| | |
|---|---|
| **I. STUDY NUMBER** | _____ |
| **II. TODAY'S DATE** | __ __/__ __/__ __ |
| **III. RA INITIALS** | ___ ___ ___ |

# ONE-YEAR QUESTIONNAIRE

## Thank you for continuing to be a part of Project Viva!

**Please complete this One-Year Questionnaire within 2 weeks and mail it in the large pre-stamped envelope to:**

**Project Viva**
**Harvard Pilgrim Health Care**
**PO Box 15710**
**Boston, MA 02215**

**Please note:**

- **This questionnaire is about your one-year old child, _____. When we refer to "your child," please respond with this one-year old child in mind.**
- **This questionnaire will take approximately 20 minutes to complete.**
- **Read each question carefully and answer it as best you can. Remember, there are no right or wrong answers.**
- **Your answers will be kept completely confidential. We use a study identification number instead of your name on all our forms.**

**If you have any questions, please feel free to call us at (617) 421-6067.**

**SECTION A: PHYSICAL ENVIRONMENT**

**This first section is about the home where your one-year old child usually sleeps at night.**

A1. Do you and your child live in the same home?

❑$_1$ Yes

❑$_2$ No (**SKIP to SECTION B**)

A2. Counting yourself, how many adults (persons older than 18) live in your home?

___ ___ adults

a) How many of these adults currently smoke?

___ ___ adults

A3. How many children between the ages of 12 and 17 live in your home?

___ ___ children age 12 to 17 (**IF "00" SKIP TO A4**)

a) How many of these children age 12 to 17 currently smoke?

___ ___ children age 12 to 17

A4. Counting your child, how many children under the age of 12 live in your home?

___ ___ children under age 12

A5. Do you <u>currently</u> smoke cigarettes?

❑$_1$ Yes →

❑$_2$ No

a) On average, how many cigarettes per day do you <u>currently</u> smoke?

- ❑$_1$ Less than 1 cigarette per day
- ❑$_2$ 1 to 4 cigarettes per day
- ❑$_3$ 5 to 14 cigarettes per day
- ❑$_4$ 15 to 24 cigarettes per day
- ❑$_5$ 25 cigarettes or more per day

A6. <u>Since your child was 6 months old,</u> on average, how many hours per week has <u>your child</u> been exposed to cigarette smoke? Please include time spent at home, in restaurants, and in day care.

- ❑$_1$ 0 to less than 1 hour per week
- ❑$_2$ 1 to 4 hours per week
- ❑$_3$ 5 to 8 hours per week
- ❑$_4$ 9 to 12 hours per week
- ❑$_5$ More than 12 hours per week

A7. <u>Since your child was 6 months old</u>, have you owned…?

| | **Yes** | **No** |
|---|---|---|
| a) A dog | ❑$_1$ | ❑$_2$ |
| b) A cat | ❑$_1$ | ❑$_2$ |
| c) Another furry pet, for example, gerbil, hamster, guinea pig or rabbit | ❑$_1$ | ❑$_2$ |
| d) A bird | ❑$_1$ | ❑$_2$ |
| e) Some other pet, for example, fish | ❑$_1$ | ❑$_2$ |

A8. How many rooms are in your home? Please do not count bathrooms, porches, balconies, or hallways.

___ ___ rooms

a) Of these rooms, how many are bedrooms (a room where someone sleeps)?

___ ___ bedrooms

A9. Which of the following best describes the building in which your child lives? Include all apartments, flats, etc., even if vacant.

- ❑1 A one-family house detached from any other houses
- ❑2 A one-family house attached to one or more houses
- ❑3 A building with 2 or 3 apartments
- ❑4 A building with 4 or more apartments
- ❑5 Other

A10. Is there carpeting or a rug in the room where your child…?

| | Yes | No |
|---|---|---|
| a) Usually sleeps at night | ❑1 | ❑2 |
| b) Spends most awake time (e.g., family/TV room) | ❑1 | ❑2 |

A11. Since your child was born, have you ever used any of the following in the room where your child sleeps?

| | Yes | No |
|---|---|---|
| a) A room air conditioner | ❑1 | ❑2 |
| b) Central air conditioner | ❑1 | ❑2 |
| c) A dehumidifier | ❑1 | ❑2 |
| d) A humidifier or vaporizer | ❑1 | ❑2 |

A12. Do you have a gas cooking stove, a gas range or a gas oven?

- ❑1 Yes
- ❑2 No
- ❑9 Don't know

A13. Is there any moisture or mildew anywhere in your home on the…

| | Yes | No | Don't Know |
|---|---|---|---|
| a) Ceiling | ❑1 | ❑2 | ❑9 |
| b) Walls | ❑1 | ❑2 | ❑9 |
| c) Windows | ❑1 | ❑2 | ❑9 |

A14. Since your child was born, has there been water damage to the building or its contents (for example, from broken pipes, leaks, or a flood)?

- ❑1 Yes
- ❑2 No
- ❑9 Don't know

A15. Since your child was born, has water collected on the basement floor?

- ❑1 Yes
- ❑2 No
- ❑9 Don't know

A16. Since your child was born, have you seen or noticed signs of any of the following in your home?

| | Yes | No | Don't Know |
|---|---|---|---|
| a) Cockroaches | ❑1 | ❑2 | ❑9 |
| b) Rats or mice | ❑1 | ❑2 | ❑9 |

## SECTION B. YOUR CHILD'S HEALTH

**These next few questions are about your child's health.**

| | | Excellent | Very Good | Good | Fair | Poor |
|---|---|---|---|---|---|---|
| B1. | In general, would you say <u>your child's</u> health is: | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |

B2. Are you worried that your child will become overweight as he/she is growing up?

❑1 Yes

❑2 No

B3. Are you worried that your child will become underweight as he/she is growing up?

❑1 Yes

❑2 No

**This next question is about over-the-counter medicines, that is, medicines you can buy without a prescription.**

B4. <u>Since your child was born</u>, how many times has he/she taken each of the following? Please count each individual dose as a single time.

| | Never | 1 to 5 times | 6 to 10 times | More than 10 times |
|---|---|---|---|---|
| a) Advil, Motrin, or any other ibuprofen? | ❑1 | ❑2 | ❑3 | ❑4 |
| b) Tylenol or other acetaminophen, non-aspirin pain reliever? | ❑1 | ❑2 | ❑3 | ❑4 |
| c) Regular aspirin? | ❑1 | ❑2 | ❑3 | ❑4 |

B5. Since your child was born, how many times has your child had an episode of…

| | Never | Once | More than once |
|---|---|---|---|
| a) Runny nose or cold | ❑1 | ❑2 | ❑3 |
| b) Barking or croupy cough | ❑1 | ❑2 | ❑3 |
| c) Diarrhea severe enough to call or visit the doctor | ❑1 | ❑2 | ❑3 |

B6. Since your child was born, has he/she ever had wheezing (or whistling in the chest)?

❑1 Yes →

❑2 No

❑9 Don't know

a) How many attacks or episodes of wheezing has he/she had?

- ❑1 One
- ❑2 More than one

b) How recent was the last attack?

- ❑1 More than one month ago
- ❑2 Within the past month, but more than a week ago
- ❑3 Within the past week, but not today
- ❑4 Having an attack today
- ❑9 Don't know

c) How often, on average, has his/her sleep been disturbed due to wheezing?

- ❑1 Never
- ❑2 Less than one night per week
- ❑3 One or more nights per week
- ❑9 Don't know

B7. Since your child was born, have you ever been told by a health care professional (such as a doctor, physician assistant or nurse practitioner) that your child has…

| | | | |
|---|---|---|---|
| a) Eczema (atopic dermatitis)? | ❑1 Yes<br>❑2 No | | |
| b) Hay fever, seasonal allergies or allergic rhinitis (runny nose due to allergies)? | ❑1 Yes<br>❑2 No | | |
| c) Ear infection (otitis media)? | ❑1 Yes →<br>❑2 No | i. How many ear infections has your child had? | ___ ___<br>**ear infections** |
| d) Sinus trouble? | ❑1 Yes<br>❑2 No | | |
| e) Bronchiolitis? | ❑1 Yes →<br>❑2 No | i. Was your child ever kept in the hospital overnight for bronchiolitis? | ❑1 Yes<br>❑2 No |
| f) Pneumonia? | ❑1 Yes →<br>❑2 No | i. Was your child ever kept in the hospital overnight for pneumonia? | ❑1 Yes<br>❑2 No |
| g) Bronchitis, croup, or any other respiratory infection? | ❑1 Yes →<br>❑2 No | i. Was your child ever kept in the hospital overnight for bronchitis, croup, or any other respiratory infection? | ❑1 Yes<br>❑2 No |
| h) Asthma? | ❑1 Yes<br>❑2 No | | |
| i) Wheezing or reactive airways? | ❑1 Yes<br>❑2 No | | |

**Look Closer!**

**If you answered "Yes" to <u>either</u> "h" or "i", please continue to question B8 on the next page.**

**If you answered "No" to <u>both</u> questions "h" and "i", please skip to question B11 on page 10.**

**Please answer these questions if you have been told by a health care professional that your child has asthma, wheezing, or reactive airways. Otherwise, please continue to question B11 on the next page.**

B8. Has your child ever taken any of the following medications? If you are not sure but still have the medicine container, please check the name of the medicine from the label on the container.

| | | | |
|---|---|---|---|
| a) Albuterol (Proventil, Ventolin) by nebulizer or inhaler | ❑1 Yes → ❑2 No | i. Has your child taken this in the past month? | ❑1 Yes ❑2 No |
| b) Albuterol syrup (Proventil, Ventolin) by mouth | ❑1 Yes → ❑2 No | i. Has your child taken this in the past month? | ❑1 Yes ❑2 No |
| c) Prednisone, Prelone, or other steroids by mouth | ❑1 Yes → ❑2 No | i. Has your child taken this in the past month? | ❑1 Yes ❑2 No |
| d) Cromolyn (Intal) or Nedocromil (Tilade) by nebulizer or inhaler | ❑1 Yes → ❑2 No | i. Has your child taken this in the past month? | ❑1 Yes ❑2 No |

e) Has your child taken any other medications for asthma, wheezing or reactive airways?

❑1 Yes →

❑2 No

i. What other medication(s) has your child taken?

_____

_____

B9. Do you have a nebulizer at home for your child's inhaled asthma treatment?

❑1 Yes

❑2 No

B10. Since your child was 6 months old, how many times has he/she been…

| | Never | Once | More than once |
|---|---|---|---|
| a) To doctor's office visits for urgent treatment for asthma, wheezing or reactive airways | ❑1 | ❑2 | ❑3 |
| b) To the emergency room to be treated for asthma, wheezing or reactive airways | ❑1 | ❑2 | ❑3 |
| c) Kept in the hospital overnight for asthma, wheezing or reactive airways | ❑1 | ❑2 | ❑3 |

B11. At your child's 1-year pediatric visit, approximately how much did your child weigh in pounds?

___ ___ pounds

❑9 I don't know /didn't have the appointment yet

B12. At your child's 1-year pediatric visit, approximately how long was your child in inches?

___ ___ inches

❑9 I don't know /didn't have the appointment yet

**SECTION C: YOUR HEALTH**

**These next questions are about <u>your health</u>.**

| | | Excellent | Very Good | Good | Fair | Poor |
|---|---|---|---|---|---|---|
| C1. | <u>In the past month,</u> in general, would you say <u>your</u> health is: | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |

C2. Has a health professional (such as a doctor, physician assistant, or nurse practitioner) <u>ever</u> told you that <u>you</u> had…

| | | Yes | No |
|---|---|---|---|
| a) | Thyroid disease | ❑1 | ❑2 |
| b) | Asthma | ❑1 | ❑2 |
| c) | Hay Fever, seasonal allergies or allergic rhinitis | ❑1 | ❑2 |
| d) | Eczema (Atopic dermatitis) | ❑1 | ❑2 |

C3. Has the <u>biological father</u> of your child <u>ever</u> had any of the following conditions diagnosed by a health professional (such as a doctor, physician assistant, or nurse practitioner)?

| | | Yes | No | Don't Know |
|---|---|---|---|---|
| a) | Asthma | ❑1 | ❑2 | ❑9 |
| b) | Hay Fever, seasonal allergies or allergic rhinitis | ❑1 | ❑2 | ❑9 |
| c) | Eczema (Atopic dermatitis) | ❑1 | ❑2 | ❑9 |

C4. How would you classify <u>your</u> current weight?

- ❑1 Markedly underweight
- ❑2 Underweight
- ❑3 Average
- ❑4 Overweight
- ❑5 Markedly Overweight

C5. <u>In the past month</u>, on average, how many hours per week have <u>you</u> spent...

a) Watching TV or video tapes?

___ ___ hours per week

b) Walking (include walking for fun or exercise, walking <u>to</u> work, but not walking <u>at</u> work)?

___ ___ hours per week

C6. <u>In the past month</u>, on average, how many hours per week have <u>you</u> spent engaged in…

a) Light or moderate recreational activities or sports such as bowling, yoga, stretching classes, skating, or other similar activities? (Do not include walking.)

___ ___ hours per week

b) Vigorous recreational activities or sports such as jogging, swimming, cycling, aerobic dance, skiing, or other similar activities?

___ ___ hours per week

C7. In the past month, have you experienced any of the following conditions…

| | Yes, this is a major problem for me | Yes, this is a minor problem for me | No, I have not experienced this |
|---|---|---|---|
| a) Hemorrhoids | ❑1 | ❑2 | ❑3 |
| b) Varicose veins | ❑1 | ❑2 | ❑3 |
| c) Problem holding urine when you jump or sneeze (Incontinence) | ❑1 | ❑2 | ❑3 |
| d) Sore Breasts | ❑1 | ❑2 | ❑3 |
| e) Back pain | ❑1 | ❑2 | ❑3 |
| f) Sciatica (shooting pain in legs or back) | ❑1 | ❑2 | ❑3 |
| g) Pain with sex or avoiding sex because of pain | ❑1 | ❑2 | ❑3 |

C8. In the past month, how many hours of sleep did you get in an average 24-hour period?

___ ___ hours of sleep

C9. In the past month, did you feel that you were getting enough sleep?

❑1 Yes

❑2 No

C10. Since your child was born, have you become pregnant?

❑1 Yes → a) Are you still pregnant?

- ❑1 Yes
- ❑2 No, I had another baby
- ❑3 No, I had a miscarriage or an abortion

❑2 No

C11. Since your child was born, not counting your routine post-partum visit, have you seen a health care provider (such as a doctor, physician assistant or nurse practitioner) for your own health?

- ❑1 Yes
- ❑2 No

C12. How much do you weigh now?

___ ___ ___ pounds **OR**

___ ___ ___ kilograms

**This next question is about your marital status.**

C13. Which of the following best describes your current marital status?

- ❑1 Married
- ❑2 Not married, but living with a partner
- ❑3 Never married
- ❑4 Divorced
- ❑5 Separated
- ❑6 Widowed

**SECTION D: UPDATE ON YOUR CHILD'S DIET**

D1. Have you <u>ever</u> breastfed your child?

❑$_1$ Yes

❑$_2$ No (**SKIP to D2**)

a) Are you still breastfeeding at all?

❑$_1$ Yes (**SKIP to D2**)

❑$_2$ No

b) How old was your child when you stopped breastfeeding?

___ ___ months **OR**

___ ___ weeks **OR**

___ ___ days

c) Did you breastfeed your child as long as you wanted to?

❑$_1$ Yes

❑$_2$ No

d) Please indicate which of the following reasons played a role in your decision to stop breastfeeding your child: (*Check all that apply)*

❑ I felt my child had the full benefits of breastfeeding

❑ I was sick or taking medication

❑ I found bottle feeding easier or more convenient

❑ Breastfeeding was too tiring

❑ I returned to work or school

❑ I wanted my body back

- ❑ I know how many ounces my child is getting with formula
- ❑ I wasn't producing enough breastmilk to satisfy my child
- ❑ I wanted someone else to be able to feed my child
- ❑ I had difficulty or didn't like pumping breastmilk
- ❑ It was too difficult to breastfeed/pump once I'd returned to work
- ❑ My child lost interest in breastfeeding
- ❑ My child bit while nursing
- ❑ Breastfeeding took too much time away from my other children
- ❑ I felt uncomfortable breastfeeding around other people
- ❑ I did not get enough support or instruction from my child's pediatrician or other health care provider
- ❑ My partner wanted me to stop breastfeeding
- ❑ Other, Specify: _____

D2. From age 6 through 8 months, which one of the following did your child mostly drink? (*Check only one*)

- ❑$_1$ Formula →
- ❑$_2$ Breastmilk
- ❑$_3$ Cow's milk
- ❑$_4$ Other milk (for example, goat's milk)

a) What brand of formula did your child mostly drink from age 6 through 8 months?

- ❑$_1$ Enfamil or Similac
- ❑$_2$ Soy-based formula (for example: Isomil, Prosobee, Nursoy)
- ❑$_3$ Other, Specify: _____

D3. From age 6 through 8 months, which of the following did your child also drink more than a few times? (*Check all that apply)*

- ❑ My child only drank what I indicated in the previous question **(SKIP TO D4)**
- ❑ Enfamil or Similac formula
- ❑ Soy-based formula (for example: Isomil, Prosobee, Nursoy)
- ❑ Other formula
- ❑ Breastmilk
- ❑ Cow's milk
- ❑ Other milk (for example, goat's milk)

D4. From age 9 through 11 months, which one of the following did your child mostly drink? (*Check only one*)

- ❑$_1$ Formula →
- ❑$_2$ Breastmilk
- ❑$_3$ Cow's milk
- ❑$_4$ Other milk (for example, goat's milk)

a) What brand of formula did your child mostly drink from age 9 through 11 months?

- ❑$_1$ Enfamil or Similac
- ❑$_2$ Soy-based formula (for example: Isomil, Prosobee, Nursoy)
- ❑$_3$ Other, Specify: _____

D5. From age 9 through 11 months, which of the following did your child also drink more than a few times? (*Check all that apply)*

- ❑ My child only drank what I indicated in the previous question **(SKIP TO D6)**
- ❑ Enfamil or Similac formula
- ❑ Soy-based formula (for example: Isomil, Prosobee, Nursoy)
- ❑ Other formula
- ❑ Breastmilk
- ❑ Cow's milk
- ❑ Other milk (for example, goat's milk)

D6. In the past month, has your child taken any of the following vitamins or supplements?

| | Yes | No |
|---|---|---|
| a) Fluoride drops, for example, Tri-Vi-Flor or Poly-Vi-Flor | ❑1 | ❑2 |
| b) Multi-vitamin drops such as Tri-Vit (Tri-Vi-Sol) or Poly-Vi-Sol | ❑1 | ❑2 |
| c) Iron drops | ❑1 | ❑2 |
| d) Other vitamins or supplements: Specify_____ | ❑1 | ❑2 |

D7. In the past month, how many ounces of fruit juice did your child drink in an average day (24-hour period)?

- ❑1 None
- ❑2 Less than 8 ounces
- ❑3 8 to 15 ounces
- ❑4 16 to 31 ounces
- ❑5 32 ounces or more

D8. In the past month, how many ounces of water did your child drink in an average day (24-hour period)?

- ❑1 None
- ❑2 Less than 8 ounces
- ❑3 8 to 15 ounces
- ❑4 16 to 31 ounces
- ❑5 32 ounces or more

D9. How old was your child when you <u>first</u> fed him/her…

| | | Have not fed this to my child | Less than 6 months old | 6 to 8 months old | 9 to 11 months old | 12 months or older |
|---|---|---|---|---|---|---|
| a) | Baby cereal | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| b) | Other starches (for example, teething biscuits, crackers, breads, pasta, rice) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| c) | Fruit juice | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| d) | Fruit (including baby food) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| e) | Vegetables (including baby food) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| f) | Meat, chicken, or turkey (including baby food) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| g) | Cow's milk (not formula) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| h) | Other cow's milk dairy products (for example, yogurt, cheese) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| i) | Soy milk (not formula) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| j) | Peanut butter | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| k) | Eggs | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| l) | Fish | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| m) | Sweets (for example, candy, soft drinks, cookies, ice cream) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |

**Please indicate how much you agree or disagree with each of the following statements.**

| | | Strongly agree | Agree | Disagree | Strongly disagree | Not applicable |
|---|---|---|---|---|---|---|
| D10. | I often have to encourage my child to eat more | ❑1 | ❑2 | ❑3 | ❑4 | |
| D11. | I have to be sure that my child finishes the bottle | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D12. | I have to be sure that my child finishes everything in the cup | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D13. | I have to be sure that my child finishes all the baby food in the jar | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D14. | I have to be sure that my child finishes all the food on the plate | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D15. | If my child refuses to eat a new food, I continue to offer it to him/her at other times | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D16. | My child likes vegetables | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D17. | My child likes fruits | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D18. | My child usually likes new foods | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| D19. | I have to be careful not to feed my child too much | ❑1 | ❑2 | ❑3 | ❑4 | |

**SECTION E: YOUR CHILD'S DEVELOPMENT**

**Please indicate how old your child was when he/she was first able to do each of the following. If your child is not yet able to do one of the activities, please check, "My child does not do this yet."**

E1. How old was your child when he/she was first able to…

| | | My child does not do this yet | Less than 6 months old | 6 to 8 months old | 9 to 11 months old | 12 months or older |
|---|---|---|---|---|---|---|
| a) | Roll over without assistance | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| b) | Sit up without being supported | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| c) | Crawl (i.e., move forward on hands and knees) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |
| d) | Walk (i.e., take at least five steps without holding on) | ❑1 | ❑2 | ❑3 | ❑4 | ❑5 |

E2. How many teeth does your child have? Please include only those teeth that have already broken through the gums (i.e., are visible).

___ ___ teeth

E3. In the past month, on average, for how long does your child sleep in a usual 24-hour period? Please include morning naps, afternoon naps and nighttime sleep.

___ ___ hours and ___ ___ minutes

**This next question is about the past week.**

E4. In the past week, how much time did your child watch T.V. or videos? By "watching" we mean that your child was in a place where he/she could see a television that was on.

___ ___ hours and ___ ___ minutes (**Total for the whole week**)

**These questions are about day care or babysitting.**

E5. Since your child was born, has he/she spent time at a day care center (i.e., a day care facility not in someone's home)?

❑$_1$ Yes → a) At what ages did your child go there? (*Check all that apply)*

- ❑ 0 to 5 months old
- ❑ 6 to 11 months old
- ❑ 12 months old or older

b) On average, how many other children were there with your child? (*Check only one*)

- ❑$_1$ 0 other children
- ❑$_2$ 1 to 5 other children
- ❑$_3$ 6 to 10 other children
- ❑$_4$ More than 10 other children

❑$_2$ No

E6. Since your child was born, has he/she spent time at day care in someone else's home?

❑$_1$ Yes → a) At what ages did your child go there? (*Check all that apply)*

- ❑ 0 to 5 months old
- ❑ 6 to 11 months old
- ❑ 12 months old or older

b) On average, how many other children were there with your child? (*Check only one*)

- ❑$_1$ 0 other children
- ❑$_2$ 1 to 5 other children
- ❑$_3$ 6 to 10 other children
- ❑$_4$ More than 10 other children

❑$_2$ No

E7. Since your child was born, has he/she spent time at a day care inside your home, including a nanny or regular babysitter?

❑$_1$ Yes →

❑$_2$ No

a) At what ages did your child go there?
(*Check all that apply)*

- ❑ 0 to 5 months old
- ❑ 6 to 11 months old
- ❑ 12 months old or older

b) On average, how many other children were there with your child? (*Check only one*)

- ❑$_1$ 0 other children
- ❑$_2$ 1 to 5 other children
- ❑$_3$ 6 to 10 other children
- ❑$_4$ More than 10 other children

**SECTION F: EMPLOYMENT UPDATE**

F1. Are you currently a student?

❑$_1$ Yes, full-time student

❑$_2$ Yes, part-time student

→ a) How old was your child when you went back to school?

____ ____ weeks **OR**

____ ____ months

❑$_3$ No

F2. Since your child was born, have you worked at a paying job?

❑$_1$ Yes →

❑$_2$ No

a) How old was your child when you started to work?

____ ____ weeks **OR**

____ ____ months

F3. What is your <u>current</u> employment status?

- ❑$_1$ Employed
- ❑$_2$ Employed, but currently on maternity/medical leave
- ❑$_3$ Not employed, not looking for work **(SKIP to SECTION G)**
- ❑$_4$ Not employed, looking for work **(SKIP to SECTION G)**

F4. <u>Currently,</u> how many hours per week do you spend at a paying job?

- ❑$_0$ 0 hours per week **(SKIP to SECTION G)**
- ❑$_1$ 1 to 14 hours per week
- ❑$_2$ 15 to 24 hours per week
- ❑$_3$ 25 to 34 hours per week
- ❑$_4$ 35 to 44 hours per week
- ❑$_5$ 45 hours or more per week

a) How many of these paid hours do you spend working at home (for example, telecommuting)?

- ❑$_0$ 0 hours per week
- ❑$_1$ 1 to 14 hours per week
- ❑$_2$ 15 to 24 hours per week
- ❑$_3$ 25 to 34 hours per week
- ❑$_4$ 35 to 44 hours per week
- ❑$_5$ 45 hours or more per week

**SECTION G: YOUR FEELINGS**

**Please take a moment to answer each of the following questions.**

| **In the past 7 days...** | | **As much as always** | **Somewhat less than usual** | **Much less than usual** | **Not at all** |
|---|---|---|---|---|---|
| G1. | I have been able to laugh and see the funny side of things | ❑1 | ❑2 | ❑3 | ❑4 |
| G2. | I have looked forward with enjoyment to things | ❑1 | ❑2 | ❑3 | ❑4 |

| **In the past 7 days...** | | **Most of the time** | **Some of the time** | **Not very often** | **Not at all** |
|---|---|---|---|---|---|
| G3. | I have blamed myself unnecessarily when things went wrong | ❑1 | ❑2 | ❑3 | ❑4 |
| G4. | I have been anxious or worried for no good reason | ❑1 | ❑2 | ❑3 | ❑4 |
| G5. | I have felt scared or panicky for no good reason | ❑1 | ❑2 | ❑3 | ❑4 |
| G6. | Things have been overwhelming me | ❑1 | ❑2 | ❑3 | ❑4 |
| G7. | I have been so unhappy that I have had difficulty sleeping | ❑1 | ❑2 | ❑3 | ❑4 |
| G8. | I have felt sad or miserable | ❑1 | ❑2 | ❑3 | ❑4 |
| G9. | I have been so unhappy that I have been crying | ❑1 | ❑2 | ❑3 | ❑4 |
| G10. | The thought of harming myself has occurred to me | ❑1 | ❑2 | ❑3 | ❑4 |

For some women, these questions may raise troubling issues. If you would like to speak with someone about these issues, we encourage you to contact your primary health care provider or call the Parental Stress Line at (800) 632-8188.

**Please fill in today's date**:

__ __/ __ __/ __ __

**MONTH / DAY / YEAR**

# THANK YOU!