

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

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

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

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.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I was regularly taking prescription medicines other than birth control .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I visited a health care worker and was checked for diabetes.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I visited a health care worker and was checked for high blood pressure .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I visited a health care worker and was checked for depression or anxiety ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I talked to a health care worker about my family medical history.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I had my teeth cleaned by a dentist or dental hygienist .....                  | <input type="checkbox"/> | <input type="checkbox"/> |

8. 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, partner, or parents
- Private health insurance purchased directly from an insurance company
- Medicaid
- TRICARE or other military health care
- Some other kind of health insurance → Please tell us:
- I did not have any health insurance during the *month before* I got pregnant

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

- No → **Go to Question 12**
- Yes

**Go to Question 11**

11. 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? 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 talked with you about it.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Taking vitamins with folic acid before pregnancy .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Being a healthy weight before pregnancy .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Getting my vaccines updated before pregnancy .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Visiting a dentist or dental hygienist before pregnancy .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Getting counseling for any genetic diseases that run in my family .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Controlling any medical conditions such as diabetes and high blood pressure .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Getting counseling or treatment for depression or anxiety .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The safety of using prescription or over-the-counter medicines during pregnancy ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. How smoking during pregnancy can affect a baby .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. How drinking alcohol during pregnancy can affect a baby .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| k. How using illegal drugs during pregnancy can affect a baby .....                      | <input type="checkbox"/> | <input type="checkbox"/> |

**12. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker tell you that you had 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 the same as gestational diabetes or diabetes that starts during pregnancy) .....
- b. High blood pressure or hypertension ..
- c. Depression .....

**13. 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. Asthma .....
- b. Anemia (poor blood, low iron) .....
- c. Heart problems .....
- d. Epilepsy (seizures) .....
- e. Thyroid problems .....
- f. Anxiety .....

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

**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

Go to  
Question 16

**15. How much longer did you want to wait to become pregnant?**

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to 5 years
- More than 5 years

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

- No
- Yes

Go to Page 4, Question 20

**17. 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 using birth control pills, condoms, withdrawal, or natural family planning.

- No
- Yes

Go to Page 4, Question 19

Go to Page 4, Question 18

18. 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 20.

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

Check ALL that apply

- Birth control pill
- Condoms
- Injection (Depo-Provera®)
- Contraceptive implant (Implanon®)
- Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- IUD (including Mirena® or ParaGard®)
- 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.)

20. How many weeks *or* months pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children).

{ \_\_\_\_\_ Weeks OR \_\_\_\_\_ Months

I didn't go for prenatal care → Go to Question 22

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

No  
 Yes → Go to Question 23

Go to Question 22

**22. 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 25.**

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

**Check ALL that apply**

- Private health insurance from my job or the job of my husband, partner, or parents
- Private health insurance purchased directly from an insurance company
- Medicaid
- TRICARE or other military health care
- Some other kind of health insurance —————> Please tell us:
- \_\_\_\_\_
- I did not have any health insurance to pay for my *prenatal care*

**24. 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 much weight I should gain during my pregnancy.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. How smoking during pregnancy could affect my baby.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Breastfeeding my baby.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. How drinking alcohol during pregnancy could affect my baby.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Using a seat belt during my pregnancy.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Medicines that are safe to take during my pregnancy.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How using illegal drugs could affect my baby.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Doing tests to screen for birth defects or diseases that run in my family.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Getting tested for HIV (the virus that causes AIDS).....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| k. What to do if I feel depressed during my pregnancy or after my baby is born.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Physical abuse to women by their husbands or partners.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |

**25. At any time during your most recent pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)?**

- No
- Yes
- I don't know

26. 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

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

Check ONE answer

- No  $\longrightarrow$  **Go to Question 29**  
 Yes, before my pregnancy  
 Yes, during my pregnancy

28. During what month and year did you get the flu shot?

/  20

Month                  Year

- I don't remember

29. This question is about the 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 my teeth cleaned by a dentist or dental hygienist.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I had insurance to cover dental care during my pregnancy.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I <u>needed</u> to see a dentist for a <b>problem</b> .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I <u>went</u> to a dentist or dental clinic about a <b>problem</b> .....                         | <input type="checkbox"/> | <input type="checkbox"/> |

30. During *your most recent* pregnancy, did you take a class or classes to prepare for childbirth and learn what to expect during labor and delivery?

- No  
 Yes

31. During *your most recent* pregnancy, did a home visitor come to your home to help you prepare for 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 pregnant women.

- No  
 Yes

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

- No  $\longrightarrow$  **Go to Question 34**  
 Yes

33. During *your most recent* pregnancy, when you went for your WIC visits, did you speak with a breastfeeding peer counselor or another WIC staff person about breastfeeding?

- No  
 Yes

34. During *your most recent* pregnancy, were you told by a doctor, nurse, or other health care worker that you had gestational diabetes (diabetes that started during *this* pregnancy)?

- No  
 Yes

**35. Did you have any of the following problems during *your most recent* pregnancy?** For each item, check **No** if you did not have the problem or **Yes** if you did.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Vaginal bleeding .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Kidney or bladder (urinary tract) infection (UTI) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <b>Severe</b> nausea, vomiting, or dehydration that sent me to the doctor or hospital .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cervix had to be sewn shut (cerclage for incompetent cervix) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. High blood pressure, hypertension (including pregnancy-induced hypertension [PIH]), preeclampsia, or toxemia ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Problems with the placenta (such as abruptio placentae or placenta previa) .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Labor pains more than 3 weeks before my baby was due (preterm or early labor) .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Water broke more than 3 weeks before my baby was due (premature rupture of membranes [PROM]) .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I had to have a blood transfusion .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I was hurt in a car accident .....   | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

No —————→ **Go to Page 8, Question 42**

↓  
 Yes

**37. 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

**38. 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 during the 3 months before you got pregnant with your new baby, go to Question 41.**

**39. 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

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

- 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

**41. 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

**42. 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 drinking alcohol around the time of pregnancy (before and during).**

**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 47**

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  
 7 to 13 drinks a week  
 4 to 6 drinks a week  
 1 to 3 drinks a week  
 Less than 1 drink a week

I didn't drink then → **Go to Question 46**

**45. During the 3 months *before* you got pregnant, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span?**

- 6 or more times  
 4 to 5 times  
 2 to 3 times  
 1 time  
 I didn't have 4 drinks or more in a 2 hour time span

**46. 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  
 7 to 13 drinks a week  
 4 to 6 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 for some women. The next questions are about things that may have happened before and during your most recent pregnancy.**

**47. 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 his 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 he 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"/> |

**48. During the 12 months before you got pregnant with your new baby, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?**

- No  
 Yes

**49. During your most recent pregnancy, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?**

- No  
 Yes

**The next questions are about your labor and delivery.**

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

____	/	____	/	20
Month		Day		Year

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

- Vaginally →  
 Cesarean delivery (c-section)

**Go to Page 10,  
Question 53**

**Go to Page 10, Question 52**

52. 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 preeclampsia, 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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53. By the end of *your most recent* pregnancy, how much weight had you gained?

Check ONE answer and fill in blank if needed

- I gained \_\_\_\_\_ pounds
- I didn't gain any weight, but I lost \_\_\_\_\_ pounds
- My weight didn't change during my pregnancy
- I don't know

## AFTER PREGNANCY

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

54. After your baby was delivered, was he or she put in an intensive care unit (NICU)?

- No
- Yes
- I don't know

55. 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 58**

56. Is your baby alive now?

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

57. Is your baby living with you now?

- No → **Go to Page 12, Question 65**
- Yes

58. 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 60**

**Go to Question 59**

**59. 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 or school
- Other \_\_\_\_\_ → Please tell us:  
\_\_\_\_\_

**If you did not breastfeed your new baby, go to Question 63.**

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

No  
 Yes → **Go to Question 62**

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

\_\_\_\_\_ Weeks OR \_\_\_\_\_ Months

Less than 1 week

**If your baby was not born in a hospital, go to Question 63.**

**62. 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 happen.

- |   | 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. Hospital staff helped me learn how to breastfeed.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I breastfed in the first hour after my baby was born.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I breastfed my baby in the hospital.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My baby was fed only breast milk at the hospital.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Hospital staff told me to breastfeed whenever my baby wanted .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The hospital gave me a breast pump to use.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The hospital gave me a gift pack with formula.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| j. The hospital gave me a telephone number to call for help with breastfeeding..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. 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 65.**

**63. 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

**64. How often does your new baby sleep in the same bed with you or anyone else?**

- Always
- Often
- Sometimes
- Rarely
- Never

65. *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  
 Yes

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 using birth control pills, condoms, withdrawal, or natural family planning.

- No  
 Yes

Go to Question 68

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 am not having sex  
 I want to get pregnant  
 I don't want to use birth control  
 I am worried about side effects from birth control  
 My husband or partner doesn't want to use anything  
 I have problems getting birth control when I need it  
 I had my tubes tied or blocked  
 My husband or partner had a vasectomy  
 I am pregnant now  
 Other \_\_\_\_\_ → Please tell us:

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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, Essure®, Adiana®)  
 Vasectomy (male sterilization)  
 Birth control pill  
 Condoms  
 Injection (Depo-Provera®)  
 Contraceptive implant (Implanon®)  
 Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)  
 IUD (including Mirena® or ParaGard®)  
 Natural family planning (including rhythm method)  
 Withdrawal (pulling out)  
 Not having sex (abstinence)  
 Other \_\_\_\_\_ → Please tell us:

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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  
 Yes

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

- Always  
 Often  
 Sometimes  
 Rarely  
 Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

72. *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, partner, or parents
- Private health insurance purchased directly from an insurance company
- Medicaid
- TRICARE or other military health care
- Some other kind of health insurance —————> Please tell us:

- I do not have health insurance *now*

**OTHER EXPERIENCES**

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

73. *Were you offered two HIV tests during your most recent pregnancy or delivery?*

- No, I wasn't offered any HIV tests
- No, I was just offered 1 test
- Yes, I was offered 2 tests

74. *At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker tell you that you had depression?*

- No
- Yes

**If your baby is not alive, is not living with you, or is still in the hospital, go to Page 14, Question 79.**

75. *How often does your new baby go to sleep with a pacifier?* **Check ONE answer**

- Always
- Often
- Sometimes
- Rarely
- Never

76. *Listed below are true statements about water safety and drowning.* For each item, check **No** if it is something you did not know or **Yes** if it is something you knew.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Drowning is the leading cause of death for children ages 1-4 .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Most of these deaths occur in swimming pools.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Infants and children usually drown without a sound.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A "Water Watcher" should be designated while children are in or around all types of water..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Children can also drown in buckets, toilets, bathtubs, or less than two inches of water .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Water buckets should be stored empty and upside down .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Toilet lids should remain closed and locked when not in use .....                              | <input type="checkbox"/> | <input type="checkbox"/> |

**77. Listed below are some statements about safety.** For each one, check **No** if it does not apply to you or **Yes** if it does.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. I know how to perform baby CPR.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My home has a working smoke alarm .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I always keep materials like cleaning supplies, medicine, and pesticides out of reach from young children ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My new baby always or almost always rides in a rear-facing infant car seat.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The Poison Control Center phone number (1-800-222-1222) is accessible in my home .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My home has a working carbon monoxide alarm .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My new baby is constantly supervised while in or around water (bathtub, pool, natural water, etc.).....         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I always or almost always use a food thermometer when cooking meat or poultry .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I plan for my new baby to wear a safety helmet when sitting on a rocking or riding toy .....                    | <input type="checkbox"/> | <input type="checkbox"/> |

**78. Did a doctor, nurse or other health care worker offer you a Tdap vaccination or tell you to get one?** A Tdap vaccination protects against tetanus, diphtheria and pertussis (or whooping cough).

- No  
 Yes  
 I don't know

**79. Did you receive the Tdap vaccination during your pregnancy?**

- No  
 Yes

**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 \$15,000  
 \$15,001 to \$19,000  
 \$19,001 to \$22,000  
 \$22,001 to \$26,000  
 \$26,001 to \$29,000  
 \$29,001 to \$37,000  
 \$37,001 to \$44,000  
 \$44,001 to \$52,000  
 \$52,001 to \$56,000  
 \$56,001 to \$67,000  
 \$67,001 to \$79,000  
 \$79,001 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?**

/  /  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 Florida.**

*Thanks for answering our questions!*

*Your answers will help us work to make Florida mothers and babies healthier.*