

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 → **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 → 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"/> |

9. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk to you about preparing for a pregnancy?

- No
- Yes

→ **Go to Question 11**

↓ **Go to Question 10**

10. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk with you about any of the things listed below about preparing for a pregnancy? 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. Getting my vaccines updated before pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Visiting a dentist or dental hygienist before pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Getting counseling for any genetic diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Getting counseling or treatment for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The safety of using prescription or over-the-counter medicines during pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. How smoking during pregnancy can affect a baby | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How drinking alcohol during pregnancy can affect a baby | <input type="checkbox"/> | <input type="checkbox"/> |
| h. How using illegal drugs during pregnancy can affect a baby | <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*.

11. 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, healthsourceri.com, or HealthCare.gov
- Medicaid or Rite Care
- 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

12. 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 13**
- 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, healthsourceri.com, or HealthCare.gov
- Medicaid or Rite Care
- TRICARE or other military health care
- Other health insurance —→ Please tell us:

- I did not have any health insurance for my *prenatal care*

13. 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, healthsourceri.com, or HealthCare.gov
- Medicaid or Rite Care
- TRICARE or other military health care
- Other health insurance —→ Please tell us:

- I do not have health insurance *now*

14. 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

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.)

15. 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 Question 18**

16. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about how eating fish containing high levels of mercury could affect your baby?

- No
 Yes

17. 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.

- | | No | Yes |
|---|--------------------------|--------------------------|
| 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"/> |

18. 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

19. 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 }

Go to Question 21

Go to Question 20

20. What were your reasons for not getting a flu shot during the 12 months before the birth of your new baby? For each item, check **No** if it was not a reason for you or **Yes** if it was.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. My doctor didn't mention anything about a flu shot | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was worried about side effects of the flu shot for me..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I was worried that the flu shot might harm my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was not worried about getting sick with the flu..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I do not think the flu shot works..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I don't normally get a flu shot | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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

- No
 Yes

22. 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.

- | | No | Yes |
|---|--------------------------|--------------------------|
| 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 problem .. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I <u>went</u> to a dentist or dental clinic about a problem | <input type="checkbox"/> | <input type="checkbox"/> |

23. 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.

- | | No | Yes |
|--|--------------------------|--------------------------|
| 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"/> |

24. During your most recent pregnancy, were you on WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)?

- No
 Yes

25. 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 started during <i>this</i> pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that started during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |

If you had depression during your most recent pregnancy, go to Question 26. Otherwise, go to Page 6, Question 28.

26. At any time during your most recent pregnancy, did you get counseling for your depression?

- No
 Yes

27. At any time during *your most recent pregnancy*, did you take prescription medicine for your depression?

- No
 Yes

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

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

- No
 Yes

Go to Question 32

29. 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

30. 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

31. 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

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.

32. 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. Cigars, cigarillos, or little filtered cigars.... | <input type="checkbox"/> | <input type="checkbox"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 33. Otherwise, go to Question 35.

33. 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

34. 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.

35. 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 Question 37**
- Yes

36. 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

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

37. During the 12 months before your new baby was born, how often did you feel unsafe in the neighborhood where you lived?

- Always
- Often
- Sometimes
- Rarely
- Never

38. 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"/> |

39. 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.

40. When was your new baby born?

<input style="width: 100%; height: 20px;" type="text"/> /	<input style="width: 100%; height: 20px;" type="text"/> /	<input style="width: 100%; height: 20px;" type="text"/> 20
Month	Day	Year

41. 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 Question 44**

42. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Question 55**

43. Is your baby living with you now?

- No → **Go to Question 55**
- Yes → **Go to Question 44**

Go to Question 44

44. 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"/> | <input type="checkbox"/> |
| b. A nurse, midwife, or doula | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A breastfeeding or lactation specialist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My baby's doctor or health care provider..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A breastfeeding support group..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A breastfeeding hotline or toll-free number..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

45. 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 47**

46. 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 49.

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

- No
 Yes

Go to Question 49

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

- Less than 1 week

____ Weeks OR ____ Months

49. Have you ever heard or read about what can happen if a baby is shaken?

- No
 Yes

If your baby is still in the hospital, go to Question 55.

50. 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

51. 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 53

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

- No
 Yes

53. 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"/> |

54. 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"/> |

55. 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 Page 10, Question 57

Go to Page 10, Question 56

56. 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 58.

57. 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:

58. 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 60

59. 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"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

61. 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

OTHER EXPERIENCES

The next questions are on a variety of topics.

62. During the 3 months before you got pregnant with your new baby, how often did you participate in any physical activities or exercise for 30 minutes or more? For example, walking for exercise, swimming, cycling, dancing, or gardening.

- Less than 1 day per week
- 1 to 2 days per week
- 3 to 4 days per week
- 5 or more days per week
- I was told by a doctor, nurse, or other health care worker not to exercise

63. During the last 3 months of your most recent pregnancy, how often did you participate in any physical activities or exercise for 30 minutes or more?

- Less than 1 day per week
- 1 to 2 days per week
- 3 to 4 days per week
- 5 or more days per week
- I was told by a doctor, nurse, or other health care worker not to exercise

64. How would you describe the time during your most recent pregnancy?

Check ONE answer

- One of the happiest times of my life
- A happy time with few problems
- A moderately hard time
- A very hard time
- One of the worst times of my life

If your baby is not alive, is not living with you, or is still in the hospital, go to Page 12, Question 73.

65. Since you delivered your new baby, would you have the kinds of help listed below if you needed them? For each one, check **No** if you would not have it or **Yes** if you would.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Someone to loan me \$50..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Someone to help me if I were sick and needed to be in bed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Someone to talk with about my problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone to help me if I were tired and feeling frustrated with my new baby | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Someone to take me and my baby to the doctor's office if I had no other way of getting there | <input type="checkbox"/> | <input type="checkbox"/> |

66. Do you have a doctor, nurse, or other health care worker that you can get in contact with 24 hours a day, 7 days a week, who will take care of your baby for both sick and "well-baby" care?

- No
- Yes

67. In general, how easy is it to calm your baby when he or she is crying or fussy?

Check ONE answer

- Very easy
- Somewhat easy
- Somewhat difficult
- Very difficult

68. During the last 2 weeks, how many hours did your baby cry and/or fuss on an average 24 hour day?

- Less than 1 hour per day
- Between 1 and 2 hours per day
- Between 2 and 3 hours per day
- Between 3 and 5 hours per day
- More than 5 hours per day

69. Are you or any other family member currently reading or looking at books with your baby?

- No
- Yes

Go to Question 71

70. If you or any other family member are *not currently* looking at books with your new baby, at what age do you think you will start reading or looking at books with your new baby?

- 3—11 months old
- 1—2 years old
- 3—4 years old
- 5 and older
- I probably will not read to my baby/child

If you have not read or looked at books with your new baby, go to Question 72.

71. During the past week, how many days did you or other family members read or look at books with your baby?

- Did not read to the baby this week
- 1—3 days this week
- 4—7 days this week

72. About how many children's books do you have in your home?

- None
- 1—5
- 6—10
- 11 or more

73. Are you aware that babies are tested in the hospital for the following conditions? For each item, check **No** if you are not aware of this or **Yes** if you are.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Conditions that run in families, such as sickle cell disease and PKU | <input type="checkbox"/> | <input type="checkbox"/> |

74. Are you limited in any way in any activities because of physical, mental, or emotional problems?

- No
- Yes

75. Have you ever been told by a doctor, nurse or other health care worker that you had asthma?

- No
- Yes

Go to Question 77

76. Do you still have asthma?

- No
- Yes

77. How many times have you moved in the *last 3 years*?

Number of times

78. Some of these things might happen to people during childhood. Childhood experiences may be important. Please tell us if any of these things ever happened to you from the time you were born through age 13.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Most of the time, I had an adult who believed in me and who I could count on to help me | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A parent or guardian I lived with got divorced or separated..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. We had to move because of problems paying the rent or mortgage..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone in my family or I went hungry because we could not afford enough food..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A parent or guardian got in trouble with the law or went to jail..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A parent or guardian I lived with had a serious drinking or drug problem | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I was in foster care (removed from my home by the court or child welfare agency)..... | <input type="checkbox"/> | <input type="checkbox"/> |

79. Thinking back to your childhood through age 13, how often was it hard for your family to pay for basic needs like food or housing?

- Very often
- Somewhat often
- Not very often
- Never

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

80. 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

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

People

82. What is today's date?

/ /

 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 Rhode Island.

Thanks for answering our questions!

Your answers will help us work to keep mothers and babies in Rhode Island healthy.