

# UT Opioid Call Back Survey

The first questions are about *you*.

## 1 Are you *currently* working for pay?

- (1)  No → **Go to Question 4**
- (2)  Yes

(Don't Read)

- (8)  Refused → **Go to Question 4**
- (9)  Don't Know/Don't Remember → **Go to Question 4**

## 2 Please tell us about your MAIN job *now*. What is your job title and what are your usual activities or duties?

2a Job Title:

---

---

---

(Don't Read)

- (8)  Refused
- (9)  Don't Know/Don't Remember

2b Job Duties:

---

---

---

(Don't Read)

- (8)  Refused
- (9)  Don't Know/Don't Remember

## 3 Thinking about your MAIN job *now*, what type of company do you work for? (What does the company do or make?)

Type of Company:

---

---

---

(Don't Read)

- (8)  Refused
- (9)  Don't Know/Don't Remember

**4 What kind of health insurance do you have now?**

I'm going to read the list of types of health insurance. For each one, please tell me if you have this kind of health insurance *now*. Do you have \_\_\_\_\_?

(**PROBE:** What kind of health insurance do you have *now*?)

	<b>No</b> (1)	<b>Yes</b> (2)	<b>Ref</b> (8)	<b>DKDR</b> (9)
a. Private health insurance from your job or the job of your husband or partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Private health insurance from your parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Private health insurance from the Health Insurance Marketplace or HealthCare.gov	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Medicaid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. TRICARE or other military health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Do you have some other health insurance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. <b>IF ANSWERED YES TO OTHER, ASK:</b> What is that? _____	---	---	---	---
h. <b>IF NONE OF THE OPTIONS ABOVE ARE 'YES', ASK:</b>  Would you say that you do not have any health insurance <i>now</i> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>INTERVIEWER: If the mother answered that she does not have any health insurance, check YES.</b>				

**The next question is about your health.**

**5 I'm going to read a list of health conditions. For each one, please tell me if you *currently* have it.**

Do you have\_\_\_\_?

	<b>No</b> (1)	<b>Yes</b> (2)	<b>Ref</b> (8)	<b>DKDR</b> (9)
a. Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Hepatitis C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Chronic Pain, which is pain on most days or every day in the past 6 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions are about your use of medications or other substances *since your baby was born*.

**6** *Since your baby was born, have you taken or used any of the following prescription pain relievers for any reason?* I'm going to read a list of options. For each one, please tell me if you have taken or used it *since your baby was born*. Have you taken or used \_\_\_\_\_?

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Hydrocodone like Vicodin®, Norco®, or Lortab®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Codeine like Tylenol® 3 or 4, these are <u>not</u> regular Tylenol®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Oxycodone like Percocet®, Percodan®, OxyContin®, or Roxicodone®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Tramadol like Ultram® or Ultracet®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Hydromorphone or meperidine like Demerol®, Exalgo®, or Dilaudid®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Oxymorphone like Opana®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Morphine like MS Contin®, Avinza®, or Kadian®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Fentanyl like Duragesic®, Fentora®, or Actiq®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**INTERVIEWER: If mom said "Yes" for any option in Question 6, continue with the next question. If not, go to Question 10.**

**7** *Where did you get the prescription pain relievers that you used since your baby was born?* I'm going to read a list of options. For each one, please tell me if it applies to you. Did you get them \_\_\_\_\_?

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. In the hospital, right after the birth of your baby	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. From an OB-GYN, midwife, or prenatal care provider	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. From a family doctor or primary care provider	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. From a dentist or oral health care provider	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. From a doctor in the emergency room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Were they pain relievers left over from an old prescription?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Did a friend or family member give them to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Did you get them <u>without a prescription</u> in some other way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Did you get them somewhere else?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. <b>If YES, ask:</b> Where? _____	---	---	---	---

**8 I'm going to read a list of reasons for using prescription pain relievers. For each one, please tell me if it was a reason for you *since your baby was born*. Was it \_\_\_\_\_?**

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. To relieve pain associated with your baby's birth, such as pain from the C-Section or a tear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. To relieve pain from an injury, condition, or surgery you've had <u>since your baby was born</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. To relax or relieve tension or stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. To help you with your feelings or emotions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. To help you sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. To feel good or get high	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Because you were "hooked" or you had to have them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Was there some other reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. <b>If YES, ask:</b> What was it? _____	---	---	---	---

**9 *Since your baby was born, how many weeks or months have you used prescription pain relievers?* Please tell me the total number of weeks or months you have used prescription pain relievers *since your baby was born*.**

- (1)  Number of weeks \_\_\_\_\_ (Range: 1-45 weeks)
- (2)  Number of months \_\_\_\_\_ (Range: 1-10 months)
- (3)  Less than a week
- (Don't Read)**
- (8)  Refused
- (9)  Don't know/Don't Remember

**10 Since your baby was born, have you taken or used any of the following other medications or drugs for any reason?**

I'm going to read a list of options. For each one, please tell me if you have taken or used it *since your baby was born*. Have you taken or used \_\_\_\_\_?

(PROBE: *Since your baby was born, have you taken or used \_\_\_\_\_?*)

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Over-the-counter pain medication such as aspirin, Tylenol®, Tylenol PM®, Tylenol Extra Strength®, Advil®, Motrin®, Aleve®, or Panadol®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Medication for depression such as Prozac®, Zoloft®, Lexapro®, Paxil®, or Celexa®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Medication for anxiety such as Valium®, Xanax®, Ativan®, Klonopin®, or other benzodiazepines, also known as "benzos"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Adderall®, Ritalin®, or another stimulant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Methadone, Subutex®, Suboxone®, or buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Naloxone or Narcan®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Cannabidiol or CBD products	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Marijuana or hash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Synthetic marijuana, or K2 or Spice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Heroin, also known as smack, junk, Black Tar, or Chiva	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Amphetamines, also known as uppers, speed, crystal meth, crank, ice, or <i>agua</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Cocaine, also known as crack, rock, coke, blow, snow, or <i>nieve</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Tranquilizers, also known as downers or ludes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Hallucinogens, such as LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, or bath salts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Sniffing gasoline, glue, aerosol spray cans, or paint to get high, also known as huffing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**The next questions are about alcohol use.**

**11** *Since your baby was born, has a doctor, nurse, or other health care worker asked you, in person or on a form, if you drink alcohol?*

- (1)  No  
(2)  Yes  
(Don't Read)  
(8)  Refused  
(9)  Don't Know/Don't Remember

**12** *Have you had any alcoholic drinks since your baby was born?*

A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

- (1)  No → **Go to Question 17**  
(2)  Yes  
(Don't Read)  
(8)  Refused → **Go to Question 17**  
(9)  Don't Know/Don't Remember → **Go to Question 17**

**13** *Since your baby was born, how many alcoholic drinks did you have in an average week? Was it \_\_\_\_\_?*

(PROBE: *Since your baby was born, how many alcoholic drinks did you have in an average week?*)

- (1)  14 drinks or more a week  
(2)  8 to 13 drinks a week  
(3)  4 to 7 drinks a week  
(4)  1 to 3 drinks a week  
(5)  Less than 1 drink a week  
(Don't Read)  
(8)  Refused  
(9)  Don't know/Don't Remember

**14** *Since your baby was born, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span?*

Would you say that it was \_\_\_\_\_?

- (1)  6 or more times  
(2)  4 to 5 times  
(3)  2 to 3 times  
(4)  1 time  
(5)  You didn't have 4 drinks or more in a 2 hour time span  
(Don't Read)  
(8)  Refused  
(9)  Don't know/Don't Remember

**15** *Since your baby was born, were you offered advice by a doctor, nurse, or other health care worker about what level of drinking alcohol is harmful or risky for your health?*

- (1)  No  
(2)  Yes  
(Don't Read)  
(8)  Refused  
(9)  Don't Know/Don't Remember

**16** *Since your baby was born, were you advised to reduce or quit your drinking by a doctor, nurse, or other health care worker?*

- (1)  No  
(2)  Yes  
(Don't Read)  
(8)  Refused  
(9)  Don't Know/Don't Remember

**INTERVIEWER: If mom didn't use ANY SUBSTANCE (alcohol, prescription medications, other medications, or drugs) since her baby was born, go to Question 25. If mom only used prescription pain relievers for less than 1 week, go to Question 25.**

**The next questions are about things you may have experienced *since your baby was born*.**

**17 Since your baby was born, have you felt that your use of any medication, drug, or alcohol interfered with important activities in your life such as working, going to school, taking care of children, enjoying hobbies, or spending time with friends and family?**

- (1)  No
- (2)  Yes
- (Don't Read)**
- (8)  Refused
- (9)  Don't know/Don't Remember

**18 Since your baby was born, have you needed treatment or counseling for your use of...**

	<b>No</b> (1)	<b>Yes</b> (2)	<b>Ref</b> (8)	<b>DKDR</b> (9)
a. Prescription <u>pain relievers</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Other drugs or medications, <u>not</u> including prescription pain relievers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Some other substance, not including cigarettes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. <b>If YES, ask:</b> For what? <input style="width: 400px; height: 15px;" type="text"/>	---	---	---	---

**INTERVIEWER: If mom answers "No" for all the options in Question 18 go to Question 25. Otherwise, continue with the next question.**

**19 Since your baby was born, have you received treatment or counseling for your use of...**

	<b>No</b> (1)	<b>Yes</b> (2)	<b>Ref</b> (8)	<b>DKDR</b> (9)
a. Prescription <u>pain relievers</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Other drugs or medications, <u>not</u> including prescription pain relievers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Some other substance, not including cigarettes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. <b>If YES, ask:</b> For what? <input style="width: 400px; height: 15px;" type="text"/>	---	---	---	---

**20 I'm going to read a list of things that can make it difficult for some people to get treatment or counseling for their use of medications, drugs, or alcohol, not counting cigarettes. For each one, please tell me if it was something that made it difficult for you to get treatment or counseling. Would you say that \_\_\_\_\_?**

	<b>No (1)</b>	<b>Yes (2)</b>	<b>Ref (8)</b>	<b>DKDR (9)</b>
a. You could not get an appointment or were put on a waiting list	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. You were able to cut down or stop using without help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. You didn't have enough money or insurance to pay for services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. You didn't know where to go for help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. You didn't have transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. You didn't want people to think you had a problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Your partner did not want you to get help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. You were afraid of losing custody of your baby or children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. You had too many other things going on	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Was there another reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. <b>If YES, ask:</b> What was it? _____	---	---	---	---

**INTERVIEWER: If mom has not received any type of treatment or counseling, go to Question 25.**

**21 Since your baby was born, what kind of treatment or counseling have you received?** I'm going to read a list of types of treatment or counseling. For each one, please tell me if you received it. Did you receive \_\_\_\_\_?

(PROBE: What type of treatment or counseling did you receive?)

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Individual counseling with a behavioral health professional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Group counseling with a behavioral health professional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Counseling with a clergy member or other religious or community counselor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Self-help or recovery group meetings such as Alcoholics Anonymous or AA, Self-Management and Recovery Training or SMART, or Moderation Management or MM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Medication-assisted treatment, also known as MAT, using medicines such as methadone, buprenorphine, Suboxone®, Subutex® or naltrexone, also known as Vivitrol®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Did you receive another type of treatment or counseling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. <b>If YES, ask:</b> What did you receive? _____	---	---	---	---

**22 Since your baby was born, where have you received treatment for your use of any medications, drugs, or alcohol, not counting cigarettes?** I'm going to read a list of places. For each one, please tell me if you received treatment there. Did you receive treatment at \_\_\_\_\_?

(PROBE: Did you receive treatment for your use of medications, drugs, or alcohol at \_\_\_\_\_?)

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. A private doctor's office	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. An emergency room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. A treatment facility as an outpatient where you did <u>not</u> stay at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. A hospital as an inpatient where you stayed at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. A residential treatment facility where you stayed at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. A prison or jail	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Did you receive treatment somewhere else?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. <b>If YES, ask:</b> Where? _____	---	---	---	---

**23 What was the outcome of the treatment or counseling you last received? Would you say that \_\_\_\_\_?**

- (1)  You are still in treatment → **Go to Question 25**
- (2)  You completed treatment, or → **Go to Question 25**
- (3)  You did not finish treatment  
**(Don't Read)**
- (8)  Refused → **Go to Question 25**
- (9)  Don't know/Don't Remember → **Go to Question 25**

**24 I'm going to read a list of reasons why some people may not finish their treatment or counseling. For each one, please tell me if it was a reason for you. Was it because \_\_\_\_\_?**

**(PROBE:** Why didn't you finish treatment or counseling?)

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. You felt the treatment or counseling was not working	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. You had a problem with the program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. You could not afford to continue treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. You didn't have anyone to help you take care of your baby or other children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. You began using medications, drugs, or alcohol or other substances again	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Was there another reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. <b>If YES, ask:</b> What was it? _____	---	---	---	---

**The next questions are about tobacco products.**

**25 Since your baby was born, have you used cigarettes, e-cigarettes or any other tobacco products?**

- (1)  No → **Go to Question 30**
- (2)  Yes  
**(Don't Read)**
- (8)  Refused → **Go to Question 30**
- (9)  Don't Know/Don't Remember → **Go to Question 30**

**26 Since your baby was born, how many cigarettes do you smoke on an average day?** A pack has 20 cigarettes.

- (1)  41 cigarettes or more
- (2)  21 to 40 cigarettes
- (3)  11 to 20 cigarettes
- (4)  6 to 10 cigarettes
- (5)  1 to 5 cigarettes
- (6)  Less than 1 cigarette a day
- (7)  You haven't smoked cigarettes
- (Don't Read)**
- (8)  Refused
- (9)  Don't Know/Don't Remember

**27 Since your baby was born, how often have you used the following tobacco products?** For each one, please tell me if you used them Every day, Some days, or Never. Have you used \_\_\_\_\_?

**(PROBE:** Would you say you have used \_\_\_\_\_ Everyday, Some Days, or Never?)

	Every Day (1)	Some Days (2)	Never (3)	Ref (8)	DKDR (9)
a. E-cigarettes or other electronic vaping products with nicotine	<input type="radio"/>				
b. Hookah	<input type="radio"/>				
c. Chewing tobacco, snuff, snus, or dip	<input type="radio"/>				
d. Cigars, cigarillos, or little filtered cigars	<input type="radio"/>				

**28 Since your baby was born, has a doctor, nurse or other health care worker advised you to quit smoking or stop using tobacco products?**

- (1)  No
- (2)  Yes
- (Don't Read)**
- (8)  Refused
- (9)  Don't Know/Don't Remember

**29 Since your baby was born, have you received smoking cessation treatment to help you stop using cigarettes or other tobacco products?** Some examples include attending counseling or calling a quit-line, using self-help materials, or using nicotine replacement treatment such as the patch, gum or other medication.

- (1)  No
- (2)  Yes
- (Don't Read)**
- (8)  Refused
- (9)  Don't Know/Don't Remember

The next questions are about your baby’s health when he or she was a newborn.

**30 After your baby was born, did a doctor, nurse, or other healthcare worker tell you that your baby had drug withdrawal, sometimes known as neonatal abstinence syndrome or neonatal opioid withdrawal syndrome?**

- (1)  No → **Go to Question 34**
- (2)  Yes
- (Don't Read)
- (8)  Refused → **Go to Question 34**
- (9)  Don't know/Don't Remember → **Go to Question 34**

**31 Did your baby receive any of the following types of special care or treatment to help him or her with drug withdrawal symptoms?** I’m going to read a list of special care or treatments. For each item, please tell me if your baby received it. Did your baby receive \_\_\_\_\_?

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Medications such as morphine, methadone, or buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Fluids through an IV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Skin-to-skin care or Kangaroo Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Sleeping in quiet, dimly lit room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. High calorie formula	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Breastfeeding or pumped breast milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Donor breast milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Did he or she receive other treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. <b>If YES, ask:</b> What did he or she receive? _____	---	---	---	---

**32 I'm going to read a list of things that a doctor, nurse, or health care workers might have done *after your baby was born*. For each one, please tell me if they did it *after your baby was born*.**

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Talk to you about why your baby had drug withdrawal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Talk to you about the treatment for babies with drug withdrawal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Talk to you about how long your baby's withdrawal signs may last	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Talk to you about the things your baby could experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Talk to you about your baby's behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Talk to you about when your baby would be able to go home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Ask you about medications you were taking or took during pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Suggest you receive counseling or treatment for your use of medications, drugs, or alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Suggest you receive services for your baby such as early intervention or home visiting programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Did a scoring test to evaluate your baby for neonatal abstinence syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**33 *After your baby was born*, did a doctor, nurse, or other health care worker suggest that you not breastfeed your baby because of concerns that any medications or drugs you were using would pass to the baby through your milk?**

- (1)  No
- (2)  Yes
- (Don't Read)**
- (8)  Refused
- (9)  Don't know/Don't Remember

**34 Was your baby born in the hospital?**

- (1)  No → **Go to Question 39**
- (2)  Yes
- (Don't Read)**
- (8)  Refused → **Go to Question 39**
- (9)  Don't know/Don't Remember → **Go to Question 39**

**35 During your hospital stay when your baby was born, did you feel you were treated poorly because of any of the following things?** I'm going to read a list. For each one, please tell me if you felt you were treated poorly because of it or not.

**(PROBE:** Did you feel you were treated poorly because of \_\_\_\_?)

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Your age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Your weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Your income	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Your education level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Your race or ethnicity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Your culture or language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Your sexual orientation or gender identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Your type of health insurance or your lack of health insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Your use of substances such as alcohol or drugs during pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Differing opinions with medical staff about how to take care of yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Differing opinions with medical staff about how to take care of your baby	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Did you feel you were treated poorly because of something else?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. <b>IF YES, ASK:</b> For what? _____	---	---	---	---

**36 Were you and your baby discharged from the hospital at the same time after the birth?** Would you say \_\_\_\_\_?

- (1)  Yes, you were discharged at the same time, and your baby went home with you
  - (2)  Yes, you were discharged at the same time, but your baby did not go home with you
  - (3)  No, you and your baby were discharged at different times
  - (4)  No, your baby passed away before leaving the hospital
- If YES, say:** We are very sorry for your loss. → **Go to Question 48**
- (Don't Read)**
- (8)  Refused
  - (9)  Don't know/Don't Remember

**37 After being discharged from the hospital following birth, did your baby have to go back to the hospital and spend the night for any reason?**

- (1)  No → **Go to Question 39**
- (2)  Yes  
**(Don't Read)**
- (8)  Refused → **Go to Question 39**
- (9)  Don't know/Don't Remember → **Go to Question 39**

**38 Why did your baby have to go back to the hospital after being discharged?** I'm going to read a list of reasons, for each one please tell me if it was a reason for your baby. Was it because of \_\_\_\_\_?

**(PROBE:** *After being discharged, did your baby have to go back to the hospital because of \_\_\_\_\_?*)

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Breathing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeding difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Dehydration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Drug withdrawal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Jaundice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Audiology screening or rescreening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Did they have to go back to the hospital for another reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. <b>If YES, ask:</b> Why? _____	---	---	---	---

**INTERVIEWER: If PIDS indicates that the baby is deceased, please answer "No" to Question 39, and select the option for deceased baby in Question 40. Otherwise, continue reading Question 39.**

**39 Is your baby living with you now?**

- (1)  No
- (2)  Yes → **Go to Question 41**  
**(Don't Read)**
- (8)  Don't know/Don't Remember → **Go to Question 48**
- (9)  Refused → **Go to Question 48**

**40 Where is he or she living now?**

- (1)  Living with biological father
- (2)  Living with another family member
- (3)  In Foster care
- (4)  Adopted by someone else, OR
- (5)  Is he or she living somewhere else?

**IF YES, ask:** Where?

- (6)  **IF NONE OF THE OPTIONS ABOVE ARE YES, ASK:**  
Is your baby deceased? **IF YES, SAY: We are so sorry for your loss.**
- (8)  Refused
- (9)  Don't know/Don't Remember

**INTERVIEWER: If the baby is not living with the mother now or the baby is deceased, please go to Question 48.**

**The following questions are about your baby's health.**

**41 How old was your baby the last time you took him or her to a health care visit or checkup?**

*If you don't remember the exact age, please tell us your best guess.*

- (1)  Age in months \_\_\_\_\_ (Range: 0 – 10)
- (2)  Baby has never had a health care visit or check up → **Go to Question 43**
- (8)  Refused → **Go to Question 43**
- (9)  Don't know/Don't Remember → **Go to Question 43**

**42 I'm going to read a list of things that a doctor, nurse, or health care worker might do during your baby's health care visits or check-ups.** For each one, please tell me how often they did this during your visits.

**(PROBE:** Would you say they would always, sometimes, or never \_\_\_\_\_?)

	Always	Some times	Never	Ref	DKDR
	(1)	(2)	(3)	(8)	(9)
a. Spend enough time with you and your baby	<input type="radio"/>				
b. Listened carefully to you	<input type="radio"/>				
c. Showed sensitivity to your family's values and customs	<input type="radio"/>				
d. Provided the information you needed concerning your baby	<input type="radio"/>				
e. Asked you if you had concerns about your baby's development	<input type="radio"/>				

**43 These next questions are about your baby's behavior. Think about what you would expect of other babies who are the same age, and tell us how much each statement applies to your baby.** For each one, please tell me if it

applies to your baby Frequently, Sometimes or Not at all.

**(PROBE:** Would you say frequently, sometimes or not at all?)

	Frequently (1)	Some times (2)	Not at all (3)	Ref (8)	DKDR (9)
a. Does your baby have a hard time being with new people?	<input type="radio"/>				
b. Does your baby have a hard time in new places?	<input type="radio"/>				
c. Does your baby have a hard time with change?	<input type="radio"/>				
d. Does your baby mind being held by other people?	<input type="radio"/>				
e. Does your baby cry a lot?	<input type="radio"/>				
f. Does your baby have a hard time calming down?	<input type="radio"/>				
g. Is your baby fussy or irritable?	<input type="radio"/>				
h. Is it hard to comfort your baby?	<input type="radio"/>				
i. Is it hard to keep your baby on a schedule or routine?	<input type="radio"/>				
j. Is it hard to put your baby to sleep?	<input type="radio"/>				
k. Is it hard for you to get enough sleep because of your baby?	<input type="radio"/>				
l. Does your baby have trouble staying asleep?	<input type="radio"/>				

**44 I'm going to read a list of things about your baby's development. For each one, please tell me how much your baby is doing it right now.** For each one, please tell me if your baby does it frequently, sometimes or not yet.

**(PROBE:** Would you say that your baby does it frequently, sometimes, or not yet?)

	Frequently (1)	Some times (2)	Not yet (3)	Ref (8)	DKDR (9)
a. Holds up arms to be picked up	<input type="radio"/>				
b. Gets into a sitting position by him or herself	<input type="radio"/>				
c. Picks up food and eats it	<input type="radio"/>				
d. Pulls up to standing	<input type="radio"/>				
e. Plays games like "peek-a-boo" or "pat-a-cake"	<input type="radio"/>				
f. Calls parents "mama" or "dada" or similar name	<input type="radio"/>				
g. Looks around when people say things like "Where's your bottle?" or "Where's your blanket?"	<input type="radio"/>				
h. Copies sounds that other people make	<input type="radio"/>				
i. Walks across a room without help	<input type="radio"/>				
j. Is able to follow directions like "Come here" or "Give me the ball"	<input type="radio"/>				

**45 Has a doctor, nurse, or other health care worker told you that your baby has any developmental delays?**

(1)  No → **Go to Question 47**

- (2)  Yes  
**(Don't Read)**
- (8)  Refused → **Go to Question 47**
- (9)  Don't know/Don't Remember → **Go to Question 47**

**46 Have you received any referrals or services to support your baby's early learning and development?** I'm going to read a list of services. For each one, please tell me if you have received a referral or service for your baby.

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Referral to a developmental specialist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Referral for physical therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Services from an early intervention program for babies and children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Services from a home visitation program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Have you received any other referrals or services for your baby?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. <b>If YES, ask:</b> What were they? _____	---	---	---	---

**47 Since your baby was born, have you used any of the following community or government supported services?** I'm going to read a list of services. For each one, please tell me if you have used it *since your baby was born*.

	No (1)	Yes (2)	Ref (8)	DKDR (9)
a. Special Supplemental Nutrition Program for Women, Infants, and Children or WIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Supplemental Nutrition Assistance Program, also known as SNAP or food stamps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. In-person parenting groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Parenting groups online or through social media	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Housing assistance programs, such as short-term rental assistance or shelters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Financial assistance programs, such as the Temporary Assistance for Needy Families program known as TANF or welfare, child-care subsidies, or home energy assistance programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Transportation assistance programs, such as transportation vouchers, reduced fare programs, volunteer drive programs or non-emergency medical transportation services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**The following questions are about things that may have happened to you in the past 30 days.**

**48 Please tell me how often the following statement was true in the *past 30 days*:**

**“I worried whether our food would run out before I got money to buy more”.**

Would you say this was often true, sometimes true or never true in the *past 30 days*?

- (1)  Often true  
(2)  Sometimes true  
(3)  Never true  
**(Don't Read)**  
(8)  Refused  
(9)  Don't know/Don't Remember

**49 Please tell me how often the following statement was true in the *past 30 days*:**

**“The food that I bought just didn't last, and I didn't have money to get more.”**

Would you say this was often true, sometimes true or never true in the *past 30 days*?

- (1)  Often true  
(2)  Sometimes true  
(3)  Never true  
**(Don't Read)**  
(8)  Refused  
(9)  Don't know/Don't Remember

**50 In the *past 30 days*, how often have you felt down, depressed, or hopeless?** Would you say it has been always, often, sometimes, rarely, or never?

- (1)  Always  
(2)  Often  
(3)  Sometimes  
(4)  Rarely  
(5)  Never  
**(Don't Read)**  
(8)  Refused  
(9)  Don't know/Don't Remember

**51 In the *past 30 days*, how often have you had little interest or little pleasure in doing things you usually enjoyed?** Would you say it has been always, often, sometimes, rarely, or never?

- (1)  Always

- (2)  Often
- (3)  Sometimes
- (4)  Rarely
- (5)  Never

**(Don't Read)**

- (8)  Refused
- (9)  Don't know/Don't Remember

**The next questions are about you and your family.**

**52 I'm going to read a list of people who might live in the same home with you *now*. For each one, please tell me if that person is living with you at this time.**

**(PROBE:** Does \_\_\_\_\_ live with you now?)

	<b>No</b> (1)	<b>Yes</b> (2)	<b>Ref</b> (8)	<b>DKDR</b> (9)
a. Your husband or partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Children less than 12 months old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. <b>IF YES, ASK:</b> How many? _____ (Range: 0-20)	---	---	---	---
d. Children 1 year to 5 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. <b>IF YES, ASK:</b> How many? _____ (Range: 0-20)	---	---	---	---
f. Children 6 years old and over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. <b>IF YES, ASK:</b> How many? _____ (Range: 0-20)	---	---	---	---
h. Your mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Your father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Your husband's or partner's parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. A friend or roommate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Other family member or relative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Does someone else live with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. <b>IF YES, ASK:</b> Who? _____	---	---	---	---
o. <b>IF NONE OF ABOVE IS 'YES', ASK:</b> Do you live alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**53 Are you pregnant *now*?**

- (1)  No → **Go to Question 55**

(2)  Yes

**(Don't Read)**

(8)  Refused → **Go to Question 55**

(9)  Don't know/Don't Remember → **Go to Question 55**

**54 Thinking back to *just before* you got pregnant, how did you feel about becoming pregnant?** I'm going to read a list of options. Please choose the one that best describes how you felt.

**(PROBE:** *Just before* you got pregnant with your baby, how did you feel about becoming pregnant?)

(1)  You wanted to be pregnant later

(2)  You wanted to be pregnant sooner

(3)  You wanted to be pregnant then

(4)  You did not want to be pregnant then or at any time in the future

(5)  You were not sure what you wanted

**(Don't Read)**

(8)  Refused

(9)  Don't know/Don't Remember

**INTERVIEWER: If the mom is currently pregnant, go to Question 58.**

**55 Are you or your husband or partner doing anything now to keep from getting pregnant?** Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

(1)  No

(2)  Yes → **Go to Question 57**

**(Don't Read)**

(8)  Refused → **Go to Question 58**

(9)  Don't know/Don't Remember → **Go to Question 58**

**56 I'm going to read a list of reasons some women or their husbands or partners have for not doing anything to keep from getting pregnant. For each one, please tell me if it is one of the reasons for you or your husband or partner *now*. Is it because\_\_\_\_\_?**

**(PROBE: Is one of the reasons you aren't doing anything to keep from getting pregnant now because\_\_\_\_\_?)**

	<b>No</b> (1)	<b>Yes</b> (2)	<b>Ref</b> (8)	<b>DKDR</b> (9)
a. You want to get pregnant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. You had your tubes tied or blocked	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. You don't want to use birth control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. You are worried about side effects from birth control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. You are not having sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Your husband or partner doesn't want to use anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. You have problems paying for birth control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Is there any other reason you're not doing anything to keep from getting pregnant now?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. <b>If YES, ask:</b> What is the reason? _____	---	---	---	---

**INTERVIEWER: If the mom and partner are not doing anything to avoid getting pregnant, go to Question 58.**

**57 I'm going to read a list of birth control methods. For each one, please tell me if you or your husband or partner are using this method *now*.**

**(PROBE:** What are you or your husband or partner using now to keep from getting pregnant?)

	<b>No</b> (1)	<b>Yes</b> (2)	<b>Ref</b> (8)	<b>DKDR</b> (9)
a. Tubes tied or blocked, female sterilization, or Essure®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Vasectomy or male sterilization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Birth control pills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Condoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Shots, injections or Depo-Provera®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Contraceptive patch or OrthoEvra® or vaginal ring or NuvaRing®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. IUD, including Mirena®, ParaGard®, Liletta®, or Skyla®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Contraceptive implant in the arm, including Nexplanon® or Implanon®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Natural family planning including rhythm method	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Withdrawal or pulling out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Not having sex or abstinence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Are you or your husband or partner using anything else to keep from getting pregnant <i>now</i> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. <b>If YES, ask:</b> What are you using? _____	---	---	---	---

**These last questions are about things that could have happened or that you may have experienced before you were 18 years of age. We understand that some of these questions may be difficult, but your answers will help us understand some of the things people may experience when they are growing up.**

**58 During the first 18 years of your life...**

	<b>No (1)</b>	<b>Yes (2)</b>	<b>Ref (8)</b>	<b>DKDR (9)</b>
a. Were your parents <i>ever</i> separated or divorced?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Was your mom less than 18 years old when she had you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Was your dad less than 18 years old when you were born?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Did you like going to school?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Did you drop out of school before you were able to graduate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Were you ever bullied?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Did you live with anyone who was a problem drinker or alcoholic?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Did you live with anyone who was depressed, mentally ill, or suicidal?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Did you live with anyone who used illegal drugs or who abused prescription medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**This finishes the interview. Is there anything else you would like to say about your experiences or the health of mothers and babies in Utah?**

---



---



---



---

**Today's Date:** \_\_\_\_\_  
 (Date survey was completed)

**Thank you for answering these questions!  
 Your answers will help us understand how to improve the health of mothers and babies.  
 Goodbye.**