Study Specific Number

The First 1,000 Days of Life

First Survey

APPROVED: Inova IRB
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Infant Nutrition

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.

(Please put ZERO in the column if your baby was not fed any of foods listed below.)

	Per week
Breast milk	
Water	
Formula	
Cow's milk	
Soy milk, rice milk, goat milk	
100% fruit or 100% vegetable juice	
Juice drinks, soft drinks, sweet tea, Kool Aid, vitamins, etc	
Baby cereal	
Dairy foods: yogurt, cheese, ice cream, pudding, etc.	
Soy foods: tofu, frozen soy desserts, etc.	
Other cereals and starches: breakfast cereals	
biscuits, crackers, breads, pasta, rice, etc	
Eggs	
Vegetables	
Fruit	
Meat, chicken, combination dinners	
Fish or shellfish	
Peanut butter, other peanut foods, or nuts	
French fries	
Sweet foods: candy, cookies, cake, etc	
Other (Please specify)	

2. Are there any difficulties with feeding your baby?

a. Yes b. No c. Not Sure

2a. If yes, please specify:

a. Too slow b. Too fast c. Choking d. Colic e. Reflux f. Spitting g. Other

Infant Growth & Development

3. How much does your baby weigh? ----- lb -----oz

4. When was the last time your baby was weighed?

   a. Within the past week b. Within the past two weeks
   c. More than two weeks ago d. Not sure

5. Where was the last time your baby was weighed?

   a. Medical office/clinic b. Home c. Not sure d. Other

6. Do you have concerns about your baby's weight?

   a. Yes b. No c. Not sure

7. Has your baby been diagnosed with any medical condition or disorder?

   a. Yes b. No c. Not sure

8. Do you have concerns with your child's health?

   a. Yes b. No c. Not sure

9. Have you made a visit to the baby's doctor for your child being sick or injured?
   (Please do not include routine well baby visit)

   a. Yes b. No c. Not sure

9a. If yes, how many times?

   a. 0-2 b. 3-6 c. more than 6 times

10. Does your child have any of the following health problems?

    a. Ear infections b. Colds c. Vomiting d. Seizures e. Constipation/Diarrhea
    f. Asthma g. Skin problems h. Allergies i. Developmental concern j. None
    k. Other Please specify ☐

11. Has your child received all the recommended immunizations?

    a. Yes b. No c. Not sure

11a. If no, why?

    a. Appointment was delayed b. Vaccine safety concerns

12. Is your baby currently taking any prescribed medication?

    a. Yes b. No c. Not sure

13. Does your baby take any “over-the-counter” medications on a regular basis?

a. Yes b. No c. Not sure

14. Is your child regularly being cared for outside of your home?

a. Yes b. No c. Not sure

14a. If yes, are you satisfied with the child care that you had?

a. Yes b. No c. Not sure

15. Does your baby sleep for at least one four hour stretch at night?

a. Yes b. No c. Not sure

16. Does your baby cry a lot?

a. Rarely b. Occasionally c. Sometimes d. Usually e. Very Often

17. Do you use television to help your baby sleep?

a. Yes b. No c. Sometimes

18. Do you have the television on while your baby is eating?

a. Yes b. No c. Sometimes

19. How much time each day does your baby spend:

a. With the television or a video **on** in the home (including daycare)?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

b. Looking at or playing with a computer or tablet/smartphone?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

c. Playing outside time?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

d. Being read to?

□Never □Less than 30 min □30 minutes-1 hour □1-2 hours □More than 2 hours

Developmental Milestones

Please indicate if your child is doing any of these activities:

	YES	NO
Plays with toy actively by moving wrists		
Reaches and grasps objects with straight elbow		
Crawls and sits up		
Begins repetitive babbling		
Associates gestures with words like “Hi” and “Bye-Bye”		
Uses vocal and non-vocal communication to express interest and influence others		
Expresses several different emotions		
Distinguishes friends from strangers		
Shows displeasure at loss of a toy		

Maternal Confidence Scale

How confident do you feel in your parenting role? **(Check appropriate box)**

	Never	Seldom	Sometimes	Often	Always
1. I know when my baby wants me to play with him/her.					
2. I know how to take care of my baby better than anyone else.					
3. When my baby is cranky, I know the reason.					
4. I can tell when my baby is tired and needs to sleep.					
5. I know what makes my baby happy.					
6. I can give my baby a bath.					
7. I can feed my baby adequately.					
8. I can hold my baby properly.					
9. I can tell when my baby is sick.					
10. I feel frustrated taking care of my baby.					
11. I would be good at helping other mothers learn how to take care of their infants.					
12. Being a parent is demanding and unrewarding.					
13. I have all the skills needed to be a good parent.					
14. I am satisfied with my role as a parent.					

Prime-MD PHQ (2 Question Screen)

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
   □Yes □No
2. During the past month, have you often been bothered by little interest or pleasure in doing things?
   □Yes □No

If you answered **NO** to both of the above questions, please skip the following questions and continue with **Social Support Survey**. If you answered **YES** to either question, please complete the 10 statements, below.

Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

EPDS

Here is an example, already completed.

I have felt happy:

- □ Yes, all the time
- ✔ Yes, most of the time
- □ No, not very often
- □ No, not at all

If you selected the second option, this would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things.
   □As much as I always could
   □Not quite so much now
   □Definitely not so much now
   □Not at all

2. I have looked forward with enjoyment to things.
   □As much as I ever did
   □Rather less than I used to
   □Definitely less than I used to
   □Hardly at all

3. I have blamed myself unnecessarily when things went wrong.
   □Yes, most of the time
   □Yes, some of the time
   □Not very often
   □No, never

4. I have been anxious or worried for no good reason.
   - □No, not at all
   - □Hardly ever
   - □Yes, sometimes
   - □Yes, very often

5. I have felt scared or panicky for not very good reason.
   - □Yes, quite a lot
   - □Yes, sometimes
   - □No, not much
   - □No, not at all

6. Things have been getting on top of me.
   - □Yes, most of the time I haven't been able to cope at all
   - □Yes, sometimes I haven't been coping as well as usual
   - □No, most of the time I have coped quite well
   - □No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.
   - □Yes, most of the time
   - □Yes, sometimes
   - □Not very often
   - □No, not at all

8. I have felt sad or miserable.
   - □Yes, most of the time
   - □Yes, quite often
   - □Not very often
   - □No, not at all

9. I have been so unhappy that I have been crying.
   - □Yes, most of the time
   - □Yes, quite often
   - □Only occasionally
   - □No, never

10. The thought of harming myself has occurred to me.
   - □Yes, quite often
   - □Sometimes
   - □Hardly ever
   - □Never

If you have any serious concerns about your mental health,

please call **211** and request a referral for assistance.

MOS Social Support Survey

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? **(Circle one number on each line.)**

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional/informational support					
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Someone whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5
Tangible support					
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were sick	1	2	3	4	5
Affectionate support					
Someone who shows you love and affection	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5
Positive social interaction					
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5
Additional item					
Someone to do things with to help you get your mind off things	1	2	3	4	5

Life Orientation Test

Strongly Agree → Strongly Disagree

	A	B	C	D	E
1. In uncertain times I usually expect the best.					
2. It's easy for me to relax.					
3. If something can go wrong for me, it will.					
4. I'm always optimistic about my future.					
5. I enjoy my friends a lot.					
6. It's important for me to keep busy.					
7. I hardly ever expect things to go my way.					
8. I don't get upset too easily.					
9. I rarely count on good things happening to me.					
10. Overall, I expect more good things to happen to me than bad.					

Life Events Evaluation

Please select any events that have occurred in your life over the past 6 months:

- □ Personal health problems
- □ Personal social problems
- □ Problems with current partner
- □ Family disruption
- □ Problems with your finances
- □ Problems with your own children
- □ Problems with your in-laws
- □ Problems within your close family
- □ Serious illness in your close family
- □ Death within your close family
- □ Loss of job (you or your partner)
- □ Problems within your work environment
- □ Work transfer (you or your partner)
- □ Change in residence
- □ Problem in finding stable housing
- □ Current partner is away often
- □ Accidents, robberies, or similar events

Is there anything more you would like to tell us about **you and your baby?**

Demographics

Are you Hispanic or Latino?

□ Yes
□ No
□ Don‘t know / Not sure
□ Decline to answer

Which one of these groups would you say best represents your race?

□ White/ Caucasian
□ Black or African American
□ Asian
□ Native Hawaiian or Other Pacific Islander
□ American Indian or Alaska Native
□ More than one race
□ Other [specify] _____
□ Don‘t know / Not sure

What is your marital status?

□ Single
□ Married
□ Divorced
□ Widowed
□ Legally separated
□ Have a significant other
□ Other
□ Decline to answer

What is your education level?

□ Completed less than the 11 grade
□ High School Graduate/GED
□ Some College
□ Associate’s Degree
□ Bachelor’s Degree
□ Master’s Degree
□ Doctorate Degree /Higher Level of Education

What is your Occupation?

□ Management, Professional, and Related Occupations
□ Service Occupations
□ Construction, Maintenance, Repair Occupations
□ Production, Transportation, Material Moving Occupations
□ Agricultural Occupations
□Sales, Office Occupations
□Homemaker
□ Decline to answer

Your annual household income from all sources:

□ Less than $25,000
□ $25,000 - $49,999
□ $50,000 - $74,999
□ $75,000 - $99,999
□ 100,000 - $149,999
□ $150,000 - $199,999
□ $200,000 - $249,999
□ Greater than $250,000
□ Don‘t know / Not sure
□ Decline to answer

Do you rent or own the housing you are currently living in?

□Rent or pay someone for housing
□Own my home
□Living with someone (no rent)

Including yourself, how many people currently live in your household (including those who live there on a part time basis)? _____

What is the ZIP Code where you live? _ _ _ _ _

□ Don‘t know / Not sure
□ Decline to answer

References

Some of questions have been adopted and modified from CDC. – do we need an asterisk to indicate which ones?

Maternal Confidence Scale
Zahr L. The relationship between maternal confidence and mother-infant behaviors in premature infants. *Research in Nursing & Health* 1991; 14(4)279–286.

Prime-MD PHQ 2
Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

EPDS
1 Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .
2 Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002,194-199

Life Orientation Test
Michael F. Scheier & Charles S. Carver. (1985). Optimism, coping, and health: Assessment and Implications of generalized outcome expectancies. *Health Psychology,* 4, 219-247

Medical Outcomes Study (MOS)Social Support Survey
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The rest of questions have been developed by Inova Translational Medicine Institute Research Team.