INFANT INTERVIEW – FORMULA FEEDING

Name/Participant ID:
Date:
Date of Birth:
Assessed By:

NUTRITION PRACTICES

1a. Did you ever breastfeed <baby's name>? ☐ Yes ☐ No

***1b. If so, how old was <baby's name> when he/she completely stopped breastfeeding or being fed breast milk?**

Age in weeks: ___

1c. What was your main reason for stopping breastfeeding?

***1d. How old was <baby's name> when he/she was first fed something other than breast milk?**

Age in weeks: ___

***1e. How old was <baby's name> when he/she was first fed formula?**

Age in weeks: ___

***Breastfeeding Description:**
☐ Exclusively Breastfeeding
☐ Primarily Exclusive/No Food Package – Exclusive Breastfeeding
☐ Primarily Exclusive/Complementary Foods – No formula or minimal formula issued
☐ Partially Breastfeeding – Formula Issued – token/novel or partial
☐ No longer Breastfeeding
☐ Never Breastfed

1f. Tell me, how it is feeding <baby's name>?
Listen, ask, and assess for

- *Hunger and satiety cues*
- *Number of wet/dirty diapers*
- *Appetite changes*
- Constipation or diarrhea
- Vomiting

1g. Describe how you prepare the formula.

- *Amount of formula*
- *Ounces/bottle and bottles/day*
- *Formula brand/type*
- *How is formula mixed*
- *Water source*
- *Contents other than formula*
- *Storage/handling*

1h. Besides formula, what else do you feed <baby's name>?
Listen, ask, and assess for

- *Early introduction of solids or other liquids*
- *Developmentally appropriate foods*
- *Cup feeding – type, use, contents*

1i. Does your baby take any vitamins or minerals? ☐ Yes ☐ No

1j. Does your baby take any herbs or dietary supplements? ☐ Yes ☐ No

1k. What other questions or concerns do you have about feeding <baby's name>? Or is there anything you would like to change?
Listen, ask, and assess for

- *Dietary progression*
- *Making baby food*
- *When to start solids*
- *Introducing a cup*
- *Weaning breast/bottle*
- *Type of solids*

Nutrition Practices:
☐ 411a– Inappropriate substitute for breast milk or formula
☐ 411b– Improper bottle/cup use
☐ 411c – Complementary foods inappropriate in type or timing
☐ 411d – Disregarding developmental needs
☐ 411e – Feeding potentially harmful foods (Food Safety)
☐ 411f – Inappropriately diluted formula
☐ 411g – Inadequate Breastfeeding (exclusively Breastfed)
☐ 411h – Diet low in calories/nutrients
☐ 411i – Unsafe handling of formula or expressed breast milk
☐ 411j – Dietary supplements with potentially harmful consequences
☐ 411k – Inadequate fluoride and/or Vitamin D supplementation (when necessary)

Other Nutrition Risk Factors:
☐ 353 – Food Allergy: Wheat, corn, soy, peanuts, eggs, milk, entire food group
☐ 428 – Complementary Feeding Practices (4 mos to <24 mos)

HEALTH/MEDICAL

2a. What concerns do you have about <baby's name>'s health?

2b. Does <baby's name> have any medical problems diagnosed by a doctor? ☐ Yes ☐ No

2c. Is <baby's name> currently on any medication? ☐ Yes ☐ No

IMMUNIZATIONS

3a. Can we look over <child's name>'s shot record today?

***3b. DTaP immunization record viewed today** ☐ Yes ☐ No *____# DTap

ORAL HEALTH

4a. What questions do you have regarding caring for <baby's name>'s gums and teeth?

☐ 381 Dental Problems

LIFE STYLE

5a. How active is <baby's name> every day?

Listen, ask, and assess for

- *Strollers*
- *Play pens*
- *Infant seats*
- *Car seats*
- *Crawling*
- *Rolling over*
- *Moving muscles (massage)*
- *Walking*

***5b. Does anyone living in your household smoke inside the home?** ☐ Yes – 904 Environmental Smoke Exposure