □Baby's home with no other children

   □Other private home with no other children

   □Baby's home with other children or baby's brothers or sisters

   □Other private home with other children or baby's brothers or sisters

   □Day care or child care center

   □Other

   Please specify: _____

4. How many days in an average week was your baby cared for by your regularly scheduled child care provider(s)? (Include days your baby was cared for by family members if they regularly provide child care while you are away from the baby)

   _____ days per week

5. On an average day when your baby was with your regular child care provider(s), how many hours was he or she with the child care provider(s)? _____ hours

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 MARK ALL THAT APPLY)**
   a. Yes, I was enrolled or got WIC food for myself
   b. Yes, my baby was enrolled or got WIC formula or food
   c. No

2. Does your baby have any serious, long-term medical problems:
   a. Yes
      i. Please explain briefly :_____
   b. No