Date:_____

Infant's Initials:_____

Infant Growth and Hormonal Development Study: Parental Questionnaire

We are asking you to fill out this questionnaire to provide us with background information about yourself, your pregnancy and your infant. We also ask about your current infant feeding and sleeping practices. This information, like all other information collected in the study, will be kept confidential.

Background Information

Maternal Age: _____ Maternal Height:_____

Maternal Pre-pregnancy Weight:_____ Current Wt: _____

Pregnancy Wt Gain:_____

Paternal Age :_____Paternal Height:_____

Paternal Weight:_____

Do you have any other children? Y / N

If yes, how many? _____

Age(s) and Sex(s):_____

_____

Maternal Educational Background:

- ☐ High school graduate
- ☐ Attending/ed college
- ☐ College graduate
- ☐ Attending/ed graduate school
- ☐ Graduate degree
- ☐ Other: _____

Paternal Educational Background:

- ☐ High school graduate
- ☐ Attending/ed college
- ☐ College graduate
- ☐ Attending/ed graduate school
- ☐ Graduate degree
- ☐ Other: _____

Family Socioeconomic Status: Please check the income level that is most appropriate for your family.

- ☐ Prefer not to answer
- ☐ Less than $25,000
- ☐ $25,000-$75,000
- ☐ Greater than $75,000

Ethnicity: Please check the ethnic identity that is most appropriate for your infant.

- □ Prefer not to answer
- □ African-American/Non-Hispanic
- □ Caucasian/Non-Hispanic
- □ Native American or Alaskan Native
- □ Asian or Pacific Islander
- □ Hispanic
- □ Other:_____

Pregnancy and Medical Conditions

Did you experience any of the following during your pregnancy?

Gestational diabetes? Y / N

Hypertension? Y / N

Smoking? Y / N If yes, how many cigarettes per day? _____

Do you have medical conditions that may have affected your pregnancy?

Kidney/Liver problems:_____

Infectious illnesses:_____

Any other conditions:_____

Did you take any medications during your pregnancy?

Medications:_____

Prenatal Vitamins: _____

Herbal Remedies/Supplements:_____

Are you currently taking any medications?

Medications:_____

Prenatal Vitamins: _____

Herbal Remedies/Supplements:_____

Birth Control Pills/Hormonal Supplements:_____

Birthing Experience

Type of birth (circle one): Vaginal Caesarian Forceps Other:_____

Length of labor (hours): _____

Type of practitioner: OB/GYN Midwife Other:_____

Hospital:_____

Were you given any medical interventions during labor?

Anathesia_____

Pitocin _____

Other_____

Infant Information

Infant date of birth _____ Time of birth _____am/pm

Infant Sex: _____ Birthweight: _____

Birth length: _____ Apgar score: _____

Gestational age at birth: _____

Infant Feeding Decisions

Are you currently breastfeeding? Y / N

If yes, why did you choose to breastfeed?

If you are not breastfeeding, did you plan on breastfeeding? Y / N

If you planned on breastfeeding and are not, why not?

Are you currently formula feeding your infant? Y / N

If yes, what type of formula? _____

If yes, why did you choose to formula feed?

Was formula offered to your infant in the hospital? Y / N

If yes, why was it suggested? _____

When was it suggested?_____

Who suggested it?_____

Did you get any feeding advice while you were in the hospital? Y / N

If yes, what was the advice?

Who advised you?

Did you have access to a lactation consultant? Y / N

If yes, did you see the lactation consultant? Y / N

Approximately how often does your infant eat?_____

Is your infant fed on a schedule? Y / N

If yes, what is that schedule?_____

Who had the most influence on what you decided to feed your infant?

Please indicate how influential the following people have been in your decisions regarding what/how to feed your infant:

	N/A (Did not consult)	Little to No Influence	Some Influence	Moderate Influence	Strong Influence	Very Strong Influence
Spouse or partner		1	2	3	4	5
Mother		1	2	3	4	5
Mother-in-law		1	2	3	4	5
Sister		1	2	3	4	5
Brother		1	2	3	4	5
Other female relative		1	2	3	4	5
Other male relative		1	2	3	4	5
Friend		1	2	3	4	5
Nurse		1	2	3	4	5
Pediatrician		1	2	3	4	5
OB-GYN		1	2	3	4	5
Midwife		1	2	3	4	5
Lactation Consultant		1	2	3	4	5
Other (please specify)		1	2	3	4	5

Infant Sleeping Behavior

Approximately how many hours per day does your infant sleep? _____

When does your infant seem to sleep the most? _____

Is he or she sleeping through the night? _____

Are you trying to get your infant to sleep on a schedule? _____

Do you feed your infant to make him/her sleepy? _____

Where does your baby usually sleep (circle all that apply):

basinet in parents' bedroom crib in own room

bed with parents carrier/ car seat

other:_____