Participant Study ID _____

Baby Study ID _____

Newborn 4 Months Post Birth Questionnaire

This questionnaire has been modified from the approved Centre for Disease Control and Prevention (CDCP) questionnaire and has been designed to ask questions only relevant to this study for your convenience. CDCP have given their permission to use this modified version their Questionnaire for the purposes of this study and have agreed for Section C: Additional questions to be added.

SECTION A: BABY'S FEEDING AND HEALTH

1. In the past 14 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.

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

Fill in only one column for each item. If your baby was not fed the food at all during the past 7 days, write 0 in the second column.

	FEEDINGS PER DAY	FEEDINGS PER WEEK
Breast milk		
Formula (write which type of formula below)	_____	_____
.....		
Cow's milk	_____	_____
Other milk: soy milk, rice milk, goat milk, etc	_____	_____
Other dairy foods: e.g. yoghurt, cheese, ice cream, pudding, etc.	_____	_____

Other soy foods: e.g. tofu, frozen soy desserts, etc	_____	_____
100% fruit or 100% vegetable juice	_____	_____
Sweet drinks: e.g. juice drinks, soft drinks, soda, sweet tea, etc.	_____	_____
Baby cereal	_____	_____
Other cereals & starches: e.g. breakfast cereals, teething biscuits, crackers, breads, pasta, rice	_____	_____
Fruit	_____	_____
Vegetables	_____	_____
French fries	_____	_____
Meat, chicken, combination dinners	_____	_____
Fish or shellfish	_____	_____
Peanut butter, other peanut foods, or nuts	_____	_____
Eggs	_____	_____
Sweet foods: e.g. sweets, cookies, cake, etc.	_____	_____
Other (Please specify below)	_____	_____

……

Section A-2 Health

2. Which of the following problems did your baby have during the past 4 weeks? (PLEASE 'X' ALL THAT APPLY)

- Fever ..... □
- Runny nose or cold ..... □
- Diarrhoea ..... □
- Respiratory Syncytial Virus (RSV) ..... □
- Vomiting ..... □
- Cough or wheeze ..... □

- Ear infection ..... □
- Asthma ..... □
- Colic ..... □
- Food allergy ..... □
- Fussy or irritable ..... □
- Eczema (atopic dermatitis) ..... □
- Reflux ..... □
- None of these ..... □

3. Was your baby given any medication (e.g. antibiotics), including over-the-counter medication in the past 4 weeks? If so please list details below

.....

4. Was your baby given any supplements (e.g. probiotics, vitamin drops) in the past 4 weeks? If so please list details below

.....

5. How many stools (dirty nappies) does your baby usually have in a 24-hour period? If less than one a day, how many days usually pass between stools?

_____ NUMBER OF STOOLS IN 24 HOURS **OR** ONE STOOL EVERY_____DAYS

6. How would you describe your baby's stool in the past 7 days? (PLEASE 'X' ALL THAT APPLY)

Hard …. □ Formed …. □ Soft …. □ Semi-watery …. □ Watery …. □

7. Has your baby been hospitalised for any reason or has your baby been taken to a hospital for any outpatient procedure or surgery in the past 4 weeks?

Yes .... □ No .... □

8. How many nights was your baby in the hospital for the most recent problem? (Write in 0 if your baby did not stay overnight.) _____NIGHTS

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

_____ NUMBER OF TEETH

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SECTION C: FOOD ALLERGY SECTION

10. Has your baby ever had problems caused by food, such as an allergic reaction, sensitivity, or intolerance?

Yes .... □ No .... □ (IF **NO** GO TO QUESTION 18).

11. What were the problems caused by (PLEASE 'X' ALL THAT APPLY)

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

12. 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.)

1 month or less .... □ 2 months .... □ 3 months .... □ 4 months .... □

13. Did you take your baby to a medical doctor because of these problems with food?

Yes .... □ No .... □

14. If your baby was tested or examined for food allergy, what method was used? (PLEASE 'X' ALL THAT APPLY)

If your baby was not tested or examined for food allergy, 'X' here □ and go to Question 7.

- Parents' description of symptoms..... □
- A skin test ..... □
- A blood test such as RAST, or CAP-RAST ..... □
- An oesophageal 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 below) ..... □

15. Was your baby diagnosed by a medical doctor as having an allergy to any food?

Yes .... □ No .... □

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16. What symptoms of a problem with food has your baby had? (PLEASE 'X' ALL THAT APPLY)

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

17. Please indicate which foods caused a problem for your baby (PLEASE 'X' ALL THAT APPLY)

- Cows' milk or other dairy products
  (including infant formula made with cows' 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 ..... □
- Vegetables ..... □
- Other food (PLEASE SPECIFY below)

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SECTION D: ADDITIONAL QUESTIONS

18. How often do you typically bathe (full body) your infant?

Daily ☐ Every other day ☐ A few times per week ☐ Once per week ☐

Other: Please list_____

19. What skin care products and how often do you use on your baby (full body, not including nappy area)?

Product	**Time**	**Response** (1 – 4)
A, Cleansers (washes/soap bars/liquid soaps)	**1,** Daily	A =
B, Moisturizers (lotions / creams / balms / oils)	**2,** Every Other Day	B =
C, Water cleansing only	**3,** A Few Times Per Week	C =
	4, Once a week	

20. Is your baby enrolled in a day-care/nursery environment outside your home?

Yes ☐ If yes, how many days per week _____ No ☐

21. Are there any pets currently living in the house?

Yes ☐ No ☐

22. Date you completed this form: Day_____Month_____Year _____

THANK YOU. Upon completion, please keep in a safe place and hand to designated staff when your frozen samples are collected, unless you are completing this form online.