UNIVERSITY OF OXFORD

INTERBIO-21st
Infant Follow-up Study: 1-year visit
Food Frequency Questionnaire

FFQ

Page 1 of 2

INTERBIO-21st PTID Number `0` `7` - ☐ ☐ ☐ ☐ ☐   **Hospital/Clinic Code** ☐ ☐

Infant Hospital Record No. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Infant Date of Birth D D M M Y Y   **Visit Date** D D M M Y Y

Please answer all yes/no questions by placing a 'X' in the corresponding box.

Section 1: Infant feeding during the first year of life

1. At discharge from the hospital, was your baby: (cross one box only)

   Exclusively breastfed? ☐   Receiving mixed feeding? ☐   Exclusively bottle fed? ☐

   If exclusively breastfed or receiving mixed feeding, continue to Question 2.
   If exclusively <u>bottle</u> fed, skip to Question 6.

2. During the first year of life, have you given your child expressed milk?   yes ☐ no ☐

3. Are you still breastfeeding your child?   yes ☐ no ☐

   If yes, how many feeds per day (expressed milk included)?   ☐ ☐ number of feeds/day

4. How old was your child when you stopped exclusively breastfeeding?   M M mths   W weeks

5. How old was your child when you started giving her/him formula?   M M mths   W weeks

   If formula has never been given, cross here: ☐

6. What type(s) of formula have you given your child? (cross all that apply)

   Standard infant formula ☐   Hydrolysed formula ☐   High energy formula ☐   Soy based formula ☐   Any other special formula ☐

7. How old was your child when you started giving her/him other types of milk?   M M mths   W weeks

   If other types of milk have never been given, cross here: ☐

8. What type(s) of milk have you given your child? (cross all that apply)

   Skimmed ☐   Semi-skimmed ☐   Whole ☐   Soya milk ☐   Other ☐

9. How old was your child when solids were first introduced?   M M mths   W weeks

10. Generally, where is most of your child's food prepared? (cross one box only)

    At home ☐   Family/friends ☐   Restaurant ☐   Shop ☐

11. Who <u>mainly</u> feeds your child at home? (cross one box only)

    Mother ☐   Father ☐   Grandparent ☐   Nanny ☐   Other ☐

12. Is your child following any special diet? (cross all that apply)

    Vegetarian ☐   Gluten-free ☐   Low-lactose ☐   Low-phenylalanine ☐   None ☐

    Other (please specify) ☐ _____

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Hospital/Clinic Code ☐ ☐

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Infant Date of Birth D D M M Y Y

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Section 2: Food frequency questionnaire

Please indicate with a 'X' in the table how often your child had each item in the past 28 days. (cross one box per row)

	Never	1-3 times a month	1-3 times a week	>3 times a week	1-3 times a day	>3 times a day
13. Breast milk	☐	☐	☐	☐	☐	☐
14. Formula/soya milk	☐	☐	☐	☐	☐	☐
15. Animal milk	☐	☐	☐	☐	☐	☐
16. Fruit/vegetable juice	☐	☐	☐	☐	☐	☐
17. Soft drinks	☐	☐	☐	☐	☐	☐
18. Water	☐	☐	☐	☐	☐	☐
19. Soup	☐	☐	☐	☐	☐	☐
20. Dairy products	☐	☐	☐	☐	☐	☐
21. Cooked cereals (e.g. porridge)	☐	☐	☐	☐	☐	☐
22. Cold cereals	☐	☐	☐	☐	☐	☐
23. Vitamin A-rich fruits/veg (e.g. carrot, spinach)	☐	☐	☐	☐	☐	☐
24. Other fruits	☐	☐	☐	☐	☐	☐
25. Other vegetables	☐	☐	☐	☐	☐	☐
26. Grains (e.g. rice)	☐	☐	☐	☐	☐	☐
27. Legumes (e.g. beans, pulses)	☐	☐	☐	☐	☐	☐
28. Pasta/noodles	☐	☐	☐	☐	☐	☐
29. Tubers (e.g. potatoes)	☐	☐	☐	☐	☐	☐
30. Bread/crackers	☐	☐	☐	☐	☐	☐
31. Biscuits/sweet snacks	☐	☐	☐	☐	☐	☐
32. Crisps/savoury snacks	☐	☐	☐	☐	☐	☐
33. Sweets/jelly	☐	☐	☐	☐	☐	☐
34. Egg	☐	☐	☐	☐	☐	☐
35. Red/organ meats (e.g. beef, lamb, pork, liver)	☐	☐	☐	☐	☐	☐
36. Fish	☐	☐	☐	☐	☐	☐
37. Poultry	☐	☐	☐	☐	☐	☐
38. Take-away food (e.g. pizza)	☐	☐	☐	☐	☐	☐
39. Spreads/oils	☐	☐	☐	☐	☐	☐

Name of Researcher	
Signature	Researcher Code