19636

8 Month-Baby Questionnaire

Upstate KIDS: The New York State Infant Development Screening Program

Infant ID

The 8-Month Questionnaire asks about the health, growth and development of your baby, since completion of the 4-Month Questionnaire. If you had a set of twins, triplets or quadruplets, a separate questionnaire is included for each baby, with the baby's name printed on your questionnaire booklet cover.

This questionnaire should take about 10-15 minutes to complete. Please try to answer each question. For check boxes with one option, please place an 'X' in the box that best fits your answer. For check boxes with more than one option, please place an 'X' in all the boxes that best fit your answer. If none of the options apply, please leave the question blank.

Please note that the final questions on this questionnaire refer to information we suggested you record in the Child Health Journal that we recently provided you. Prior to completing each of the questionnaires about your baby (both now and in the future), it will be helpful if you have filled out the Child Health Journal first.

Upstate KIDS: The New York State Infant Development Screening Program

If you have any questions or concerns, please call our toll-free number: 1-888-870-0247

Upstate Kids Infant Development Screening Program

OFFICE USE ONLY:
VERIFIED BY:

8 Month-Baby Questionnaire

Upstate KIDS: The New York State Infant Development Screening Program

Questions 1-11 ask about how your baby is being fed

Infant Feeding

1. Are your currently breastfeeding your baby? (**Select one answer using an 'X'**)

☐ Yes ⟶ (Please mark the box below that best describes your current breastfeeding practices):

- ☐ I am exclusively breastfeeding (not giving any formula or food) **GO TO QUESTION 4**
- ☐ I am partially breastfeeding (supplementing with formula or food)

☐ No ⟶ (Please mark the box below that best describes why and when you stopped breastfeeding your baby.):

- ☐ I never tried breastfeeding

I tried breastfeeding but stopped due to one of the following issues; please also specify the date you stopped. Please provide as much of the date as you remember

☐☐ / ☐☐ / ☐☐☐☐

Why did you stop?

- ☐ Baby had difficulty latching on or sucking properly
- ☐ Pain in my breast(s)
- ☐ Infection in the breast(s)
- ☐ Insufficient milk supply
- ☐ Returned to work
- ☐ Other; please specify

☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐

2. If you are giving your baby formula or food, please check all types you are using.

(**Mark all that apply using an 'X'**)

- ☐ Follow-on or stage 2 formula with calcium and iron
- ☐ Mead Johnson (Enfamil ®, Enfamil LIPIL®, IproSobee ®, Nutramigen®)
- ☐ Ross (Similac ®, Similac Advance ®, Isomil ®, Alimentum®)
- ☐ Nestle Carnation (Good Start ®, Alsoy ®, Follow-up ®)
- ☐ Store brands (for example, Wal-Mart, Target)
- ☐ Other formula type
- ☐ Cow's milk
- ☐ Goat's milk
- ☐ Hypo-allergenic
- ☐ Soy milk or soy formula
- ☐ Unpasterurized milk
- ☐ Rice cereal
- ☐ Wheat cereal
- ☐ Pureed fruits or vegetables
- ☐ Solid fruits or vegetables
- ☐ Meats
- ☐ Egg
- ☐ Finger food (cheerios, crackers)
- ☐ Cheese, other dairy food

3.What is the source of water that is usually used to prepare your baby's formula? (**Select one answer using an 'X'**)

- ☐ Does not apply: only use already prepared formula (ready-to-serve)
- ☐ Does not apply: don't use formula
- ☐ Bottled water
- ☐ Tap water from a private well
- ☐ Tap water from the public water system
- ☐ Filtered tap water (Brita or home or faucet filter)

4.What type of baby bottle do you use to feed your baby? (**Select one answer using an 'X'**)

- ☐ Do not use bottles
- ☐ Glass bottles
- ☐ Disposable plastic liners and bottles
- ☐ Nondisposable re-usable plastic
- ☐ Both disposable and nondisposable (re-usable) plastic bottles and disposable liners

5. Bisphenol-A (BPA) is something found in many plastic products. While its effect on child health is not known at this time, we would like to know if your child uses any BPA-free plastic items (such as plastic bottels, cups, bowls)?

- ☐ No
- ☐ Yes

→If yes, which items are BPA-free (**Mark all that apply using an 'X')**

- ☐ Nondisposable bottles
- ☐ Disposable bottles
- ☐ Disposable plastic liners
- ☐ Sippy cups
- ☐ Bowls/dishes
- ☐ Spoons
- ☐ Teething ring/toys

6. Are you giving your baby water to drink? (**Select one answer using an 'X'**)

- ☐ No
- ☐ Yes

→ What is the usual source of drinking water for your baby? (**Select one answer using an 'X'**)

- ☐ Bottled water
- ☐ Tap water from a private well
- ☐ Tap water from the public water system
- ☐ Filtered tap water (Brita or faucet filter)

7. Have you introduced juice into your baby's diet? (**Select one answer using an 'X'**)

- ☐ No
- ☐ Yes; write in your baby's age (in months) when you first gave juice ☐☐

8. How would you describe your baby's appetite on a typical day? (**Select one answer using an 'X'**)

- ☐ Very good (eats all meals without fuss)
- ☐ Good (eats most meals without fuss)
- ☐ Medium (eats half meals without fuss/half meals with fuss)
- ☐ Poor (eats most meals with fuss)
- ☐ Very poor (eats all meals with fuss)

9. Do you have any concerns about feeding your baby?

☐ No ⟶ **GO TO QUESTION 11**

☐ Yes; (**Mark all that apply using an 'X'**)

☐ Drowsiness: has difficulty staying alert while nursing/feeding

☐ Easily distracted while nursing/feeding so doesn't eat enough

☐ Has weak sucking while bottle or breastfeeding

☐ Sleeps too much so that not enough time for feeding

☐ Aspiration: child inhales food or stomach contents into the lungs

☐ Spitting up: mild expulsion of swallowed food or liquid (regurgitation)

☐ Reflux: stomach contents backing up into baby's throat after a meal (gastroesophageal reflux-GERD)

☐ Vomiting: forceful expulsion of stomach contents

10. Have you sought any medical advice or treatment for any of the above eating conditions? (**Mark all that apply using an 'X'**)

☐ No

☐ Yes; Specify the issues you discussed (**Mark all that apply using an 'X'**)

☐ Drowsiness: has difficulty staying alert while nursing/feeding

☐ Easily distracted while nursing/feeding so doesn't eat enough

☐ Has weak sucking while bottle or breastfeeding

☐ Sleeps too much so that not enough time for feeding

☐ Aspiration: child inhales food or stomach contents into the lungs

☐ Spitting up: mild expulsion of swallowed food or liquid (regurgitation)

☐ Reflux: stomach contents backing up into baby's throat after a meal (gastroesophageal reflux-GERD)

☐ Vomiting: forceful expulsion of stomach contents

11. Does your baby currently get multivitamin drops? (**Select one answer using an 'X'**)

☐ No

☐ Yes; Specify type of vitamin normally given (Select one answer using an 'X')

☐ Multivitamins only

☐ Multivitamins plus iron

☐ Multivitamins plus fluoride

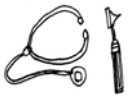
☐ Multivitamins plus fluoride and iron

→ How many days a week on average does your baby get multivitamin drops, and how old was your baby (in weeks) when you started the drops?

TIMES PER WEEK **AGE IN WEEKS**

Questions 12-13 are updates about your baby's health since the 4-month questionnaire.

Infant Health



12. Is your baby seeing a physician because of a specific medical concern? (**Mark all that apply using an 'X'**)

☐ No

☐ Yes; **(Mark all that apply using an 'X')**

☐ For birth defect

☐ Because of early delivery (Preterm birth)

☐ For slow growth following birth

☐ For being a multiple (twins, triplets, quadruplets)

☐ For a medical condition; specify:

☐ Other reason; specify:

13. Has your baby ever been admitted to the hospital, even for a few hours, since age 4 months?

☐ No

☐ Yes ; (**Select one answer using an 'X'**)

☐ For illness; specify:

☐ For day surgery (outpatient) specify:

☐ For surgery that required admission for more than 1 day, specify:

14. Does your baby <u>currently</u> use a medical device in the home?

☐ No

☐ Yes ; → If you marked yes, what type of medical device or monitor does your baby use? (**Select one answer using an 'X'**)

☐ Apnea or respiratory (breathing) monitor

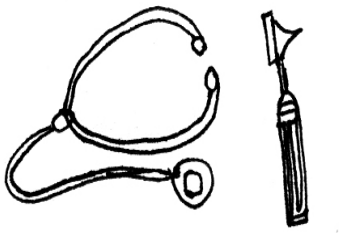
☐ Combined heart rate and respiratory monitor

☐ Ventilator

☐ Dialysis equipment

☐ Catheter

☐ Other; please specify



Questions 15-23 ask about your baby's health <u>since birth</u>.

15. Has your baby ever been prescribed an antibiotic since birth?

☐ No

☐ Yes

A. → If yes, specify how many times | | |

B. → At what age was the first antibiotic given (write in age in weeks <u>OR</u> months)

WEEKS		**MONTHS**	

16. Has your baby had an ear infection diagnosed by a doctor at any point since birth?

☐ No

☐ Yes

→ If yes; specify the total number of infections and how each of them were treated | | |

(**Mark all that apply using an 'X'**)

# of infections:

☐ Oral antibiotics | | |

☐ Pain Killers (e.g., Tylenol) | | |

☐ Ear drops for wax | | |

☐ Ear drops with antibiotic | | |

☐ Decongestants | | |

☐ Ear tubes | | |

17. Have you been told by a doctor or health practitioner that your baby is allergic to any food, medication or other things?

☐ No

☐ Yes; → If yes; what are the specific allergies? (**Mark all that apply using an 'X'**)

☐ Food → What are the specific food allergies? (**Mark all that apply using an 'X'**)

☐ Nuts ☐ Cow's milk ☐ Wheat ☐ Soy

☐ Peanuts ☐ Dairy ☐ Gluten ☐ Eggs

☐ Fish ☐ Shellfish

☐ Medicines

☐ Dust

☐ Animals

☐ Pollen

☐ Ragweed

☐ Don't know

18. Has your baby ever had frequent sneezing and/or prolonged blocked or runny nose for several months when he/she did not have a cold or the flu?

☐ No

☐ Yes

19. Not including diaper rash or a rash around the scalp, has your child ever had a recurrent (coming and going) dry and itchy red rash for at least 3 months?

☐ No

☐ Yes

20. Did a doctor or health care practitioner ever tell you that your baby had infantile eczema or atopic dermatitis (dry, itchy inflammation of the skin, redness and swelling)?

☐ No

☐ Yes → If yes; specify location on body (**Mark all that apply using an 'X'**)

☐ Palms of hands ☐ Chest

☐ Arms ☐ Abdomen

☐ Soles of feet ☐ Back

☐ Legs ☐ Buttocks

21. Has your child had any wheezing attacks? (By wheezing, we mean breathing that sounds like a high-pitched whistling or a squeaking sound coming from the baby's chest not throat)?

☐ No

☐ Yes

→ If yes; how many wheezing attacks has your child experienced since birth (**Write in number**) ☐☐

22. Which type of diapers do you typically use? (**Select one answer using an 'X'**)

☐ Cloth diapers

☐ Disposable diapers

☐ No diapers (Diaper-free)

23. Do you use any products to prevent diaper rash or irritation in the diaper area?

☐ No

☐ Yes

→ If yes; mark the products you use (**Mark all that apply using an 'X'**)

☐ Gels ☐ Powders ☐ Lotions

24. Has your baby ever developed a diaper rash?

☐ No

☐ Yes → If yes; write in the number of times since birth

times since birth **SEVERITY OF RASH**

Severe

☐☐  Severe (very red, requiring medication from doctor; severe raised bumps in skin, severe breaks in skin and swelling)

Moderate

☐☐  Moderate (pink to red in color, some bumps or breaks in skin, some swelling)

Mild

☐☐  Mild (pink in color, no bumps or breaks in skin)

Questions 25-31 ask about childcare

25. Does your child attend daycare, or is s/he watched by a care provider, at least once per week? (A care provider is someone other than the child's parents/guardians who watches the child.)

☐ No,⟶ **GO TO QUESTION 34**

☐ Yes

26. If yes, what was your child's primary type of daycare? (**Select one answer using an 'X'**)

☐ A home-based daycare

☐ A group daycare facility

☐ My home with a nanny or sitter (not live-in)

☐ My home with a live-in nanny

☐ My home with a family member

☐ A family member's home

☐ Other; please specify

27. Are there other types of child care settings that you use at least once per week

☐ No, ⟶ **GO TO QUESTION 29**

☐ Yes,

28. If yes, what are the other types of child care setting you use most often? (**Mark all that apply using an 'X'**)

☐ A private home daycare

☐ A group daycare facility

☐ My home with a nanny or sitter (not live in)

☐ My home with a live-in nanny

☐ My home with a family member

☐ A family member's home

29. If you indicated above that your child is watched by a family member on a regular basis, which family member is the care provider used most often (do not include occasional sitting)? (**Select one answer using an 'X'**)

☐ Baby's Grandmother

☐ Baby's Grandfather

☐ Baby's Aunt

☐ Baby's Uncle

☐ Baby's older sibling

☐ Baby's cousin

☐ Other;

30. On average, for how many total hours per week does your child attend child care or get watched by a care provider?

HOURS

31. How old was your child (in months) when he/she began daycare or being watched by a care privider on a regular basis?

MONTHS

32. About how many children are usually cared for together, at the same time in the same group, at the daycare setting used most often for your child.

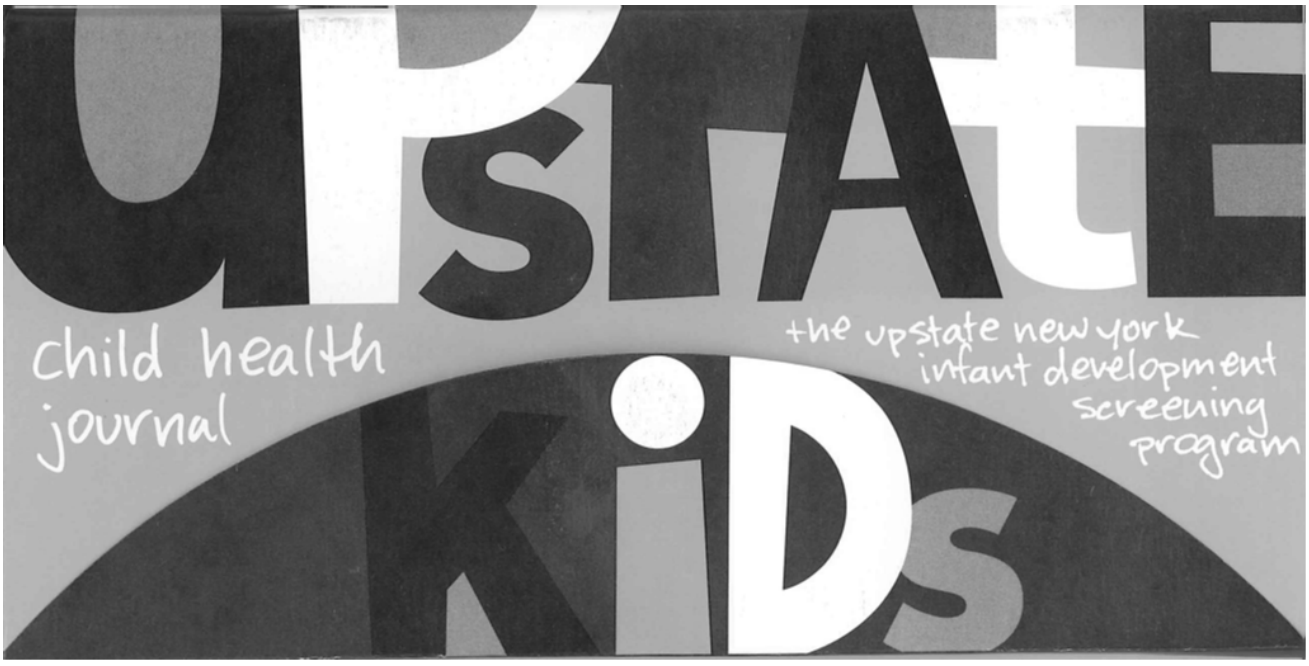
CHILDREN

33. About how many adults usually care for your child at the same time at the daycare setting most often used?

ADULTS

Questions 34 thru 38 are based on information you may have collected in the Upstate KIDS Child Health journal recently provided to you in your initial survey packet.

Like this one (but in color)



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TIP: If you have begun completing the Upstate KIDS Child Health Journal recently provided to you, this information would be listed on pages 1-7 of the Journal.

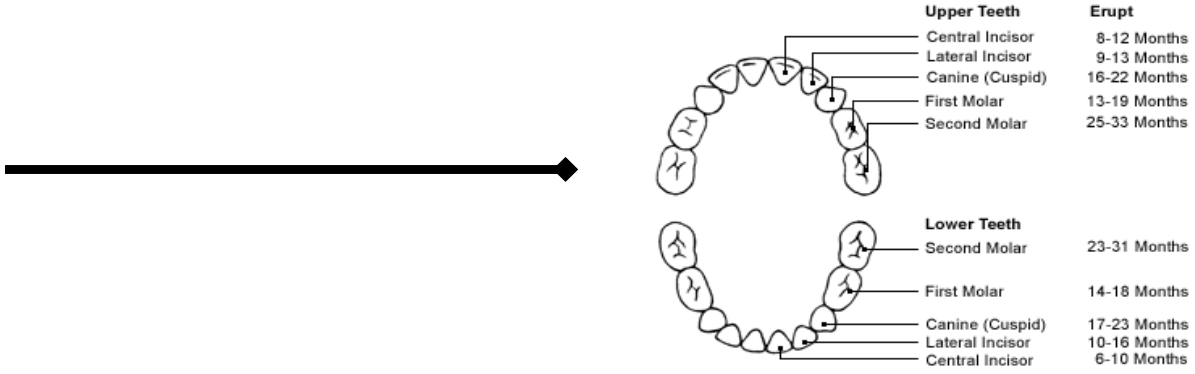
34. Please use your baby's journal (page 1-7) to answer the following question about any vaccinations your baby has received. If you cannot remember or did not record vaccination dates, please provide as much of the date as you can remember. If your baby received a combined vaccine, such as pediarix ® or Comvax ®, you do not also have to mark that the individual vaccines were received.

Vaccine	Dose	Recommended Age Range	Received	Date of Vaccine (mm / dd / yyyy)
Hepatitis B (HepB)	3	**6-18 months**	☐	/ /
Diphtheria, Tetanus, Acellular Pertussis (DTaP)	2	**4 months**	☐	/ /
	3	**6 months**	☐	/ /
Haemophilus influenza type b (Hib, flu)	2	**4 months**	☐	/ /
	3	**6 months**	☐	/ /
Pneumococcal (PCV)	2	**4 months**	☐	/ /
	3	**6 months**	☐	/ /
Rotavirus	2	**4 months**	☐	/ /
	3	**6 months**	☐	/ /
Inactivated poliovirus (IPV, polio)	2	**4 months**	☐	/ /
	3	**6-18 months**	☐	/ /
Influenza ('flu shot')	1	**6 months**	☐	/ /
Combined vaccine (Pediarix®) Combines DTaP, Hepatitis B, IPV (polio)	2	**4 months**	☐	/ /
	3	**6 months**	☐	/ /
Combined vaccine (Comvax®) Combines Hepatitis B and Hib (flu)	2	**4 months**	☐	/ /
Other combined vaccine	1		☐	/ /

Please specify the vaccine name

35. Please complete the chart below about which teeth, if any, your baby has. The figure below illustrates the location of various types of teeth and is identical to page 10 of your baby's journal. Feel free to review the journal in completing this chart. (Fill in box and write in dates for each tooth.)

Tooth	Side	Yes, came in	Date of eruption mm / dd / yyyy
Bottom central incisor	Left	☐	☐☐ / ☐☐ / ☐☐☐☐
Bottom central incisor	Right	☐	☐☐ / ☐☐ / ☐☐☐☐
Top central incisor	Left	☐	☐☐ / ☐☐ / ☐☐☐☐
Top central incisor	Right	☐	☐☐ / ☐☐ / ☐☐☐☐
Bottom lateral incisor	Left	☐	☐☐ / ☐☐ / ☐☐☐☐
Bottom lateral incisor	Right	☐	☐☐ / ☐☐ / ☐☐☐☐
Top lateral incisor	Left	☐	☐☐ / ☐☐ / ☐☐☐☐
Top lateral incisor	Right	☐	☐☐ / ☐☐ / ☐☐☐☐



36. Please complete the chart regarding which developmental milestones your baby has reached. Feel free to consult your baby's journal (pages 8 and 9) to answer this question.

Milestone	Definition	Achieved since month 4	Date of Achievement mm / dd / yyyy
Sitting without support	Infant can sit up straight with head erect for at least 10 seconds without using arms or hands to balance body or support the position.	☐	☐☐ / ☐☐ / ☐☐☐☐
Hands-and-knees crawling	Infant alternately moves forward or backward on hands and knees. The stomach does not touch the supporting surface, and there are at least three movements in a row.	☐	☐☐ / ☐☐ / ☐☐☐☐
Standing with assistance	Child can stand in upright position on both feet, holding onto a stable object (like, furniture), for at least 10 seconds without leaning on it.	☐	☐☐ / ☐☐ / ☐☐☐☐
Walking with assistance	Child can take at least five steps sideways or forward while in an upright position and holding on to a stable object (like furniture).	☐	☐☐ / ☐☐ / ☐☐☐☐
Standing alone	Child can stand in an upright position on both feet (not on the toes) for at least 10 seconds with no contact with a person or object.	☐	☐☐ / ☐☐ / ☐☐☐☐
Walking alone	Child can take at least five steps independently in an upright position with no contact with a person or object.	☐	☐☐ / ☐☐ / ☐☐☐☐

BABY'S GROWTH

37. Please fill in the chart below about your baby's growth and well-baby check-ups since 4 months of age. For each visit, please include your baby's age (in months or weeks) and the actual date of the check-up. If you cannot remember the complete date, please provide as much of the date as you can remember. Feel free to consult your baby's journal (pages 14-28) to answer this question.

Age at Visit (months or weeks)	**Date of Visit** (mm/dd/yyyy)	**Length** (inches or centimeters)	**Weight** (pounds or grams)	**Head Circumference** (inches or centimeters)
☐☐ Months or ☐☐☐ weeks	☐☐ / ☐☐ / ☐☐☐☐	☐☐ in or ☐☐☐ cm	☐☐ lbs ☐☐ oz or ☐☐☐☐ grams	☐☐ in or ☐☐☐ cm
☐☐ Months or ☐☐☐ weeks	☐☐ / ☐☐ / ☐☐☐☐	☐☐ in or ☐☐☐ cm	☐☐ lbs ☐☐ oz or ☐☐☐☐ grams	☐☐ in or ☐☐☐ cm
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☐☐ Months or ☐☐☐ weeks	☐☐ / ☐☐ / ☐☐☐☐	☐☐ in or ☐☐☐ cm	☐☐ lbs ☐☐ oz or ☐☐☐☐ grams	☐☐ in or ☐☐☐ cm

SICK VISITS

38. Please fill in the chart below about sick visits since birth. For each visit, please include the actual date of the check-up, the health concern, and the treatment. If you cannot remember the complete date, please provide as much of the date as you can remember. This information is in the Sick Visits section of your baby's journal.

Please enter the number of your response(s), if other, please specify.

Date of Visit - mm/dd/yyyy)	Health Concern:	Treatment:
12 / 15 / 2008	1-Ear Infection, 2-Cold, 3-Vomiting, 4-Diarrhea, 5-Rash, 6-Pink Eye, 7-Other	1-Antibiotic, 2-Tylenol, 3-Pedialyte, 4-Topical Drops, 5-Ointment, 6-Other

Date of Visit - mm/dd/yyyy)	Health Concern:	Treatment:
/ /		
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THANK YOU FOR YOUR PARTICIPATION IN

UPSTATE KIDS

Please mail this form out to us soon!
If you misplaced the postage-paid envelope that was mailed with this questionnaire, please call us and we will mail you another return envelope.
1-888-870-0247 (Toll-free)

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