

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) | <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"/> |

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"/> |

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

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

Check ALL that apply

- ☐ Private health insurance from my job or the job of my husband or partner
- ☐ Private health insurance from my parents
- ☐ Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- ☐ Medicaid (or FAMIS/FAMIS MOMS)
- ☐ 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

If you did not have health insurance during the month before you got pregnant, go to Question 10. Otherwise, go to Question 11.

10. What was the reason that you did not have any health insurance during the *month before* you got pregnant with your new baby?

Check ALL that apply

- ☐ Health insurance was too expensive
- ☐ I could not get health insurance from my job or the job of my husband or partner
- ☐ I applied for health insurance, but was waiting to get it
- ☐ I had problems with the health insurance application or website
- ☐ My income was too high to qualify for Medicaid (or FAMIS/FAMIS MOMS)
- ☐ My income was too high to qualify for a tax credit from the Health Insurance Marketplace or HealthCare.gov
- ☐ I didn't know how to get health insurance
- ☐ Other _____ → Please tell us:

11. 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 12**
- ☐ 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 (or FAMIS/FAMIS MOMS)
- ☐ TRICARE or other military health care
- ☐ Other health insurance _____ → Please tell us:

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

12. 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 (or FAMIS/FAMIS MOMS)
- ☐ TRICARE or other military health care
- ☐ Other health insurance _____ → Please tell us:

- ☐ I do not have health insurance *now*

13. 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

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

- ☐ No
- ☐ Yes _____ → **Go to Page 4, Question 17**

15. 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 _____ → **Go to Page 4, Question 17**
- ☐ Yes

Go to Page 4, Question 16

16. 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.)

17. 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 19

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

- ☐ No
- ☐ Yes

Go to Question 20

Go to Question 19

19. 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..... ☐ ☐
- b. I didn't have enough money or insurance to pay for my visits..... ☐ ☐
- c. I didn't have any transportation to get to the clinic or doctor's office ☐ ☐
- d. The doctor or my health plan would not start care as early as I wanted..... ☐ ☐
- e. I had too many other things going on ☐ ☐
- f. I couldn't take time off from work or school..... ☐ ☐
- g. I didn't have my Medicaid (or FAMIS/FAMIS MOMS) card..... ☐ ☐
- h. I didn't have anyone to take care of my children ☐ ☐
- i. I didn't know that I was pregnant..... ☐ ☐
- j. I didn't want anyone else to know I was pregnant ☐ ☐
- k. I didn't want prenatal care..... ☐ ☐

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

20. 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"/> |

21. How did the doctor, nurse, or other health care worker who provided your prenatal care suggest you deliver your new baby?

Check ONE answer

- ☐ He or she suggested I deliver my baby vaginally (naturally)
- ☐ He or she suggested I have a cesarean delivery (c-section)
- ☐ He or she didn't suggest how I deliver my baby

22. 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

23. 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

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

- ☐ No
- ☐ Yes
- ☐ I don't know

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..... ☐ ☐
- b. A dental or other health care worker talked with me about how to care for my teeth and gums..... ☐ ☐
- c. I had insurance to cover dental care during my pregnancy..... ☐ ☐
- d. I needed to see a dentist for a **problem** .. ☐ ☐
- e. I went to a dentist or dental clinic about a **problem** ☐ ☐

27. 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 (or FAMIS/FAMIS MOMS) 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"/> |

28. 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

→ **Go to Question 30**

29. During your most recent pregnancy, did the home visitor who came to your home talk with you about any of the things listed below? For each one, check **No** if they did not talk with you about it or **Yes** if they did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. How smoking during pregnancy could affect my baby | <input type="checkbox"/> | <input type="checkbox"/> |
| b. How drinking alcohol during pregnancy could affect my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Doing tests to screen for birth defects or diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The importance of getting tested for HIV or other sexually transmitted infections.. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Physical or emotional abuse to women by their husbands or partners..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Breastfeeding my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My emotional well-being..... | <input type="checkbox"/> | <input type="checkbox"/> |

30. 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"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |

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

- ☐ No
☐ Yes
☐ I don't know

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

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

- ☐ No → **Go to Question 37**
☐ Yes

33. 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

34. 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 36.

35. 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:

36. 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

37. 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

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.

38. 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"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 39. Otherwise, go to Question 41.

39. 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

40. 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.

41. 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 44**
- ☐ Yes

42. 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

43. 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.

44. 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

45. 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

46. 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. Someone else | <input type="checkbox"/> | <input type="checkbox"/> |

47. 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. Someone else | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

48. When was your new baby born?

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

49. How was your new baby delivered?

- ☐ Vaginally
☐ Cesarean delivery (c-section)

50. 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 53**

51. Is your baby alive now?

- ☐ No → *We are very sorry for your loss.*
☐ Yes → **Go to Page 11, Question 68**

Go to Question 52

52. Is your baby living with you now?

- ☐ No → **Go to Page 11, Question 66**
☐ Yes

53. 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:

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

- ☐ No
☐ Yes → **Go to Page 10, Question 56**

55. 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 59.

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

- ☐ No
☐ Yes

Go to Question 59

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

- ☐ Less than 1 week

_____ Weeks **OR** _____ Months

58. What were your reasons for stopping breastfeeding?

Check ALL that apply

- ☐ My baby had difficulty latching or nursing
☐ Breast milk alone did not satisfy my baby
☐ I thought my baby was not gaining enough weight
☐ My nipples were sore, cracked, or bleeding or it was too painful
☐ I thought I was not producing enough milk, or my milk dried up
☐ I had too many other household duties
☐ I felt it was the right time to stop breastfeeding
☐ I got sick or I had to stop for medical reasons
☐ I went back to work
☐ I went back to school
☐ My partner did not support breastfeeding
☐ My baby was jaundiced (yellowing of the skin or whites of the eyes)
☐ Other _____ → Please tell us:

59. What kind of health insurance is your new baby covered by 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 (or FAMIS/FAMIS MOMS Plus)
☐ TRICARE or other military health care
☐ Other health insurance → Please tell us:

- ☐ I do not have any health insurance for my new baby

60. 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 66.

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

Check ONE answer

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

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

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

Go to Question 64

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

- ☐ No
☐ Yes

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

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

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

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

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

66. 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

Go to Question 68

67. Since your new baby was born, did the home visitor who came to your home talk with you about any of the things listed below? For each one, check **No** if they did not talk with you about it or **Yes** if they did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Breastfeeding my baby | <input type="checkbox"/> | <input type="checkbox"/> |
| b. How long to wait before getting pregnant again | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Family planning services or using contraception | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Postpartum depression | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Resources in my community to support new parents | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Getting to and staying at a healthy weight after delivery | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How to quit or keep from smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| h. How to get the health care that my baby or I need | <input type="checkbox"/> | <input type="checkbox"/> |

68. 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 12, Question 70

Go to Page 12, Question 69

69. 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 71.

70. 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:

71. 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 73

72. Did any of these things keep you from having a postpartum checkup?

Check ALL that apply

- ☐ I didn't have health insurance to cover the cost of the visit
- ☐ I felt fine and did not think I needed to have a visit
- ☐ I couldn't get an appointment when I wanted one
- ☐ I didn't have any transportation to get to the clinic or doctor's office
- ☐ I had too many things going on
- ☐ I couldn't take time off from work
- ☐ Other —————→ Please tell us:

If you did not have a postpartum checkup, go to Question 74.

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

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

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

OTHER EXPERIENCES

The next questions are on a variety of topics.

76. During the 12 months before your new baby was born, did you experience discrimination, harassment, or were you made to feel inferior because of the things listed below? For each item, check **No if you did not experience these things or **Yes** if you did experience them.**

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. My race, ethnicity, or culture | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My insurance or Medicaid status | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My marital status | <input type="checkbox"/> | <input type="checkbox"/> |

77. During any of the following time periods, did your husband or partner threaten you, limit your activities against your will, or make you feel unsafe in any other way? For each time period, check **No if it did not happen then or **Yes** if it did.**

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. During the 12 months before I got pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Since my new baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you were on Medicaid (or FAMIS/FAMIS MOMS) before you got pregnant, go to Question 80.

78. Did you try to get Medicaid, FAMIS, or FAMIS MOMS coverage during your most recent pregnancy?

☐ No → **Go to Question 80**

☐ Yes

79. Did you have any problems getting Medicaid, FAMIS, or FAMIS MOMS during your most recent pregnancy?

☐ No

☐ Yes

80. Did you worry that wearing your seat belt during pregnancy would hurt your new baby?

☐ No

☐ Yes

81. Please tell us if you have heard of the following Virginia programs. For each item, check **No** if you have not heard about it or **Yes** if you have.

	No	Yes
a. Quit Now Virginia (1-800-Quit-Now)	<input type="checkbox"/>	<input type="checkbox"/>
b. 2-1-1 Virginia	<input type="checkbox"/>	<input type="checkbox"/>
c. Text4baby	<input type="checkbox"/>	<input type="checkbox"/>
d. Virginia Department of Health Family Planning Clinics	<input type="checkbox"/>	<input type="checkbox"/>
e. Care Connection for Children.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Loving Steps / Healthy Start	<input type="checkbox"/>	<input type="checkbox"/>
g. Nurse – Family Partnership (NFP).....	<input type="checkbox"/>	<input type="checkbox"/>
h. Healthy Families	<input type="checkbox"/>	<input type="checkbox"/>
i. Part C Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>
j. Project LINK.....	<input type="checkbox"/>	<input type="checkbox"/>
k. CHIP of Virginia	<input type="checkbox"/>	<input type="checkbox"/>
l. Safety Seat Check Station	<input type="checkbox"/>	<input type="checkbox"/>
m. Low Income Safety Seat Program.....	<input type="checkbox"/>	<input type="checkbox"/>
n. Head Start.....	<input type="checkbox"/>	<input type="checkbox"/>
o. Early Head Start.....	<input type="checkbox"/>	<input type="checkbox"/>

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

82. 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

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

 People

84. 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 Virginia.

Thanks for answering our questions!

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

