

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. What is your date of birth?

/

/

MonthDayYear

2. Before you got pregnant, did you...?
For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Have serious difficulty hearing, or are you deaf? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have serious difficulty seeing, even when wearing glasses, or are you blind? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have serious difficulty walking or climbing stairs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have difficulty with dressing or bathing yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about the time before you got pregnant.

3. 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 at all
- ☐ 1 to 3 times a week
- ☐ 4 to 6 times a week
- ☐ Every day of the week

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 (<u>not</u> 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"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Anemia (poor blood, low iron) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. PCOS (polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> |

5. In the 12 months before you got pregnant with your new baby, did you have any of the following healthcare visits?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Regular checkup with a family doctor..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regular checkup with an OB/GYN | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Visit for an injury, illness, or chronic condition | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Visit to urgent care or the emergency room..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Visit for family planning or to get birth control | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Visit for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Visit to have my teeth cleaned | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

If you had any healthcare visits in the 12 months before you got pregnant, go to Question 7.

6. Why didn't you have any healthcare visits in the 12 months before you got pregnant with your new baby?

Check ALL that apply

- ☐ I didn't know I needed one
- ☐ I didn't have enough money or insurance to pay for the visit
- ☐ I felt fine and didn't 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 other things going on
- ☐ I couldn't take time off from work or school
- ☐ I didn't have anyone to take care of my children
- ☐ The doctor's office was too far away
- ☐ Other _____ ➔ Please tell us:

If you did not have any healthcare visits, go to Question 9.

7. During any of your healthcare visits in the 12 months before you got pregnant, did a healthcare provider do any of the following things? For each one, check **No or **Yes**.**

Talk to me about...

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. My weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regularly checking my blood pressure.... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My desire to have or not have children.... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Birth control methods | <input type="checkbox"/> | <input type="checkbox"/> |
| e. How I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sexually transmitted infections such as chlamydia, gonorrhea, syphilis, or HIV | <input type="checkbox"/> | <input type="checkbox"/> |

Ask me...

- | | | |
|---|--------------------------|--------------------------|
| g. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I felt depressed or anxious | <input type="checkbox"/> | <input type="checkbox"/> |

8. In the 12 months before you got pregnant with your new baby, did a healthcare provider talk to you about preparing for a pregnancy?

- ☐ No
☐ Yes

The next questions are about your **health insurance**.

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 (paid for by me, someone else, or through a job)
- ☐ Medicaid
- ☐ Other health insurance —————→ Please tell us:

- ☐ I didn't have any health insurance during the *month before* I got pregnant

10. During your most recent pregnancy, what kind of health insurance did you have?

Check ALL that apply

- ☐ Private health insurance (paid for by me, someone else, or through a job)
- ☐ Medicaid
- ☐ Other health insurance —————→ Please tell us:

- ☐ I didn't have any health insurance *during my pregnancy*

11. What kind of health insurance do you have *now*?

Check ALL that apply

- ☐ Private health insurance (paid for by me, someone else, or through a job)
- ☐ Medicaid
- ☐ Other health insurance —————→ Please tell us:

- ☐ I don't have any health insurance *now*

If you have health insurance *now*, go to Question 13.

12. What is the reason that you do not have any health insurance *now*?

Check ALL that apply

- ☐ Health insurance is too expensive
- ☐ I can't get health insurance from my job or the job of my spouse or partner
- ☐ I applied for health insurance, but I'm still waiting to get it
- ☐ I had problems with the health insurance application or website
- ☐ My income is too high to qualify for Medicaid
- ☐ My income is too high to qualify for a tax credit from the Health Insurance Marketplace or HealthCare.gov
- ☐ I don't know how to get health insurance
- ☐ Other —————→ Please tell us:

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 or your spouse or partner doing anything to keep from getting pregnant? This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

- ☐ No
- ☐ Yes —————→ **Go to Page 4, Question 16**

Go to Page 4, Question 15

15. What were your 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 couldn't get pregnant at that time
- ☐ I didn't want to use birth control
- ☐ I had side effects from the birth control method I was using
- ☐ I had problems getting birth control I wanted
- ☐ I thought my spouse or partner or I was sterile (couldn't get pregnant at all)
- ☐ My spouse or partner didn't want to use condoms
- ☐ My spouse or partner didn't want me to use birth control
- ☐ I forgot to use a birth control method
- ☐ Other _____ → Please tell us:

DURING PREGNANCY

The next questions are about your prenatal care. This can include visits to a doctor, nurse, or other healthcare worker before your baby was born to get checkups and advice about pregnancy. (It may help to look at the calendar to answer these questions.)

16. Did you get prenatal care during your *most recent* pregnancy?

- ☐ No _____ →
- ☐ Yes

Go to Question 19

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

- ☐ No
- ☐ Yes

18. During any of your prenatal care visits, did a healthcare provider do any of the following things? For each one, check **No** or **Yes**.

No Yes

Talk to me about...

- a. How much weight I should gain during pregnancy ☐ ☐
- b. Doing tests to screen for birth defects or diseases that run in my family ☐ ☐
- c. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due) ☐ ☐
- d. What to do if I feel depressed or anxious during my pregnancy or after my baby is born ☐ ☐

Ask me...

- e. If I planned to breastfeed my new baby.. ☐ ☐
- f. If I planned to use birth control after my baby was born ☐ ☐
- g. If I was taking any prescription medication ☐ ☐
- h. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco ☐ ☐
- i. If I was drinking alcohol ☐ ☐
- j. If someone was hurting me emotionally or physically ☐ ☐
- k. If I was using illegal drugs ☐ ☐
- l. If I was using marijuana ☐ ☐
- m. If I wanted to be tested for HIV ☐ ☐

19. During the 12 months before your new baby was born, did a healthcare provider *offer* you the following shots or vaccinations?

For each one, check **No** or **Yes**.

No Yes

- a. Flu shot ☐ ☐
- b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough]) ☐ ☐
- c. COVID-19 shot ☐ ☐
- d. RSV shot (given during pregnancy to protect the baby from respiratory syncytial virus) ☐ ☐

20. Did you get the following shots or vaccinations *before* or *during* your pregnancy?

For each shot, check ALL that apply:

B for **3 months before** pregnancy

D for **During** pregnancy

or check **N** if you **Did not** get the shot in the 3 months before or during pregnancy

- | | B | D | N |
|-----------------------|--------------------------|--------------------------|--------------------------|
| a. Flu shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. RSV shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

- ☐ No
☐ Yes

22. 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 one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I couldn't find a dentist or dental clinic that would take pregnant patients..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I couldn't find a dentist or dental clinic that would take Medicaid patients..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't think it was safe to go to the dentist during pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I couldn't afford to go to a dentist or dental clinic | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I couldn't find a dentist or dental clinic close by that I could get to..... | <input type="checkbox"/> | <input type="checkbox"/> |

23. During your most recent pregnancy, did a healthcare provider tell you that you had any of the following health conditions?

For each one, check **No** or **Yes**.

- | | 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"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Anemia (poor blood, low iron) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. PCOS (polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> |

If you had high blood pressure before or during your pregnancy, go to Question 24. If you didn't, go to Page 6, Question 25.

24. During your most recent pregnancy, did a healthcare provider do any of the following things to help you manage your high blood pressure? For each one, check **No or **Yes**.**

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Refer me to a different healthcare provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tell me to regularly check my blood pressure during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about getting to a healthy weight after pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about regularly checking my blood pressure after pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about the risk for having high blood pressure (chronic hypertension) and heart disease after pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |

25. During your most recent pregnancy, did you get information about “warning signs” you should watch for during and after your pregnancy that require immediate medical attention? Some of these “warning signs” include fever, frequent or severe headaches, dizziness, or severe stomach pain.

- ☐ No
☐ Yes

→ **Go to Question 27**

26. During your most recent pregnancy, did you get information about warning signs from any of the following sources?
 For each one, check **No** or **Yes**.

No Yes

- a. A healthcare provider (such as a doctor, nurse, or midwife) ☐ ☐
- b. Websites or social media (such as Facebook, Instagram, or X/Twitter) ☐ ☐
- c. Any source of information that used the slogan “**Hear Her**” (such as websites, social media, or paper handouts) ☐ ☐
- d. Family or friends ☐ ☐

The next questions are about cigarettes, e-cigarettes, and other tobacco products.

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

- ☐ No
☐ Yes

→ **Go to Question 31**

28. In the 3 months before you got pregnant, how many cigarettes did you smoke on an average day?

- ☐ More than one pack (21 or more cigarettes)
☐ One-half to one pack (11 to 20 cigarettes)
☐ Less than half a pack (1 to 10 cigarettes)
☐ I didn’t smoke then

29. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day?

- ☐ More than one pack (21 or more cigarettes)
☐ One-half to one pack (11 to 20 cigarettes)
☐ Less than half a pack (1 to 10 cigarettes)
☐ I didn’t smoke then

30. How many cigarettes do you smoke on an average day now?

- ☐ More than one pack (21 or more cigarettes)
☐ One-half to one pack (11 to 20 cigarettes)
☐ Less than half a pack (1 to 10 cigarettes)
☐ I don’t smoke now

31. In the past 2 years, have you used e-cigarettes (“vapes”) or other electronic nicotine products?

- ☐ No
☐ Yes

→ **Go to Question 35**

32. During the 3 months before you got pregnant, on average, how often did you use e-cigarettes (“vapes”) or other electronic nicotine products?

- ☐ Every day
☐ Some days
☐ I didn’t use e-cigarettes or other electronic nicotine products then

33. During the last 3 months of your pregnancy, on average, how often did you use e-cigarettes (“vapes”) or other electronic nicotine products?

- ☐ Every day
☐ Some days
☐ I didn’t use e-cigarettes or other electronic nicotine products then

34. In the past 2 years, did you ever use e-cigarettes (“vapes”) or other electronic nicotine products as a way of cutting down or stopping cigarette smoking?

- ☐ No
☐ Yes

The next questions are about drinking alcohol. A drink can be 1 glass of wine, can or bottle of beer or hard seltzer, shot of liquor, or mixed drink.

35. During the 3 months *before* you got pregnant, how many alcoholic drinks did you have in an average week?

Check ONE answer

- ☐ 14 or more drinks 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

36. During your most recent pregnancy, did you have any alcoholic drinks during...?

For each one, check **No** or **Yes**.

No Yes

- a. The first 3 months of pregnancy (1st trimester)? *This includes the time before knowing you were pregnant*..... ☐ ☐
b. The second 3 months of pregnancy (2nd trimester)? ☐ ☐
c. The last 3 months of pregnancy (3rd trimester)? ☐ ☐

If you did not have any alcoholic drinks during your pregnancy, go to Question 39.

37. During your most recent pregnancy, did you have 4 or more alcoholic drinks in a 2-hour time span during...?

For each one, check **No** or **Yes**.

No Yes

- a. The first 3 months of pregnancy (1st trimester)? *This includes the time before knowing you were pregnant*..... ☐ ☐
b. The second 3 months of pregnancy (2nd trimester)? ☐ ☐
c. The last 3 months of pregnancy (3rd trimester)? ☐ ☐

38. During your most recent pregnancy, did a healthcare provider or home health visitor tell you that it was okay to drink a little alcohol during pregnancy?

- ☐ No
☐ Yes

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

39. Did any of the following things happen during the 12 months before your new baby was born? For each one, check **No or **Yes**.**

No Yes

- a. I got separated or divorced ☐ ☐
b. I was evicted or forced to move ☐ ☐
c. I didn't have a regular place to sleep ☐ ☐
d. I was homeless or had to sleep outside, in a car, or in a shelter ☐ ☐
e. My spouse, partner, or I lost a job ☐ ☐
f. My spouse, partner, or I had a cut in work hours or pay ☐ ☐
g. I had problems paying the rent, mortgage, or other bills ☐ ☐
h. My spouse or partner went to jail/prison .. ☐ ☐
i. I went to jail/prison ☐ ☐
j. Someone close to me had a problem with drinking or drugs ☐ ☐
k. Someone close to me was very sick or died ☐ ☐

40. 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 one, check **No or **Yes**.**

No Yes

- a. My spouse or partner ☐ ☐
b. My ex-spouse or ex-partner ☐ ☐
c. Someone else ☐ ☐

41. 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 one, check **No** or **Yes**.

- | | No | Yes |
|-------------------------------------|--------------------------|--------------------------|
| a. My spouse or partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse 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.

42. After the delivery, how long did your new baby stay in the hospital?

- ☐ Less than 3 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 45**

43. Is your baby alive now?

- ☐ No → *We are very sorry for your loss.*
- ☐ Yes → **Go to Page 10, Question 54**

44. Is your baby living with you now?

- ☐ No → **Go to Page 10, Question 54**
- ☐ Yes → **Go to Question 45**

Go to Question 45

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

Check ONE answer

- ☐ I didn't breastfeed my baby → **Go to Question 47**
- ☐ I breastfed my baby for less than 1 week
- ☐ I breastfed my baby for:

week(s) **OR** month(s)
- ☐ I'm still breastfeeding or feeding pumped milk to my new baby → **Go to Question 48**

46. What were your reasons for stopping breastfeeding?

Check ALL that apply

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

If you ever breastfed your baby, go to Question 48.

47. 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 other things going on
- ☐ 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 your baby was not born in a hospital, go to Question 49.

48. During your hospital stay after your new baby was born, did any of the following things happen? For each one, check No or Yes.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Hospital staff talked to me about how to breastfeed (how often and long to breastfeed) | <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 as soon as possible after my baby was born | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My baby was placed in skin-to-skin contact as soon as possible after birth | <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 helped me recognize when my baby was hungry..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The hospital gave me a gift pack with formula | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The hospital gave me information about who I could contact for breastfeeding support when I left the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is still in the hospital, go to Page 10, Question 54.

49. In the past 2 weeks, how did you place your new baby to sleep at night and during naps? For each one, check No or Yes.

- | | No | Yes |
|---------------------------|--------------------------|--------------------------|
| a. On their side | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On their back..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. On their stomach | <input type="checkbox"/> | <input type="checkbox"/> |

50. In the past 2 weeks, when you were sleeping, how often has your new baby slept alone in their own crib or bed?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never _____ →

Go to Question 52

51. In the past 2 weeks, was your baby's crib or bed in the same room where you or another adult slept?

- ☐ No
- ☐ Yes

52. In the past 2 weeks, where have you placed your new baby to sleep at night or during naps? For each one, check No or Yes.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. In a crib, portable crib, or bassinet | <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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a swing, rocker, or other inclined sleeper | <input type="checkbox"/> | <input type="checkbox"/> |
| f. In an in-bed sleeper | <input type="checkbox"/> | <input type="checkbox"/> |
| g. In a baby board or cradleboard | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

53. In the *past 2 weeks*, has your new baby been placed to sleep with the following?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. In a sleeping sack or wearable blanket..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In a swaddled blanket..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Comforters, quilts, blankets, or non-fitted sheets..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Soft toys, cushions, or pillows, including nursing pillows | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Crib bumper pads (mesh or non-mesh)... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:

If your baby was not born in a hospital, go to Question 55.

54. During your hospital stay after your new baby was born, did a healthcare provider do any of the following things?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Talked with me about birth control methods I can use after giving birth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tied or blocked my tubes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Placed an IUD | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Placed a contraceptive implant in my arm..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Gave me a contraceptive shot/injection.. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Gave me or prescribed a contraceptive method for me to start at a later time (such as birth control pills, patch, ring)..... | <input type="checkbox"/> | <input type="checkbox"/> |

55. Are you or your spouse or partner doing anything *now* to keep from getting pregnant? This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

- ☐ No
☐ Yes → **Go to Question 57**
☐ I'm pregnant now → **Go to Question 58**

Go to Question 56

56. What are your reasons for not doing anything to keep from getting pregnant *now*?

Check ALL that apply

- ☐ I want to get pregnant or don't mind if I do
- ☐ I had my tubes tied or blocked
- ☐ My spouse or partner had a vasectomy
- ☐ I don't want to use birth control
- ☐ I'm worried about side effects from birth control
- ☐ My spouse or partner doesn't want to use condoms
- ☐ My spouse or partner doesn't want me to use birth control
- ☐ We are same-sex spouses/partners
- ☐ I have problems getting birth control I want
- ☐ I don't think I can get pregnant because I'm breastfeeding
- ☐ I'm not having sex
- ☐ Other _____ → Please tell us:

If you're not doing anything to keep from getting pregnant *now*, go to Question 58.

57. What kind of birth control are you or your spouse or partner using *now* to keep from getting pregnant?

Check ALL that apply

- ☐ Tubes tied or blocked
- ☐ My spouse or partner had a vasectomy
- ☐ Birth control pills
- ☐ Condoms
- ☐ Shots or injections
- ☐ Contraceptive patch or vaginal ring
- ☐ IUD
- ☐ Contraceptive implant in the arm
- ☐ Withdrawal (pulling out)
- ☐ Natural family planning or fertility awareness methods (such as rhythm or calendar method or fertility apps)
- ☐ Breastfeeding for birth control (Lactational Amenorrhea Method or LAM)
- ☐ Other _____ → Please tell us:

58. Since your new baby was born, have you had a postpartum checkup for yourself? A postpartum checkup is a regular health checkup you have up to 12 weeks after giving birth.

- ☐ No
☐ Yes

Go to Question 60

59. During your postpartum checkup, did a healthcare provider do any of the following things? For each one, check **No** or **Yes**.

No Yes

Talk to me about...

- a. Healthy eating, exercise, and losing weight gained during pregnancy..... ☐ ☐
- b. How long to wait before getting pregnant again..... ☐ ☐
- c. Birth control methods..... ☐ ☐
- d. Warning signs of medical problems I might be at risk for due to my pregnancy..... ☐ ☐
- e. Regularly checking my blood pressure.... ☐ ☐
- f. What to do if I feel depressed or anxious..... ☐ ☐

Ask me...

- g. If I was smoking cigarettes or using e-cigarettes ("vapes") or other smokeless tobacco..... ☐ ☐
- h. If someone was hurting me emotionally or physically..... ☐ ☐

A healthcare provider...

- i. Tested me for diabetes..... ☐ ☐
- j. Prescribed me medication for depression or anxiety..... ☐ ☐

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

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

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

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

62. Since your new baby was born, how often have you felt nervous, anxious, or on edge?

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

63. Since your new baby was born, how often have you not been able to stop or control worrying?

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

64. Has a healthcare provider asked you a series of questions, in person or on a form, to know if you were feeling down, depressed, anxious, or irritable during the following time periods? For each one, check **No** or **Yes**.

No Yes

- a. During my most recent pregnancy ☐ ☐
- b. Since my new baby was born ☐ ☐

OTHER EXPERIENCES

The next questions are on a variety of topics.

65. How would you describe your sexual orientation?

- ☐ Heterosexual or "straight"
☐ Lesbian or Gay
☐ Bisexual
☐ Prefer to self-describe → Please tell us:

66. Please tell us how often each of the following happened during the 12 months before your new baby was born.

- a. I worried whether my food would run out before I got money to buy more
- ☐ Often ☐ Sometimes ☐ Never
- b. The food that I bought just didn't last, and I didn't have money to get more
- ☐ Often ☐ Sometimes ☐ Never

67. During the 12 months before your new baby was born, did lack of transportation keep you from any of the following?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Going to medical appointments | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Going to non-medical appointments, meetings, or work | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Doing errands | <input type="checkbox"/> | <input type="checkbox"/> |

68. During your most recent pregnancy, did you feel you needed any of the following services?

For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. SNAP (the Supplemental Nutrition Assistance Program) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Counseling for family or personal problems | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help to quit smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help to reduce violence in my home | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Help to quit using drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Assistance with housing or rent | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

69. During your most recent pregnancy, did you receive any of the following services?

For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. SNAP (the Supplemental Nutrition Assistance Program) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Counseling for family or personal problems | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help to quit smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help to reduce violence in my home | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Help to quit using drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Assistance with housing or rent | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

70. The following questions are about the people in your life and the support they provided you *while you were pregnant*.

For each one, check **No** or **Yes**.

No Yes

- a. Did you have someone you could go to if you felt lonely? ☐ ☐
- b. Did you have someone you could talk with about things that were important to you or how you were feeling? ☐ ☐
- c. Did you have someone you could count on to listen to your problems, worries, and fears? ☐ ☐
- d. Did you have someone who showed you love and affection? ☐ ☐
- e. Did you have someone who did things with you to relax or have fun? ☐ ☐
- f. Did you have someone you could count on to loan you money for things like food or bills? ☐ ☐
- g. Did you have someone who could take care of your children if you needed help? ☐ ☐
- h. Did you have someone who could help with daily chores if you were sick? ☐ ☐
- i. Did you have someone who could take you to the clinic or doctor's office if you needed a ride? ☐ ☐

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

☐ No

☐ Yes

Go to Question 73

72. Did any of the following things affect your decision about taking leave from work *after* your new baby was born?

For each one, check **No** or **Yes**.

No Yes

- a. I couldn't financially afford to take leave .. ☐ ☐
- b. I was afraid I'd lose my job if I took leave or stayed out longer ☐ ☐
- c. I had too much work to do to take leave or stay out longer ☐ ☐
- d. My job doesn't have paid leave..... ☐ ☐
- e. My job doesn't offer a flexible work schedule..... ☐ ☐
- f. I hadn't built up enough leave time to take any or more time off ☐ ☐

73. Did you use doula support during any of the following time periods? A doula is a trained pregnancy and labor companion who gives

comfort, emotional support, and information during birth. A doula does not provide medical care. For each time period, check **No** or **Yes**.

No Yes

- a. During my most recent pregnancy ☐ ☐
- b. During the birth of my new baby..... ☐ ☐
- c. Since my new baby was born ☐ ☐

74. While getting healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?
For each one, check **No** if you did not experience discrimination because of it or **Yes** if you did.

	No	Yes
a. My race, ethnicity, or skin color	<input type="checkbox"/>	<input type="checkbox"/>
b. My disability status	<input type="checkbox"/>	<input type="checkbox"/>
c. My immigration status.....	<input type="checkbox"/>	<input type="checkbox"/>
d. My age	<input type="checkbox"/>	<input type="checkbox"/>
e. My weight.....	<input type="checkbox"/>	<input type="checkbox"/>
f. My income.....	<input type="checkbox"/>	<input type="checkbox"/>
g. My sex	<input type="checkbox"/>	<input type="checkbox"/>
h. My sexual orientation.....	<input type="checkbox"/>	<input type="checkbox"/>
i. My religion	<input type="checkbox"/>	<input type="checkbox"/>
j. My language or accent	<input type="checkbox"/>	<input type="checkbox"/>
k. My type or lack of health insurance.....	<input type="checkbox"/>	<input type="checkbox"/>
l. My use of substances (alcohol, tobacco, or other drugs).....	<input type="checkbox"/>	<input type="checkbox"/>
m. My involvement with the justice system (jail or prison)	<input type="checkbox"/>	<input type="checkbox"/>
n. Another reason.....	<input type="checkbox"/>	<input type="checkbox"/>
Please tell us:		
<div></div>		

75. During your life until now, how often have you been discriminated against, prevented from doing something, hassled, or made to feel inferior because of your race, ethnicity, or skin color?

☐ Very often
☐ Somewhat often
☐ Not very often
☐ Never

76. Have you ever been treated unfairly due to your race, ethnicity, or skin color in any of the following situations?
For each one, check **No** or **Yes**.

	No	Yes
a. Job (hiring, promotion, firing).....	<input type="checkbox"/>	<input type="checkbox"/>
b. Housing (renting, buying, mortgage)	<input type="checkbox"/>	<input type="checkbox"/>
c. Police (stopped, searched, threatened)....	<input type="checkbox"/>	<input type="checkbox"/>
d. In the courts	<input type="checkbox"/>	<input type="checkbox"/>
e. At school or my child’s school	<input type="checkbox"/>	<input type="checkbox"/>
f. Getting medical care.....	<input type="checkbox"/>	<input type="checkbox"/>

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

77. During the 12 months before your new baby was born, what was your yearly total household income before taxes? Include your income, your spouse 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 getting now.

☐ \$0 to \$18,000
☐ \$18,001 to \$23,000
☐ \$23,001 to \$27,000
☐ \$27,001 to \$32,000
☐ \$32,001 to \$37,000
☐ \$37,001 to \$42,000
☐ \$42,001 to \$48,000
☐ \$48,001 to \$60,000
☐ \$60,001 to \$85,000
☐ \$85,001 or more

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

Number of people

79. What is today’s date?

/ /
Month Day Year

The next questions are about *you*.

S1. What is your living situation *today*?

Check ONE answer

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I'm worried about losing it in the future
- ☐ I don't have a steady place to live (I'm temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

S2. During the *last 12 months*, how often were you **unable to afford to eat balanced meals**?

A balanced meal includes all the types of food that you think should be in a healthy meal. For example, a starch like potatoes or rice, vegetables or fruit, and some protein like meat, fish, cheese, or eggs.

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

S3. During the *last 12 months*, how often did your healthcare providers explain things about your health in a way that was easy to understand?

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

S4. Since your new baby was born, have you felt that you've needed mental health services such as counseling, medications, or support groups to help with feelings of anxiety, depression, grief, or other issues?

- ☐ No —————→ Go to Question S7
- ☐ Yes

Go to Question S5

S5. Were you able to get the mental health services that you needed?

- ☐ No
- ☐ Yes —————→ Go to Question S7

S6. Which of these statements explains why you did not get the mental health services you needed?

Check ALL that apply

- ☐ I couldn't afford the cost
- ☐ I couldn't get an appointment as soon as I needed
- ☐ My health insurance doesn't cover any type of mental health services
- ☐ My health insurance doesn't pay enough for mental health services
- ☐ I didn't know where to go to get services
- ☐ I was concerned that the information I shared might not be kept confidential
- ☐ I didn't want others to find out that I needed treatment
- ☐ I was concerned that I might be committed to a psychiatric hospital
- ☐ I was concerned that I might have to take medicine
- ☐ I had no transportation, treatment was too far away, or the hours were not convenient
- ☐ I didn't have time (because of a job, childcare, or other commitments)
- ☐ Other —————→ Please tell us:

S7. During the *last 12 months*, how often would you say you get the social and emotional support you need?

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

S8. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because their mind is troubled all the time.

Within the last 30 days, how often have you felt this kind of stress?

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

We would love to hear more about your story!
Is there anything else you would like to share with us about your experiences
around the time of your pregnancy? Please use this space to tell us.

Thanks for answering our questions!

Your answers will help us work to make mothers and babies in Utah healthier.

