I. STUDY NUMBER _____

II. TODAY'S DATE __ __/__ __/__ __

III. RA INITIALS ___ ___ ___

SIX-MONTH INTERVIEW

Okay great. So, let's start the interview. I'd like to begin by stressing that there are no right or wrong answers. Please just answer as best as you can. Also, some of the questions may seem personal. Remember that all of this information will be kept confidential, and you do not have to answer any question that you do not want to.

IV. **TIME START**: ___ ___ : ___ ___ (00:00 – 24:00)

SECTION A: PHYSICAL ENVIRONMENT

This first section is about the home where your baby usually sleeps at night.

A1. Do you and your baby 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 smoke regularly?

___ ___ ADULTS

A3. How many children between the ages of 12 and17 live in your home?

___ ___ CHILDREN AGE 12 to 17

(**IF "OO" SKIP TO A4**)

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

___ ___ CHILDREN AGE 12 to 17

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

___ ___ CHILDREN UNDER AGE 12

A5. Since your baby was born, have you owned…?

a) A dog	❑1 YES ❑2 NO (SKIP to b)	i. Do you currently have a dog?	❑1 YES ❑2 NO
b) A cat	❑1 YES ❑2 NO (SKIP to c)	i. Do you currently have a cat?	❑1 YES ❑2 NO
c) A furry pet, for example, gerbil, hamster?	❑1 YES ❑2 NO (SKIP to d)	i. Do you currently have a furry pet?	❑1 YES ❑2 NO
d) Some other pet, for example, bird, fish?	❑1 YES ❑2 NO (SKIP to A6)	i. Do you currently have this other pet?	❑1 YES ❑2 NO

A6. 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?

____ ____ BEDROOMS

A7. Is the floor in the room where your baby usually sleeps at night covered by an area rug, wall to wall carpeting, or something else?

❑1 AREA RUG

❑2 WALL TO WALL CARPETING

❑3 SOMETHING ELSE

A8. Is the floor in the room where your baby spends most awake time (for example family or TV room) covered by an area rug, wall to wall carpeting, or something else?

❑1 AREA RUG

❑2 WALL TO WALL CARPETING

❑3 SOMETHING ELSE

A9. Have you ever used a humidifier or vaporizer in the room where your baby usually sleeps at night?

- ❑1 YES
- ❑2 NO (**SKIP to A10**)

a) **HAND PARTICIPANT RESPONSE CARD #1**

In the past month, how many times have you used the humidifier/vaporizer?

- ❑1 0 to 1 times
- ❑2 2 to 4 times
- ❑3 5 to 9 times
- ❑4 10 to 19 times
- ❑5 20 times or more

A10. **HAND PARTICIPANT RESPONSE CARD #1**

In the past month, how many times has someone cleaned (for example, vacuumed, swept, or dusted) the room where your baby usually sleeps at night?

- ❑1 0 to 1 times
- ❑2 2 to 4 times
- ❑3 5 to 9 times
- ❑4 10 to 19 times
- ❑5 20 times or more

A11. In the past month, how many times has your baby been in a room when someone was cleaning it (vacuuming, sweeping or dusting)?

- ❑ 1 0 to 1 times
- ❑ 2 2 to 4 times
- ❑ 3 5 to 9 times
- ❑ 4 10 to 19 times
- ❑ 5 20 times or more

A12. In the past month, how many times has someone washed or changed your baby's crib or bed sheets?

- ❑ 1 0 to 1 times
- ❑ 2 2 to 4 times
- ❑ 3 5 to 9 times
- ❑ 4 10 to 19 times
- ❑ 5 20 times or more

A13. Since your baby was born, has there been any mold or mildew on walls or other surfaces, other than food, inside your home?

- ❑ 1 YES
- ❑ 2 NO
- ❑ 9 DON'T KNOW

A14. Have you ever seen a cockroach in your current home?

- ❑ 1 YES
- ❑ 2 NO

SECTION B: POST PARTUM HEALTH

This section is about your health.

B1. Have you seen your obstetrics health care provider for your routine post-partum visit (your follow up appointment, usually about 6 weeks after delivery)?

❑$_1$ YES

❑$_2$ NO

B2. <u>Since your baby was born</u>, have you experienced any of the following conditions…

		i) Was this a major or minor problem for you?	**ii) Is this still a problem?**
a) Hemorrhoids	❑$_1$YES ❑$_2$ NO (**SKIP to b**)	❑$_1$ MAJOR ❑$_2$ MINOR	❑$_1$ YES ❑$_2$ NO
b) Varicose veins	❑$_1$YES ❑$_2$ NO (**SKIP to c**)	❑$_1$ MAJOR ❑$_2$ MINOR	❑$_1$ YES ❑$_2$ NO
c) Problem holding urine when you jump or sneeze (Incontinence)	❑$_1$YES ❑$_2$ NO (**SKIP to d**)	❑$_1$ MAJOR ❑$_2$ MINOR	❑$_1$ YES ❑$_2$ NO
d) Sore Breasts	❑$_1$YES ❑$_2$ NO (**SKIP to e**)	❑$_1$ MAJOR ❑$_2$ MINOR	❑$_1$ YES ❑$_2$ NO
e) Pain with sex	❑$_1$YES ❑$_2$ NO (**SKIP to f**)	❑$_1$ MAJOR ❑$_2$ MINOR	❑$_1$ YES ❑$_2$ NO
f) Back pain	❑$_1$YES ❑$_2$ NO (**SKIP to g**)	❑$_1$ MAJOR ❑$_2$ MINOR	❑$_1$ YES ❑$_2$ NO
g) Sciatica (shooting pain in legs or back)	❑$_1$YES ❑$_2$ NO (**SKIP to B3**)	❑$_1$ MAJOR ❑$_2$ MINOR	❑$_1$ YES ❑$_2$ NO

B3. Since your baby was born, has a health professional, such as a doctor, physician's assistant, or nurse practitioner, told you that you had any of the following conditions?

	YES	NO
a) Thyroid condition	❑1	❑2
b) Serious heart condition	❑1	❑2
c) Blood clots in your legs or lungs	❑1	❑2
d) Mastitis (breast infection needing prescription antibiotics)	❑1	❑2

B4. In the past month, how many hours of sleep do you get in an average 24-hour period?

___ ___ HOURS

B5. In the past month, do you feel that you are getting enough sleep?

❑1 YES

❑2 NO

B6. Since your baby was born, has your menstrual cycle (monthly period) started?

❑1 YES

❑2 NO **(SKIP to B7)**

❑3 NOT SURE **(SKIP to B7)**

a) How old was the baby when your menstrual cycle (monthly period) returned?

___ ___ WEEKS OLD OR

___ ___ MONTHS OLD

B7. Since your baby was born, have you had sexual intercourse?

❑1 YES

❑2 NO (**SKIP to B9**)

B8. Since your baby was born, have you become pregnant?

❑1 YES

❑2 NO (**SKIP to B9**)

a) Are you still pregnant?

❑1 YES (**SKIP to B11**)

❑2 NO

B9. Are you currently taking birth control pills (oral contraceptives)?

❑1 YES (**SKIP to B11**)

❑2 NO

B10. Are you currently using Depo Provera (an injection or shot of female hormones to prevent pregnancy)?

❑1 YES

❑2 NO

These next few questions are about vitamins and supplements you may be taking or that you may have taken since your baby was born.

Since your baby was born, have you taken any…

	A YES/NO	B IF YES: When did you start taking them?	C Are you still taking them?	D IF NO: When did you stop taking them?	E ALL: What brand and type do/did you take?	F ALL: On average, how many tablets have you taken per wk during this time period (DTTP) ?
B11. Multi or prenatal vitamins?	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	_____ BRAND _____ TYPE	__ __/WK

Since your baby was born, have you taken any…

	A YES/NO	B IF YES: When did you start taking them?	C Are you still taking them?	D IF NO: When did you stop taking them?	E ALL: What brand and type do/did you usually take?	F ALL: On average, how many tablets have you taken per wk DTTP?
B12. Antacid tablets with calcium on a regular basis or another calcium supplement	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	❑1 ANTACID, REGULAR ❑2 ANTACID, EXTRA ❑3 ANTACID, ULTRA ❑4 OTHER CALCIUM	___ ___ / WK

Since your baby was born, have you taken any…

	A YES/NO	B IF YES: When did you start taking them?	C Are you still taking them?	D IF NO: When did you stop taking them?	E ALL: On average, how many tablets have you taken per wk DTTP?
B13. Iron	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	___ ___ / WK

Since your baby was born, have you taken any…

	A YES/NO	B IF YES: When did you start taking them?	C Are you still taking them?	D IF NO: When did you stop taking them?	E ALL: What is the dose/ strength of each tablet?	F ALL: On average, how many tablets have you taken per wk DTTP?
B14 Vitamin B6	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__ __ __ MG	___ ___ / WK
B15 Vitamin C (ascorbic acid)	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__,__ __ __ MG	___ ___ / WK
B16 Vitamin D	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__ __ __ MG	___ ___ / WK
B17 Vitamin E	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__ __ __ IU	___ ___ / WK
B18 Folate, Folic Acid	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__,__ __ __ MCG	___ ___ / WK
B19 Metamucil or other fiber supplements	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__ __ TBS OR __ __ PACKETS	___ ___ / WK

B20 Cod liver oil	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__ __ TSP OR __ __ CAPSULES	___ ___ / WK
B21 Fish Oil (Omega 3 fatty acids)	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	__ __ , __ __ __ MG	___ ___ / WK
B22 Other vitamins or supplements? _____	❑1 YES ❑2 NO	❑ >1 YR __ __/__ __/__ __ M D Y	❑1 YES ❑2 NO	__ __/__ __/__ __ M D Y	_____ (AMT) _____ (UNIT)	___ ___ / WK

SECTION C: YOUR BABY'S DEVELOPMENT

This section is about your baby's development.

C1. Have you ever been told by a health care professional, such as a doctor, physician's assistant or nurse practitioner, that your baby has…

	YES	NO
a) Eczema (atopic dermatitis)?	❑1	❑2
b) Asthma, wheezing, or reactive airways?	❑1	❑2
c) Pneumonia?	❑1	❑2
d) Any other respiratory infection, including middle ear infection (otitis media)?	❑1	❑2

C2. Is your baby able to roll over without assistance?

❑1 YES

❑2 NO

C3. Is your baby able to sit up without being supported?

❑1 YES

❑2 NO

C4. Has your baby started to crawl?

❑1 YES

❑2 NO

C5. How many teeth does your baby have?

___ TEETH

We are interested in knowing on average how many hours your baby sleeps in the morning, afternoon and night in a 24-hour period.

C6. In the past month, on average, for how long does your baby nap during the morning?

___ ___ HOURS and ___ ___ MINUTES
OR

___ ___ MINUTES

C7. In the past month, on average, for how long does your baby nap during the afternoon?

___ ___ HOURS and ___ ___ MINUTES
OR

___ ___ MINUTES

C8. In the past month, on average, how many hours does your baby sleep during the night?

___ ___ HOURS

This next question is about the past week.

C9. In the past week, how much time did your baby watch T.V. or videos? By "watching", we mean the amount of time that the child is in a place where he/she can see a television that is on.

___ ___ HOURS and ___ ___ MINUTES
OR

___ ___ MINUTES

These questions are about day care or babysitting.

Since your baby was born, has he/she spent time at …?

	A **YES/NO**	**B** **IF YES: How old was your baby when he/she started there?**	**C** **Does your baby still spend time there?**	**D** **IF NO: How old was your baby when he/she stopped going there?**	**E** **IF YES: In the past month, on average, how many hours per week did your baby spend there?**	**F** **On average, how many children were/are there who were/are with your baby?**
C10. A day care center	❑1 YES ❑2 NO	___ ___ MONTHS OLD ___ ___ WEEKS OLD	❑1 YES (GO TO E) ❑2 NO (GO TO D)	___ ___ MONTHS OLD ___ ___ WEEKS OLD	___ ___ HOURS PER WEEK	___ ___ CHILDREN
C11. Day care in someone else's home	❑1 YES ❑2 NO	___ ___ MONTHS OLD ___ ___ WEEKS OLD	❑1 YES (GO TO E) ❑2 NO (GO TO D)	___ ___ MONTHS OLD ___ ___ WEEKS OLD	___ ___ HOURS PER WEEK	___ ___ CHILDREN
C12. Day care inside your home (including nanny, or regular babysitter)	❑1 YES ❑2 NO	___ ___ MONTHS OLD ___ ___ WEEKS OLD	❑1 YES (GO TO E) ❑2 NO (GO TO D)	___ ___ MONTHS OLD ___ ___ WEEKS OLD	___ ___ HOURS PER WEEK	___ ___ CHILDREN

SECTION D: YOUR BABY'S DIET

This last section is about your baby's diet.

In the past month, has your baby taken any…

	A **YES/NO**	**B** **IF YES: When did your baby start taking them?**	**C** **Is your baby still taking them?**	**D** **IF NO: When did your baby stop taking them?**	**E** **ALL: On average, how many times per week has your baby taken this DTTP?**
D1. Fluoride drops, for example, Tri-Vi-Flor or Poly-Vi-Flor	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	___ ___ / WK
D2. Tri-Vit (Tri-Vi-Sol)	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	___ ___ / WK
D3. Poly-Vi-Sol	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	___ ___ / WK
D4. Iron drops	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	___ ___ / WK
D5. Other vitamins or supplements: Specify_____	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	❑1 YES ❑2 NO	___ ___ MONTHS OR ___ ___ WEEKS	___ ___ / WK

D6. Have you <u>ever</u> breastfed your baby? By breastfeeding, we mean that you have put your baby to your breast, whether or not your baby actually received breast milk, <u>or</u> that you have fed your baby your breastmilk.

❑$_1$ YES

❑$_2$ NO **(FORMULA ONLY - END)**

a) Are you now feeding your baby any infant formula?

❑$_1$ YES

❑$_2$ NO **(BREAST ONLY - END)**

b) Are you now feeding your baby any breast milk?

❑$_1$ YES **(MIXED)**

❑$_2$ NO **(FULLY WEANED)**

TIME STOP: ___ ___ : ___ ___ (00:00 – 24:00)

FOR RA:

❑$_1$ FORMULA ONLY (F)

❑$_2$ BREAST ONLY (B)

❑$_3$ MIXED (M)

❑$_4$ FULLY WEANED (W)