

Please check the box next to your answer or follow the directions included with the question. You may be asked to skip some questions that do not apply to you.

## BEFORE PREGNANCY

The first questions are about you.

### 1. How tall are *you* without shoes?

Feet  Inches

OR  Centimeters

### 2. Just before you got pregnant with your new baby, how much did you weigh?

Pounds OR  Kilos

### 3. What is *your* date of birth?

/  /   
Month Day Year

The next questions are about the time before you got pregnant with your new baby.

### 4. During the 3 months before you got pregnant with your new baby, did you have any of the following health conditions? For each one, check **No** if you did not have the condition or **Yes** if you did.

No Yes

- a. Type 1 or Type 2 diabetes (**not** gestational diabetes or diabetes that starts during pregnancy) .....
- b. High blood pressure or hypertension .....
- c. Depression .....

### 5. During the *month* before you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

- I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the *month* before I got pregnant
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week

### 6. In the 12 months before you got pregnant with your new baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?

- No  $\longrightarrow$  **Go to Page 2, Question 9**
- Yes

### 7. What type of health care visit did you have in the 12 months before you got pregnant with your new baby?

**Check ALL that apply**

- Regular checkup at my family doctor's office
- Regular checkup at my OB/GYN's office
- Visit for an illness or chronic condition
- Visit for an injury
- Visit for family planning or birth control
- Visit for depression or anxiety
- Visit to have my teeth cleaned by a dentist or dental hygienist
- Other  $\longrightarrow$  Please tell us:

**8. During any of your health care visits in the 12 months before you got pregnant, did a doctor, nurse, or other health care worker do any of the following things?** For each item, check **No** if they did not or **Yes** if they did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid...  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Talk to me about how I could improve my health before a pregnancy .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS).....   | <input type="checkbox"/> | <input type="checkbox"/> |

**The next questions are about your health insurance coverage before, during, and after your pregnancy with your new baby.**

**9. During the *month before* you got pregnant with your new baby, what kind of health insurance did you have?**

**Check ALL that apply**

- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid (not managed care)
- Medicaid managed care including STAR, STAR+PLUS, or STAR Health
- CHIP or CHIP Perinatal
- TRICARE or other military health care
- Other health insurance —→ Please tell us:
- I did not have any health insurance during the *month before* I got pregnant

**10. During your *most recent pregnancy*, what kind of health insurance did you have for your prenatal care?**

**Check ALL that apply**

- I did not go for prenatal care —→ **Go to Question 11**
- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid (not managed care)
- Medicaid managed care including STAR, STAR+PLUS, or STAR Health
- CHIP or CHIP Perinatal
- TRICARE or other military health care
- Other health insurance —→ Please tell us:
- I did not have any health insurance for my *prenatal care*

### 11. What kind of health insurance do you have now?

**Check ALL that apply**

- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid (not managed care)
- Medicaid managed care including STAR, STAR+PLUS, or STAR Health
- CHIP or CHIP Perinatal
- TRICARE or other military health care
- Other health insurance → Please tell us:

- I do not have health insurance *now*

### 12. Thinking back to *just before* you got pregnant with your new baby, how did you feel about becoming pregnant?

**Check ONE answer**

- I wanted to be pregnant later
- I wanted to be pregnant sooner
- I wanted to be pregnant then
- I didn't want to be pregnant then or at any time in the future
- I wasn't sure what I wanted

### 13. When you got pregnant with your new baby, were you trying to get pregnant?

- No
- Yes →

**Go to Question 16**

### 14. When you got pregnant with your new baby, were you or your husband or partner doing anything to keep from getting pregnant?

Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- No
- Yes →

**Go to Question 16**

**Go to Question 15**

### 15. What were your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant?

**Check ALL that apply**

- I didn't mind if I got pregnant
- I thought I could not get pregnant at that time
- I had side effects from the birth control method I was using
- I had problems getting birth control when I needed it
- I thought my husband or partner or I was sterile (could not get pregnant at all)
- My husband or partner didn't want to use anything
- I forgot to use a birth control method
- Other → Please tell us:

## DURING PREGNANCY

The next questions are about the prenatal care you received during your most recent pregnancy. Prenatal care includes visits to a doctor, nurse, or other health care worker before your baby was born to get checkups and advice about pregnancy. (It may help to look at the calendar when you answer these questions.)

### 16. How many weeks or months pregnant were you when you had your first visit for prenatal care?

{  Weeks OR  Months

- I didn't go for prenatal care →

**Go to Page 4, Question 18**

**Go to Page 4, Question 17**

**17. Did you get prenatal care as early in your pregnancy as you wanted?**

- No  
 Yes

→ **Go to Question 19**

**18. Did any of these things keep you from getting prenatal care when you wanted it?** For each item, check **No** if it did not keep you from getting prenatal care or **Yes** if it did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan would not start care as early as I wanted.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid card.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't have anyone to take care of my children.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I didn't know that I was pregnant.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I didn't want anyone else to know I was pregnant.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I didn't want prenatal care.....  | <input type="checkbox"/> | <input type="checkbox"/> |

**If you did not get prenatal care, go to Question 22.**

**19. Where did you go *most of the time* for your prenatal care visits?** Do not include visits for WIC.

**Check ONE answer**

- Private doctor's office  
 Hospital clinic  
 Health department clinic  
 Clinic or office where I saw multiple doctors for my prenatal care visits  
 Clinic or office where I received group prenatal care  
 Other → Please tell us:

**20. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?** Please count only discussions, not reading materials or videos. For each item, check **No** if no one talked with you about it or **Yes** if someone did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. How smoking during pregnancy could affect my baby.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Breastfeeding my baby.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. How drinking alcohol during pregnancy could affect my baby.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Using a seat belt during my pregnancy ...   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Medicines that are safe to take during my pregnancy.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. How using illegal drugs could affect my baby.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Doing tests to screen for birth defects or diseases that run in my family.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. What to do if I feel depressed during my pregnancy or after my baby is born.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Physical abuse to women by their husbands or partners.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |

**21. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the things listed below?** For each item, check **No** if they did not ask you about it or **Yes** if they did.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. If I knew how much weight I should gain during pregnancy.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If I was taking any prescription medication.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| c. If I was smoking cigarettes.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If I was drinking alcohol .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| e. If someone was hurting me emotionally or physically.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I was feeling down or depressed.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was using drugs such as marijuana, cocaine, crack, or meth ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I wanted to be tested for HIV (the virus that causes AIDS) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I planned to breastfeed my new baby..                              | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If I planned to use birth control after my baby was born .....        | <input type="checkbox"/> | <input type="checkbox"/> |

**22. Have you ever heard or read that taking a vitamin with folic acid can help prevent some birth defects?**

- No  
 Yes

**23. During the 12 months before the delivery of your new baby, did a doctor, nurse, or other health care worker offer you a flu shot or tell you to get one?**

- No  
 Yes

**24. During the 12 months before the delivery of your new baby, did you get a flu shot?**

**Check ONE answer**

- No  
 Yes, before my pregnancy  
 Yes, during my pregnancy

**25. During your most recent pregnancy, did you get a Tdap shot or vaccination?** A Tdap vaccination is a tetanus booster shot that also protects against pertussis (whooping cough).

- No  
 Yes  
 I don't know

**26. During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?**

- No  
 Yes

**27. This question is about other care of your teeth during your most recent pregnancy.** For each item, check **No** if it is not true or does not apply to you or **Yes** if it is true.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. I knew it was important to care for my teeth and gums during my pregnancy.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A dental or other health care worker talked with me about how to care for my teeth and gums..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had insurance to cover dental care during my pregnancy.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I <u>needed</u> to see a dentist for a <b>problem</b> ..   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I <u>went</u> to a dentist or dental clinic about a <b>problem</b> .....                         | <input type="checkbox"/> | <input type="checkbox"/> |

**28. Did any of the following things make it hard for you to go to a dentist or dental clinic during your most recent pregnancy?** For each item, check **No** if it was not something that made it hard for you or **Yes** if it was.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. I could not find a dentist or dental clinic that would take pregnant patients ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I could not find a dentist or dental clinic that would take Medicaid patients ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I did not think it was safe to go to the dentist during pregnancy.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I could not afford to go to the dentist or dental clinic.....                       | <input type="checkbox"/> | <input type="checkbox"/> |

**29. During your most recent pregnancy, did you have any of the following health conditions?**

For each one, check **No** if you did not have the condition or **Yes** if you did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Gestational diabetes (diabetes that <b>started</b> during <i>this</i> pregnancy) .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that <b>started</b> during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**30. During your most recent pregnancy, did a doctor, nurse, or other health care worker give you a series of weekly shots of a medicine called progesterone, Makena®, or 17P (17 alpha-hydroxyprogesterone) to try to keep your new baby from being born too early?**

- No  
 Yes  
 I don't know

**The next questions are about smoking cigarettes around the time of pregnancy (before, during, and after).**

**31. Have you smoked any cigarettes in the past 2 years?**

- No —————> **Go to Question 35**  
 Yes

**32. In the 3 months *before* you got pregnant, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.**

- 41 cigarettes or more  
 21 to 40 cigarettes  
 11 to 20 cigarettes  
 6 to 10 cigarettes  
 1 to 5 cigarettes  
 Less than 1 cigarette  
 I didn't smoke then

**33. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.**

- 41 cigarettes or more  
 21 to 40 cigarettes  
 11 to 20 cigarettes  
 6 to 10 cigarettes  
 1 to 5 cigarettes  
 Less than 1 cigarette  
 I didn't smoke then

**34. How many cigarettes do you smoke on an average day now? A pack has 20 cigarettes.**

- 41 cigarettes or more  
 21 to 40 cigarettes  
 11 to 20 cigarettes  
 6 to 10 cigarettes  
 1 to 5 cigarettes  
 Less than 1 cigarette  
 I don't smoke now

**35. How many cigarette smokers, not including yourself, lived in your home during your most recent pregnancy?**

Number of smokers

**36. Which of the following statements best describes the rules about smoking *inside* your home *now*, even if no one who lives in your home is a smoker?**

**Check ONE answer**

- No one is allowed to smoke anywhere inside my home  
 Smoking is allowed in some rooms or at some times  
 Smoking is permitted anywhere inside my home

The next questions are about using other tobacco products around the time of pregnancy.

**E-cigarettes (electronic cigarettes) and other electronic nicotine products** (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.

A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

**37. Have you used any of the following products in the past 2 years?** For each item, check **No** if you did not use it or **Yes** if you did.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. E-cigarettes or other electronic nicotine products.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hookah.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chewing tobacco, snuff, snus, or dip.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nicotine replacement therapy products (such as nicotine patch, nicotine gum, or nicotine lozenge)..... | <input type="checkbox"/> | <input type="checkbox"/> |

**If you used e-cigarettes or other electronic nicotine products in the past 2 years, go to Question 38. Otherwise, go to Question 40.**

**38. During the 3 months before you got pregnant, on average, how often did you use e-cigarettes or other electronic nicotine products?**

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

**39. During the last 3 months of your pregnancy, on average, how often did you use e-cigarettes or other electronic nicotine products?**

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

The next questions are about drinking alcohol around the time of pregnancy.

**40. Have you had any alcoholic drinks in the past 2 years?** A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

- No → **Go to Page 8, Question 43**
- Yes

**41. During the 3 months before you got pregnant, how many alcoholic drinks did you have in an average week?**

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

**42. During the last 3 months of your pregnancy, how many alcoholic drinks did you have in an average week?**

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

**Pregnancy can be a difficult time. The next questions are about things that may have happened *before* and *during* your most recent pregnancy.**

**43. This question is about things that may have happened during the 12 months before your new baby was born.** For each item, check **No** if it did not happen to you or **Yes** if it did. (It may help to look at the calendar when you answer these questions.)

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. A close family member was very sick and had to go into the hospital.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I got separated or divorced from my husband or partner.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I moved to a new address.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was homeless or had to sleep outside, in a car, or in a shelter.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My husband or partner lost their job .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I lost my job even though I wanted to go on working.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My husband, partner, or I had a cut in work hours or pay.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I was apart from my husband or partner due to military deployment or extended work-related travel..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I argued with my husband or partner more than usual.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. My husband or partner said they didn't want me to be pregnant.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I had problems paying the rent, mortgage, or other bills.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. My husband, partner, or I went to jail .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Someone very close to me had a problem with drinking or drugs.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Someone very close to me died.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**44. In the 12 months before you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?** For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

- |                                     | No                       | Yes                      |
|-------------------------------------|--------------------------|--------------------------|
| a. My husband or partner .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Another family member .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone else .....               | <input type="checkbox"/> | <input type="checkbox"/> |

**45. During your most recent pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?** For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

- |                                     | No                       | Yes                      |
|-------------------------------------|--------------------------|--------------------------|
| a. My husband or partner .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Another family member .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone else .....               | <input type="checkbox"/> | <input type="checkbox"/> |

## AFTER PREGNANCY

**The next questions are about the time since your new baby was born.**

**46. When was your new baby born?**

	/		/	20
Month		Day		Year

**47. Did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)?**

- No —————→ **Go to Question 49**  
 Yes  
 I don't know —————→ **Go to Question 49**

**Go to Question 48**



**48. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)?**

**Check ALL that apply**

- My water broke and there was a fear of infection
- I was past my due date
- My health care provider worried about the size of the baby
- My baby was not doing well and needed to be born
- I had a complication in my pregnancy (such as low amniotic fluid or pre-eclampsia)
- I wanted to schedule my delivery
- I wanted to give birth with a specific health care provider
- Other \_\_\_\_\_ → Please tell us:

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**49. How was your new baby delivered?**

- Vaginally \_\_\_\_\_ → **Go to Question 51**
- Cesarean delivery (c-section)

**Go to Question 50**

**50. What was the reason that your new baby was born by cesarean delivery (c-section)?**

**Check ALL that apply**

- I had a previous cesarean delivery (c-section)
- My baby was in the wrong position (such as breech)
- I was past my due date
- My health care provider worried that my baby was too big
- I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)
- I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)
- My health care provider tried to induce my labor, but it didn't work
- Labor was taking too long
- The fetal monitor showed that my baby was having problems before or during labor (fetal distress)
- I wanted to schedule my delivery
- I didn't want to have my baby vaginally
- Other \_\_\_\_\_ → Please tell us:

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**51. After your baby was delivered, how long did he or she stay in the hospital?**

- Less than 24 hours (less than 1 day)
- 24 to 48 hours (1 to 2 days)
- 3 to 5 days
- 6 to 14 days
- More than 14 days
- My baby was not born in a hospital
- My baby is still in the hospital \_\_\_\_\_ → **Go to Page 10, Question 54**

**52. Is your baby alive now?**

- No \_\_\_\_\_ → *We are very sorry for your loss.*
- Yes

**Go to Page 10, Question 53**

**53. Is your baby living with you now?**

- No → **Go to Page 12, Question 69**
- Yes

**54. Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources?** For each one, check **No** if you did not receive information from this source or **Yes** if you did.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. My doctor.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A nurse, midwife, or doula.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A breastfeeding or lactation specialist ....     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My baby's doctor or health care provider.....    | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A breastfeeding support group.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A breastfeeding hotline or toll-free number..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Family or friends .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:

**55. Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time?**

- No
- Yes → **Go to Question 57**

**56. What were your reasons for not breastfeeding your new baby?**

**Check ALL that apply**

- I was sick or on medicine
- I had other children to take care of
- I had too many household duties
- I didn't like breastfeeding
- I tried but it was too hard
- I didn't want to
- I went back to work
- I went back to school
- Other → Please tell us:

**If you did not breastfeed your new baby, go to Question 61.**

**57. Are you currently breastfeeding or feeding pumped milk to your new baby?**

- No
- Yes → **Go to Question 59**

**58. How many weeks or months did you breastfeed or feed pumped milk to your baby?**

- Less than 1 week

Weeks **OR**  Months

If your baby was not born in a hospital, go to Question 60.

**59. This question asks about things that may have happened at the hospital where your new baby was born.** For each item, check **No** if it did not happen or **Yes** if it did.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Hospital staff gave me information about breastfeeding.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My baby stayed in the same room with me at the hospital.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I breastfed my baby in the hospital.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Hospital staff helped me learn how to breastfeed .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I breastfed in the first hour after my baby was born .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My baby was placed in skin-to-skin contact within the first hour of life.....    | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My baby was fed only breast milk at the hospital.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Hospital staff told me to breastfeed whenever my baby wanted .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The hospital gave me a breast pump to use.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. The hospital gave me a gift pack with formula .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| k. The hospital gave me a telephone number to call for help with breastfeeding..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Hospital staff gave my baby a pacifier .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |

**60. How old was your new baby the first time he or she had liquids other than breast milk (such as formula, water, juice, or cow's milk)?**

Weeks **OR**  Months

- My baby was less than 1 week old  
 My baby has not had any liquids other than breast milk

If your baby is still in the hospital, go to Page 12, Question 69.

**61. In which *one* position do you *most often* lay your baby down to sleep now?**

Check ONE answer

- On his or her side  
 On his or her back  
 On his or her stomach

**62. In the *past 2 weeks*, how often has your new baby slept alone in his or her own crib or bed?**

- Always  
 Often  
 Sometimes  
 Rarely  
 Never

Go to Question 64

**63. When your new baby sleeps alone, is his or her crib or bed in the same room where *you* sleep?**

- No  
 Yes

**64. Listed below are some more things about how babies sleep. How did your new baby *usually* sleep in the *past 2 weeks*?** For each item, check **No** if your baby did not *usually* sleep like this or **Yes** if he or she did.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. In a crib, bassinet, or pack and play .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On a twin or larger mattress or bed .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| c. On a couch, sofa, or armchair .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In an infant car seat or swing.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a sleeping sack or wearable blanket.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. With a blanket.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. With toys, cushions, or pillows, including nursing pillows ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. With crib bumper pads (mesh or non-mesh) .....                   | <input type="checkbox"/> | <input type="checkbox"/> |

**65. Did a doctor, nurse, or other health care worker tell you any of the following things?**

For each thing, check **No** if they did not tell you or **Yes** if they did.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Place my baby on his or her back to sleep .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Place my baby to sleep in a crib, bassinet, or pack and play ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Place my baby's crib or bed in my room ..                          | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What things should and should not go in bed with my baby .....     | <input type="checkbox"/> | <input type="checkbox"/> |

**66. Was your new baby seen by a doctor, nurse, or other health care worker for a *one week* *checkup* after he or she was born?**

- No  
 Yes  
 My baby was still in the hospital at that time

**67. Has your new baby had a well-baby checkup?**

A well-baby checkup is a regular health visit for your baby usually at 1, 2, 4, and 6 months of age.

- No  
 Yes

**68. Did your new baby have any well-baby shots or vaccinations before he or she was 3 months old?** Do not count shots or vaccinations given in the hospital right after birth.

- No  
 Yes  
 My child has not had any well-baby shots, but he or she is not 3 months old yet

**69. Are you or your husband or partner doing anything *now* to keep from getting pregnant?**

Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- No  
 Yes → **Go to Question 71**

**Go to Question 70**

**70. What are your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant *now*?**

**Check ALL that apply**

- I want to get pregnant  
 I am pregnant now  
 I had my tubes tied or blocked  
 I don't want to use birth control  
 I am worried about side effects from birth control  
 I am not having sex  
 My husband or partner doesn't want to use anything  
 I have problems paying for birth control  
 Other → Please tell us:

**If you or your husband or partner is not doing anything to keep from getting pregnant *now*, go to Question 72.**

**71. What kind of birth control are you or your husband or partner using *now* to keep from getting pregnant?**

**Check ALL that apply**

- Tubes tied or blocked (female sterilization or Essure®)  
 Vasectomy (male sterilization)  
 Birth control pills  
 Condoms  
 Shots or injections (Depo-Provera®)  
 Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)  
 IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)  
 Contraceptive implant in the arm (Nexplanon® or Implanon®)  
 Natural family planning (including rhythm method)  
 Withdrawal (pulling out)  
 Not having sex (abstinence)  
 Other → Please tell us:

**72. Since your new baby was born, have you had a postpartum checkup for yourself?** A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.

- No  
 Yes

→ **Go to Question 74**

**73. During your postpartum checkup, did a doctor, nurse, or other health care worker do any of the following things?** For each item, check **No** if they did not do it or **Yes** if they did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid ...   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about healthy eating, exercise, and losing weight gained during pregnancy.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about how long to wait before getting pregnant again .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about birth control methods I can use after giving birth.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®) .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Ask me if I was smoking cigarettes .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if someone was hurting me emotionally or physically.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if I was feeling down or depressed .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Test me for diabetes .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**74. Since your new baby was born, how often have you felt down, depressed, or hopeless?**

- Always  
 Often  
 Sometimes  
 Rarely  
 Never

**75. Since your new baby was born, how often have you had little interest or little pleasure in doing things you usually enjoyed?**

- Always  
 Often  
 Sometimes  
 Rarely  
 Never

**76. Since your new baby was born, have you asked for help for depression from a doctor, nurse, or other health care worker?**

- No  
 Yes

**77. Since your new baby was born, has a doctor, nurse, or other health care worker told you that you had depression?**

- No  
 Yes

#### OTHER EXPERIENCES

**The next questions are on a variety of topics.**

**78. During the last 3 months of your most recent pregnancy, about how many servings of fruit did you have in a day?**

**Check ONE answer**

- Zero servings (none)  
 1 or 2 servings per day  
 3 or 4 servings per day  
 5 or more servings per day

**79. During the last 3 months of your most recent pregnancy, about how many servings of vegetables did you have in a day?**

**Check ONE answer**

- Zero servings (none)  
 1 or 2 servings per day  
 3 or 4 servings per day  
 5 or more servings per day

**80. When you got pregnant with your new baby, who lived in the same house with you?**

**Check ALL that apply**

- My husband or partner
- Children aged less than 12 months → How many children?
- Children aged 1 year to 5 years → How many children?
- Children aged 6 years and over → How many children?
- My mother
- My father
- My husband's or partner's parent(s)
- Friend or roommate
- Other family member or relative
- Other → Please tell us:
- I lived alone

**81. Who lives in the same house with you now?**

**Check ALL that apply**

- My husband or partner
- Children aged less than 12 months → How many children?
- Children aged 1 year to 5 years → How many children?
- Children aged 6 years and over → How many children?
- My mother
- My father
- My husband's or partner's parent(s)
- Friend or roommate
- Other family member or relative
- Other → Please tell us:
- I live alone

**82. When you got pregnant, how old was your new baby's father?**

- Years old
- I don't know

**The last questions are about the time during the 12 months before your new baby was born.**

**83. During the 12 months before your new baby was born, what was your yearly total household income before taxes?** Include your income, your husband's or partner's income, and any other income you may have received. *All information will be kept private and will not affect any services you are now getting.*

- \$0 to \$16,000
- \$16,001 to \$20,000
- \$20,001 to \$24,000
- \$24,001 to \$28,000
- \$28,001 to \$32,000
- \$32,001 to \$40,000
- \$40,001 to \$48,000
- \$48,001 to \$57,000
- \$57,001 to \$60,000
- \$60,001 to \$73,000
- \$73,001 to \$85,000
- \$85,001 or more

**84. During the 12 months before your new baby was born, how many people, including yourself, depended on this income?**

People

**85. What is today's date?**

/  /  20

Month Day Year

**Please use this space for any additional comments you would like to make about your experiences around the time of your pregnancy or the health of mothers and babies in Texas.**

***Thanks for answering our questions!***

***Your answers will help us work to keep mothers and babies in Texas healthy.***

