

**Project FIRST**

R867-97P  
OMB No. 0910-0558  
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**SECTION A: HEALTH AND HEALTH CARE**

1. Are you currently pregnant and at least 18 years old?  
Yes.....  No.....  → (THANK YOU, PLEASE RETURN QUESTIONNAIRE IN THE ENCLOSED POSTAGE PAID ENVELOPE)
2. When is your baby due? (PLEASE WRITE IN MONTH AND DAY)  
MONTH: \_\_\_\_\_ DAY: \_\_\_\_\_
3. Who provides your prenatal care? (PLEASE "X" ALL THAT APPLY)  
An obstetrician .....   
A family doctor, general practitioner, internist, or other physician .....   
A midwife or nurse midwife .....   
Another type of health care provider.....   
I am not getting prenatal care from a health professional.....  → (GO TO QUESTION 5)
4. How many weeks pregnant were you when you went for your first prenatal visit?  
4 weeks or less.....  13 to 18 weeks.....   
5 to 8 weeks .....  19 to 24 weeks.....   
9 to 12 weeks .....  25 weeks or more .....
5. Are you covered by any kind of health insurance or any kind of health care plan, such as insurance obtained through an employer or a government program like Medicaid?  
Yes .....  No.....
6. In the past month, were you enrolled in the WIC program or did you get WIC food or vouchers for yourself or for any of your children? (WIC is a program that gives food to pregnant and nursing women, babies, and young children.) (PLEASE "X" ALL THAT APPLY)  
Yes, I was enrolled or got WIC food for myself .....  Yes, my child was enrolled or got WIC food .....  No.....
7. What was your weight just before you became pregnant? \_\_\_\_\_ POUNDS
8. How tall are you? \_\_\_\_\_ FEET \_\_\_\_\_ INCHES
9. What is your age? \_\_\_\_\_ YEARS
10. On the average, how many cigarettes do you smoke a day now? (Write in 0 if you do not smoke).  
\_\_\_\_\_ CIGARETTES PER DAY
11. How many people not including yourself smoke inside your home most days? (Include family members, friends, and anyone else.)  
0.....  1.....  2.....  3.....  4 or more .....
12. Have you had gestational diabetes with this pregnancy?  
Yes.....  No.....  Don't know ....
13. As best you know, which of the following health conditions do you yourself or your baby's other relatives have? (PLEASE "X" ALL THAT APPLY)

	<u>YOU, THE BABY'S MOTHER</u>	<u>THE BABY'S FATHER</u>	<u>THE BABY'S BROTHER OR SISTER</u>	<u>THE BABY'S GRANDPARENTS, AUNTS, OR UNCLES</u>	<u>NONE OF THESE RELATIVES</u>
Juvenile onset diabetes (Type I).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult onset diabetes (Type II).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to pollen, dust, animals, latex, or anything else.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overweight or obesity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Since you learned that you were pregnant, have you eaten more, less, or about the same of the following foods? If you did not eat the food before you learned that you are pregnant and you don't eat the food now, please mark "Did Not Eat Before or Now."
- |  | <u>EAT<br/>MORE</u>      | <u>EAT<br/>LESS</u>      | <u>EAT ABOUT<br/>THE SAME</u> | <u>DID NOT EAT<br/>BEFORE OR NOW</u> |
|--|--------------------------|--------------------------|-------------------------------|--------------------------------------|
| Milk or other dairy foods.....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Eggs.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Canned tuna.....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Swordfish, shark, tile fish, or king mackerel..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Any other type of fish.....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Shellfish.....                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Luncheon meats.....                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Nuts, peanuts, or peanut butter.....               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Alcoholic drinks.....                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Vitamin or mineral supplements.....                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |
| Any herbal or botanical supplement.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/>             |

IF YOU HAVE **NOT EATEN LESS** OF ANY FOOD LISTED IN QUESTION 14, GO TO QUESTION 16.

15. For each food that you are eating less of, please indicate the reason. (PLEASE "X" ALL THAT APPLY)

	UPSETS MY STOMACH OR MAKES ME FEEL SICK	MAY HARM MY BABY	TO PREVENT A FOOD ALLERGY IN MY BABY	OTHER REASON
Milk or other dairy foods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canned tuna.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swordfish, shark, tile fish, or king mackerel.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other type of fish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shellfish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Luncheon meats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuts, peanuts, or peanut butter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic drinks.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin or mineral supplements.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any herbal or botanical supplement.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION B: EMPLOYMENT**

16. Did you work for pay at any time from the 3 months before you became pregnant up to the present time?  
 Yes.....  No.....  →(GO TO QUESTION 23)
17. Using 1 to mean "None" and 5 to mean "Very much," how much satisfaction do you get from your paid work?  

<b><u>NONE (1)</u></b>	<b><u>(2)</u></b>	<b><u>(3)</u></b>	<b><u>(4)</u></b>	<b><u>VERY MUCH (5)</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. About how much of your family's income comes from the money you earn from work? (If you are no longer working, answer for the time you were working. If you have reduced your work hours because of your pregnancy, answer for the time before you reduced your hours.)  
 Less than half.....  About half.....  More than half.....
19. Do you work for pay now?  
 Yes, the same number of hours as before pregnancy.....   
 Yes, but with reduced hours.....   
 Yes, but on leave until after the baby's birth.....  → (GO TO QUESTION 21)  
 No.....  → (GO TO QUESTION 23)
20. How many hours per week do you usually work at this job now? (If you work at two or more jobs, answer for the total number of hours you work.)  

1 to 9 hours per week..... <input type="checkbox"/>	30 to 34 hours per week..... <input type="checkbox"/>
10 to 19 hours per week..... <input type="checkbox"/>	35 to 40 hours per week..... <input type="checkbox"/>
20 to 29 hours per week..... <input type="checkbox"/>	More than 40 hours per week..... <input type="checkbox"/>
21. Thinking of work leave that you can use for maternity leave, how many weeks are you eligible for if you have no complications? (Please write in the number of weeks of leave you are eligible for in each of the categories listed below. If you have no leave that you can use for maternity leave, write 0 in all.)  

_____ WEEKS OF FULLY PAID LEAVE	_____ WEEKS OF PARTIALLY PAID LEAVE	_____ WEEKS OF UNPAID LEAVE
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22. In your opinion, how supportive of breastfeeding is your place of employment?  

Not at all supportive..... <input type="checkbox"/>	Somewhat supportive..... <input type="checkbox"/>
Not too supportive..... <input type="checkbox"/>	Very supportive..... <input type="checkbox"/>
23. Do you plan to work for pay during your baby's first year?  
 Yes.....  No.....  →(GO TO SECTION C)
24. How many weeks after the baby is born do you plan to return to work?  

Fewer than 4 weeks..... <input type="checkbox"/>	13 to 16 weeks..... <input type="checkbox"/>
4 to 6 weeks..... <input type="checkbox"/>	17 to 20 weeks..... <input type="checkbox"/>
7 to 9 weeks..... <input type="checkbox"/>	21 to 30 weeks..... <input type="checkbox"/>
10 to 12 weeks..... <input type="checkbox"/>	More than 30 weeks..... <input type="checkbox"/>
25. How many hours per week do you plan to work?  

1 to 9 hours per week..... <input type="checkbox"/>	30 to 34 hours per week..... <input type="checkbox"/>
10 to 19 hours per week..... <input type="checkbox"/>	35 to 40 hours per week..... <input type="checkbox"/>
20 to 29 hours per week..... <input type="checkbox"/>	More than 40 hours per week..... <input type="checkbox"/>
26. How many hours per week would you prefer to work when you return to work?  

1 to 9 hours per week..... <input type="checkbox"/>	30 to 34 hours per week..... <input type="checkbox"/>
10 to 19 hours per week..... <input type="checkbox"/>	35 to 40 hours per week..... <input type="checkbox"/>
20 to 29 hours per week..... <input type="checkbox"/>	More than 40 hours per week..... <input type="checkbox"/>
	Would prefer not to work..... <input type="checkbox"/>
27. What will you do with your baby while you are working? (PLEASE "X" ALL THAT APPLY)  

My baby will be cared for by a family member..... <input type="checkbox"/>	I will keep my baby with me while I work at home..... <input type="checkbox"/>
My baby will be cared for by someone not in my family..... <input type="checkbox"/>	I have not decided yet..... <input type="checkbox"/>
I will keep my baby with me while I work outside my home..... <input type="checkbox"/>	

**SECTION C: INFANT FEEDING**

28. What method do you plan to use to feed your new baby in the first few weeks?  
 Breastfeed only (baby will not be given formula).....   
 Formula feed only.....  →(GO TO QUESTION 34)  
 Both breast and formula feed.....  →(GO TO QUESTION 30)  
 Don't know yet.....  →(GO TO QUESTION 33)



