
Pregnancy Risk Assessment Monitoring System (PRAMS)

Phase 9 Core Mail Questionnaire – English

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*.

Core 1. What is your date of birth?

____ / ____ / ____
 Month Day Year

Core 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.

Core 3. 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. <i>Site-added options from Standard question L11</i> | <input type="checkbox"/> | <input type="checkbox"/> |

Core 4. 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: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

If you did **not** have any healthcare visits in the **12 months before** you got pregnant, go to Question Core 6.

Core 5. 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**.

	No	Yes
Talk to me about...		
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"/>

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

Core 6. 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 (*Site Medicaid name*)
- Site-specific option (Other government plan or program such as SCHIP/CHIP)*
- Site-specific option (Other government plan or program not listed above such as MCH program, indigent program or family planning program)*
- Site-specific option (TRICARE or other military health care)*
- Site-specific option (IHS or tribal)*
- Other health insurance
- Please tell us: _____
- I didn't have any health insurance during the *month before* I got pregnant

Core 7. 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 (*Site Medicaid name*)
- Site-specific option (Other government plan or program such as SCHIP/CHIP)*
- Site-specific option (Other government plan or program not listed above such as MCH program, indigent program or family planning program)*
- Site-specific option (TRICARE or other military healthcare)*
- Site-specific option (Indian Health Services (IHS) or tribal)*
- Other health insurance
- Please tell us: _____
- I didn't have any health insurance *during my pregnancy*

Core 8. 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 (*Site Medicaid name*)
- Site-specific option (Other government plan or program such as SCHIP/CHIP)*
- Site-specific option (Other government plan or program not listed above such as MCH program, indigent program or family planning program)*
- Site-specific option (TRICARE or other military health care)*
- Site-specific option (IHS or tribal)*
- Other health insurance
- Please tell us: _____
- I don't have any health insurance *now*

Core 9. 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

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.)

Core 10. Did you get prenatal care during your *most recent* pregnancy?

- No → **Go to Question Core12**
- Yes

Core 11. 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	<input type="checkbox"/>	<input type="checkbox"/>
b. Doing tests to screen for birth defects or diseases that run in my family	<input type="checkbox"/>	<input type="checkbox"/>
c. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)	<input type="checkbox"/>	<input type="checkbox"/>
d. What to do if I feel depressed or anxious during my pregnancy or after my baby is born	<input type="checkbox"/>	<input type="checkbox"/>
Ask me...		
e. If I planned to breastfeed my new baby	<input type="checkbox"/>	<input type="checkbox"/>
f. If I planned to use birth control after my baby was born	<input type="checkbox"/>	<input type="checkbox"/>
g. If I was taking any prescription medication	<input type="checkbox"/>	<input type="checkbox"/>
h. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>
i. If I was drinking alcohol	<input type="checkbox"/>	<input type="checkbox"/>
j. If someone was hurting me emotionally or physically	<input type="checkbox"/>	<input type="checkbox"/>
k. If I was using illegal drugs	<input type="checkbox"/>	<input type="checkbox"/>
l. If I was using marijuana	<input type="checkbox"/>	<input type="checkbox"/>
m. If I wanted to be tested for HIV	<input type="checkbox"/>	<input type="checkbox"/>

Core 12. 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough]) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot | <input type="checkbox"/> | <input type="checkbox"/> |

Core 13. 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"/> |

Core 14. During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?

- No
 Yes

Core 15. 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"/> |

If you had high blood pressure before or during your pregnancy, go to Question Core 16. If you didn't, go to Question Core 17.

Core 16. 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"/> |

Core 17. *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 → **Go to Question Core19**
- Yes

Core 18. *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) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Websites or social media (such as Facebook, Instagram, or Twitter) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any source of information that used the slogan “ Hear Her ” (such as websites, social media, or paper handouts) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |

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

Core 19. *Have you smoked any cigarettes in the **past 2 years**?*

- No → **Go to Question Core 23**
- Yes

Core 20. *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

Core 21. *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

Core 22. *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

Core 23. *In the **past 2 years**, have you used e-cigarettes (“vapes”) or other electronic nicotine products?*

- No → **Go to Question Core 27 (Instruction 7)**
- Yes

Core 24. 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

Core 25. 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

Core 26. 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.

Core 27. 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)?
<i>This includes the time before knowing you were pregnant</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3rd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |

If you did **not** have any alcoholic drinks **during** your pregnancy, go to Question Core 29.

Core 28. 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)?
<i>This includes the time before knowing you were pregnant</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3rd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |

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

Core 29. 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was evicted or forced to move | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have a regular place to sleep | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was homeless or had to sleep outside, in a car, or in a shelter | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My spouse, partner, or I lost a job | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My spouse, partner, or I had a cut in work hours or pay | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I had problems paying the rent, mortgage, or other bills | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My spouse or partner went to jail/prison | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I went to jail/prison | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Someone close to me had a problem with drinking or drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Someone close to me was very sick or died | <input type="checkbox"/> | <input type="checkbox"/> |

Core 30. 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Site option (Another family member) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Site option (Someone else) | <input type="checkbox"/> | <input type="checkbox"/> |

Core 31. 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. Site option (Another family member) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Site option (Someone else) | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

Core 32. 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 Core 35**

Core 33. Is your baby alive now?

- No → **We are very sorry for your loss.**

- Go to Question Core 41**
Yes

Core 34. Is your baby living with you now?

- No → **Go to Question Core 41**
 Yes

Core 35. 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
 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

If your baby is still in the hospital, go to Question [Core 41].

Core 36. 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"/> |

Core 37. 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 Core 39**

Core 38. In the *past 2 weeks*, was your baby's crib or bed in the same room where you or another adult slept?

- No
 Yes

Core 39. 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
 Please tell us: _____

Core 40. 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: _____

Core 41. 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 Core 43**
- I'm pregnant now → **Go to Question Core 44**

Core 42. 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 Core 44.

Core 43. 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: _____

Core 44. *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 → **Go to Question Core 46**
- Yes

Core 45. *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	<input type="checkbox"/>	<input type="checkbox"/>
b. How long to wait before getting pregnant again	<input type="checkbox"/>	<input type="checkbox"/>
c. Birth control methods	<input type="checkbox"/>	<input type="checkbox"/>
d. Warning signs of medical problems I might be at risk for due to my pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
e. Regularly checking my blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
f. What to do if I feel depressed or anxious	<input type="checkbox"/>	<input type="checkbox"/>
Ask me...		
g. If I was smoking cigarettes or using 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"/>
A healthcare provider...		
i. Tested me for diabetes	<input type="checkbox"/>	<input type="checkbox"/>
j. Prescribed me medication for depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>

Core 46. *Since your new baby was born, how often have you felt down, depressed, or hopeless?*

- Always
- Often
- Sometimes
- Rarely
- Never

Core 47. *Since your new baby was born, how often have you had little interest or little pleasure in doing things?*

- Always
- Often
- Sometimes
- Rarely
- Never

Core 48. *Since your new baby was born, how often have you felt nervous, anxious, or on edge?*

- Always
- Often
- Sometimes

- Rarely
- Never

Core 49. *Since your new baby was born, how often have you not been able to stop or control worrying?*

- Always
- Often
- Sometimes
- Rarely
- Never

Core 50. *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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Since my new baby was born | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER EXPERIENCES

The next questions are on a variety of topics.

Core 51. *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

Core 52. *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"/> |

Core 53. *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
 - d. My age
 - e. My weight
 - f. My income
 - g. My sex or gender
 - h. My sexual orientation
 - i. My religion
 - j. My language or accent
 - k. My type or lack of health insurance
 - l. My use of substances (alcohol, tobacco, or other drugs)
 - m. My involvement with the justice system (jail or prison)
 - n. Another reason
- Please tell us: _____

Core 54. 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

Core 55. 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*.

Core 56. 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.*

(Note: Sites can add additional categories as long as the categories are collapsible back to the existing core categories.)

- \$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

Core 57. During the *12 months before* your new baby was born, how many people, *including yourself*, depended on this income?

Number of people _____

Core 58. What is today's date?

_____/_____/_____
Month Day Year