

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. Before you got pregnant with your new baby, did you ever have any other babies who were born alive?

No Yes

→ **Go to Question 7**

5. Did the baby born just before your new one weigh 5 pounds, 8 ounces (2.5 kilos) or less at birth?

No
 Yes

6. Was the baby just before your new one born earlier than 3 weeks before his or her due date?

No
 Yes

7. At any time during the 12 months before you got pregnant with your new baby, did you do any of the following things? For each item, check No if you did not do it or Yes if you did it.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I was dieting (changing my eating habits) to lose weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was exercising 3 or more days of the week for fitness outside of my regular job | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I was regularly taking prescription medicines other than birth control..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A health care worker checked me for diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I talked to a health care worker about my family medical history | <input type="checkbox"/> | <input type="checkbox"/> |

8. 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) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |

9. 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

10. 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

Yes

→ **Go to Question 13**

11. 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:

12. 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.*

13. 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
- PeachCare for Kids
- 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

14. 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 15**
- 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
- PeachCare for Kids
- TRICARE or other military health care
- Other health insurance → Please tell us:

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

15. 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
- PeachCare for Kids
- TRICARE or other military health care
- Other health insurance → Please tell us:

- I do not have health insurance *now*

16. 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

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

- No
- Yes → **Go to Page 4, Question 21**

18. 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 Page 4, Question 20**

Go to Page 4, Question 19

19. 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:

If you or your husband or partner was not doing anything to keep from getting pregnant, go to Question 21.

20. What method of birth control were you using when you got pregnant?

Check ALL that apply

- Birth control pills
- Condoms
- Shots or injections (Depo-Provera®)
- Contraceptive implant in the arm (Nexplanon® or Implanon®)
- Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- 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.)

21. 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 23**

22. 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"/> |

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 have your teeth cleaned by a dentist or dental hygienist?

- No
 Yes

26. 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"/> |

27. 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"/> |

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 Page 7, Question 38

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

If you did not smoke at any time in the 3 months before you got pregnant, go to Question 37.

31. During any of your prenatal care visits, did a doctor, nurse, or other health care worker advise you to quit smoking?

- No
 Yes
 I didn't go for prenatal care → **Go to Question 33**

32. Listed below are some things about quitting smoking that a doctor, nurse, or other health care worker might have done during any of your prenatal care visits. For each thing, check **No** if it was not done or **Yes** if it was.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Spend time with me discussing how to quit smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Suggest that I set a specific date to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Suggest I attend a class or program to stop smoking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Provide me with booklets, videos, or other materials to help me quit smoking on my own | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Refer me to counseling for help with quitting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Ask if a family member or friend would support my decision to quit..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Refer me to a national or state quit line ... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Recommend using nicotine gum | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Recommend using a nicotine patch..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Prescribe a nicotine nasal spray or nicotine inhaler | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Prescribe a pill like Zyban® (also known as Wellbutrin® or bupropion) to help me quit..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Prescribe a pill like Chantix® (also known as varenicline) to help me quit | <input type="checkbox"/> | <input type="checkbox"/> |

33. During your most recent pregnancy, did you do any of the following things about quitting smoking? For each thing, check **No** if you did not do it or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Set a specific date to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Use booklets, videos, or other materials to help me quit | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Call a national or state quit line or go to a website..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Attend a class or program to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Go to counseling for help with quitting... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Use a nicotine patch, gum, lozenge, nasal spray or inhaler | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Take a pill like Zyban® (also known as Wellbutrin® or bupropion) to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Take a pill like Chantix® (also known as varenicline) to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Try to quit on my own (e.g., cold turkey).. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

34. During your most recent pregnancy, did your health insurance pay for medications or any other services to help you quit smoking?

Check ONE answer

- No, my insurance did not pay
 Yes, but I had to make a co-payment
 Yes, with no co-payment
 I wasn't trying to quit smoking
 I didn't have health insurance
 I don't know

35. Did you quit smoking around the time of your most recent pregnancy?

Check ONE answer

- No
- No, but I cut back
- Yes, I quit before I found out I was pregnant
- Yes, I quit when I found out I was pregnant
- Yes, I quit later in my pregnancy

36. Listed below are some things that can make it hard for some people to quit smoking.

For each item, check **No** if it is not something that might make it hard for you or **Yes** if it is.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Cost of medicines or products to help with quitting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cost of classes to help with quitting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Fear of gaining weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Loss of a way to handle stress | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other people smoking around me | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cravings for a cigarette..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Lack of support from others to quit..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Worsening depression | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Worsening anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Some other reason..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

37. 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

38. Which of the following statements best describes the rules about smoking *inside* your home during your most recent pregnancy, even if no one who lived in your home was a smoker?

Check ONE answer

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

39. 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.

40. 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 41. Otherwise, go to Question 43.

41. 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

42. 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.

43. 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 46**
- Yes

44. 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

45. 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.

46. 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"/> |

47. During the 12 months before your new baby was born, did you feel emotionally upset (for example, angry, sad, or frustrated) as a result of how you were treated *based on your race*?

- No
 Yes

48. 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"/> |

49. 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.

50. When was your new baby born?

<input type="text"/> _____ Month	/	<input type="text"/> _____ Day	/	<input type="text"/> 20 _____ Year
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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 Question 54**

52. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 12, Question 66**

53. Is your baby living with you now?

- No → **Go to Page 12, Question 64**
- 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 → **Go to Question 59**
- Yes

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

- No
- Yes → **Go to Question 58**

57. 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 59.

58. 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"/> |

If your baby is still in the hospital, go to Page 12, Question 64.

59. 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

60. 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 62

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

- No
- Yes

62. 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"/> |

63. 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"/> |

64. Since your new baby was born, has a home visitor come to your home to help you learn how to take care of yourself or your new baby? A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps mothers of newborns.

- No —————→ **Go to Question 66**
- Yes

65. What kind of home visitor has come to your home since your new baby was born?

- A nurse or nurse's aide
- A teacher or health educator
- A doula or midwife
- Someone else —————→ Please tell us:
- I don't know

66. 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 —————→ **Go to Question 68**
- Yes

Go to Question 67

67. 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 69.

68. 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:

69. 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 → **Go to Question 71**

Yes

70. 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"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

72. 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.

73. At any time during your most recent pregnancy, did you work at a job for pay?

No → **Go to Page 14, Question 76**

Yes

74. Please tell us about your MAIN job during your most recent pregnancy. What was your job title and what were your usual activities or duties?

Job title:

Job duties:

75. Thinking about your MAIN job during your most recent pregnancy, what type of company did you work for (what did the company do or make)?

Type of company:

Four horizontal lines for writing the type of company.

I don't know

If your baby is not alive or is not living with you, go to Question 77.

76. Since your new baby was born, have you used any of these services? For each one, check No if you did not use the service or Yes if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Parenting classes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Counseling for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> |

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

77. 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

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

People

79. What is today's date?

<input type="text"/>	/	<input type="text"/>	/	<input type="text" value="20"/>
Month		Day		Year

The next questions are about your ability to do different activities.

D1. Do you have difficulty seeing, even when wearing glasses or contact lenses?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D2. Do you have difficulty hearing, even if using a hearing aid(s)?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D3. Do you have difficulty walking or climbing steps?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D4. Do you have difficulty remembering or concentrating?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D5. Do you have difficulty with self care, such as washing all over or dressing?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D6. Using your usual language, do you have difficulty communicating, for example, understanding or being understood?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

The next questions are about the use of pain relievers *during* pregnancy.

O1. During your most recent pregnancy, did you use any of the following over-the-counter pain relievers? Over-the-counter pain relievers are those *usually* available without a prescription. For each one, check **No** if you did not use it *during* your pregnancy or **Yes** if you did.

No Yes

- a. Acetaminophen (like regular Tylenol®, Tylenol Extra Strength®, or Tylenol PM®).....
- b. Ibuprofen (like Motrin® or Advil®), including high dose pills that may be prescribed
- c. Aspirin (like Bayer® or Ecotrin®)
- d. Naproxen (like Aleve® or Midol®)

O2. During your most recent pregnancy, did you use any of the following *prescription* pain relievers? For each one, check **No** if you did not use it *during* your pregnancy or **Yes** if you did. Do *not* include pain relievers you used *only* during labor and delivery.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Hydrocodone (like Vicodin [®] , Norco [®] , or Lortab [®])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Codeine (like Tylenol [®] #3 or #4, <u>not</u> regular Tylenol [®]) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Oxycodone (like Percocet [®] , Percodan [®] , OxyContin [®] , or Roxicodone [®])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Tramadol (like Ultram [®] or Ultracet [®])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hydromorphone or meperidine (like Demorol [®] , Exalgo [®] , or Dilaudid [®])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Oxymorphone (like Opana [®])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Morphine (like MS Contin [®] , Avinza [®] , or Kadian [®])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Fentanyl (like Duragesic [®] , Fentora [®] , or Actiq [®])..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you checked “Yes” for any of the options in Question O2, continue with the next question. If not, go to Question O10.

The next questions are only about the use of *prescription* pain relievers listed in Question O2.

O3. Where did you get the *prescription* pain relievers that you used *during* your most recent pregnancy?

Check ALL that apply

- OB-GYN, midwife, or prenatal care provider
- Family doctor or primary care provider
- Dentist or oral health care provider
- Doctor in the emergency room
- I had pain relievers left over from an old prescription
- Friend or family member gave them to me
- I got the pain relievers without a prescription some other way
- Other _____ → Please tell us:

O4. What were your reasons for using *prescription* pain relievers *during* your most recent pregnancy?

Check ALL that apply

- To relieve pain from an injury, condition, or surgery I had **before** pregnancy
- To relieve pain from an injury, condition, or surgery that happened **during** my pregnancy
- To relax or relieve tension or stress
- To help me with my feelings or emotions
- To help me sleep
- To feel good or get high
- Because I was “hooked” or I had to have them
- Other _____ → Please tell us:

O5. In each of the following time periods during your pregnancy, for how many weeks or months did you use *prescription pain relievers*? Please write the total number of weeks or months in each time period.

a. In the **first** 3 months of pregnancy

____ Weeks **OR** ____ Months

- Less than a week
 Never

b. In the **second** 3 months of pregnancy

____ Weeks **OR** ____ Months

- Less than a week
 Never

c. In the **last** 3 months of pregnancy

____ Weeks **OR** ____ Months

- Less than a week
 Never

O6. During your most recent pregnancy, did you want or need to cut down or stop using *prescription pain relievers*?

- No → **Go to Question O10**
 Yes

O7. During your most recent pregnancy, did you have trouble cutting down or stopping use of the *prescription pain relievers*?

- No
 Yes

O8. During your most recent pregnancy, did you get help from a doctor, nurse, or other health care worker to cut down or stop using *prescription pain relievers*?

- No → **Go to Question O10**
 Yes

O9. During your most recent pregnancy, did you receive medication-assisted treatment to help you stop using *prescription pain relievers*? This is when a doctor prescribes medicines such as methadone, buprenorphine, Suboxone®, Subutex®, or naltrexone (Vivitrol®).

- No
 Yes

O10. Do you think the use of *prescription pain relievers during pregnancy* could be harmful to a *baby's* health?

Check ONE answer

- Not harmful at all
 Not harmful, if taken as prescribed
 Harmful, even if taken as prescribed

O11. Do you think the use of *prescription pain relievers* could be harmful to a woman's own health?

Check ONE answer

- Not harmful at all
 Not harmful, if taken as prescribed
 Harmful, even if taken as prescribed

O12. At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker talk with you about how using *prescription pain relievers* during pregnancy could affect a baby?

- No
 Yes

The last question is about the use of other medications or drugs during pregnancy.

O13. During your most recent pregnancy, did you take or use any of the following medications or drugs for any reason? For each item, check **No** if you did not take or use it or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Medication for depression (like Prozac [®] , Zoloft [®] , Lexapro [®] , Paxil [®] , or Celexa [®]) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Medication for anxiety (like Valium [®] , Xanax [®] , Ativan [®] , Klonopin [®] , or other "benzos" (benzodiazepines)) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Methadone, Subutex [®] , Suboxone [®] , or buprenorphine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Naloxone..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cannabidiol (CBD) products..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Adderall [®] , Ritalin [®] , or another stimulant.. | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Marijuana or hash..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Synthetic marijuana (K2, Spice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Heroin (smack, junk, Black Tar, or <i>Chiva</i>).. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Amphetamines (uppers, speed, crystal meth, crank, ice, or <i>agua</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Cocaine (crack, rock, coke, blow, snow, or <i>nieve</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Tranquilizers (downers or ludes)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, or bath salts)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing) | <input type="checkbox"/> | <input type="checkbox"/> |

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 Georgia.

Thanks for answering our questions!

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

