

**FMMP 2006 Additional Questions  
Breast Feeding**

**Did your mother breast feed you?**

\_\_\_\_\_ **NO**

\_\_\_\_\_ **YES**

\_\_\_\_\_ **DON'T KNOW**

**FOR WOMEN ONLY:**

**Did you breast feed any of your children?**

\_\_\_\_\_ **I did not have any live born children.**

**If you had any live born children, please list them in order, by their first names, and tell us whether you breast fed each child.**

	<b>First Name</b>	<b>Birth date</b>	<b>Breast Fed?</b>	<b>For more than 6 weeks?</b>
<b>Child #1</b>		___/___/___	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>
<b>Child #2</b>		___/___/___	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>
<b>Child #3</b>		___/___/___	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>
<b>Child #4</b>		___/___/___	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>
<b>Child #5</b>		___/___/___	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>

(The birth date column is an addition to last year's question).

**If you had more than five live born children, please write their breast feeding information on a separate piece of paper. Thank you.**