

**Pregnancy Risk Assessment Monitoring System (PRAMS)**

Phase 8 Standard Questions

February 2017

**NOTE: Skip A1–A5 if the mother was not trying to get pregnant (E5).  
A1 is required if A2, A4 or A5 is used.**

**BEFORE A1, if E6, E5, E3 are used, insert instruction box that says, “If you were not trying to get pregnant when you got pregnant with your new baby, go to Question...”**

**A1. Did you take any fertility drugs or receive any medical procedures from a doctor, nurse, or other health care worker to help you get pregnant with your *new* baby?** This may include infertility treatments such as fertility-enhancing drugs or assisted reproductive technology.

No → Go to Question ##

Yes

**A2. Did you use any of the following fertility treatments *during the month you got pregnant with your new baby*? Check ALL that apply**

Fertility-enhancing drugs prescribed by a doctor (fertility drugs include Clomid®, Serophene®, Pergonal®, or other drugs that stimulate ovulation)

Artificial insemination or intrauterine insemination (treatments in which sperm, but NOT eggs, were collected and medically placed into a woman’s body)

Assisted reproductive technology (treatments in which BOTH a woman’s eggs and a man’s sperm were handled in the laboratory, such as in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer)

Other medical treatment → Please tell us: \_\_\_\_\_

I wasn’t using fertility treatments *during the month* that I got pregnant with my new baby

**A4. How long had you been trying to get pregnant *before* you took any fertility drugs or used any medical procedures to help you get pregnant with your new baby?** Do not count long periods of time when you and your partner were apart or not having sex.

0 to 5 months

6 to 11 months

1 to 2 years

3 to 4 years

5 to 6 years

More than 6 years

- A5. How many cycles of fertility treatments (complete or incomplete) did you have before you got pregnant with your *new* baby?**
- 1 cycle
  - 2 to 3 cycles
  - 4 to 6 cycles
  - 7 or more cycles

**NOTE: Skip B1 if infant is not alive or not living with the mother (Core 32 and/or Core 33).  
Skip B1 if the mother ever breastfed (Core 35).**

**Change the skip arrow on Core Q35 from “no” to “yes” and AFTER B1, insert instruction box that says, “If you did not breastfeed your new baby, go to Question ....”**

- B1. What were your reasons for not breastfeeding your new baby? Check ALL that apply**

I was sick or on medicine  
 I had other children to take care of  
 I had too many household duties  
 I didn't like breastfeeding  
 I tried but it was too hard  
 I didn't want to  
 I went back to work  
 I went back to school  
 Other → Please tell us: \_\_\_\_\_

**NOTE: Skip B2 if infant is not alive or not living with the mother (Core 32 and/or Core 33).  
Skip B2 if the mother did not breastfeed or is still breastfeeding (Core 35 and/or Core 36).**

- B2. What were your reasons for stopping breastfeeding? Check ALL that apply**

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

**NOTE: Skip B3 if infant is not alive or not living with the mother (Core 32 and/or Core 33).  
Skip B3 if infant was not born in a hospital (Core 31).  
Skip B3 if mother said that she did not breastfeed (Core 35).**

**BEFORE B3, insert instruction box that says, “If your baby was not born in a hospital, go to Question ##.”**

**B3. This question asks about things that may have happened at the hospital where your new baby was born.** For each item, check **No** if it did not happen or **Yes** if it did.

	<b>No</b>	<b>Yes</b>
a. Hospital staff gave me information about breastfeeding .....	<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. I breastfed my baby in the hospital .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Hospital staff helped me learn how to breastfeed .....	<input type="checkbox"/>	<input type="checkbox"/>
e. I breastfed in the first hour after my baby was born.....	<input type="checkbox"/>	<input type="checkbox"/>
f. My baby was placed in skin-to-skin contact within the first hour of life.....	<input type="checkbox"/>	<input type="checkbox"/>
g. My baby was fed only breast milk at the hospital.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Hospital staff told me to breastfeed whenever my baby wanted.....	<input type="checkbox"/>	<input type="checkbox"/>
i. The hospital gave me a breast pump to use.....	<input type="checkbox"/>	<input type="checkbox"/>
j. The hospital gave me a gift pack with formula.....	<input type="checkbox"/>	<input type="checkbox"/>
k. The hospital gave me a telephone number to call for help with breastfeeding.....	<input type="checkbox"/>	<input type="checkbox"/>
l. Hospital staff gave my baby a pacifier.....	<input type="checkbox"/>	<input type="checkbox"/>

**B4. During your most recent pregnancy, what did you think about breastfeeding your new baby? Check ONE answer**

- I knew I wanted to breastfeed
- I thought I might breastfeed
- I knew I would *not* breastfeed
- I didn't know what to do about breastfeeding

**NOTE: Skip B5–B6 if infant is not alive or not living with the mother (Core 32 and/or Core 33).  
B6 needs B5, but B5 can be used alone.**

**B5. Did anyone suggest that you *not* breastfeed your new baby?**

- No → **Go to Question ##**
- Yes

**B6. Who suggested that you *not* breastfeed your new baby? Check ALL that apply**

- My husband or partner
- My mother, father, or in-laws
- Other family member or relative
- My friends
- My baby's doctor, nurse, or other health care worker
- My doctor, nurse, or other health care worker
- Other → Please tell us: \_\_\_\_\_

**NOTE: B12 must be used with B7-B8. Skip B7-B8 if mother was not on WIC during her pregnancy (B12). B8 goes before B7.**

**B7. When you went for WIC visits during *your most recent* pregnancy, did you receive information on breastfeeding?**

- No
- Yes

**B8. During *your most recent* pregnancy, when you went for your WIC visits, did you speak with a breastfeeding peer counselor or another WIC staff person about breastfeeding?**

- No
- Yes

**B9. Before your new baby was born, did any of the following things happen? Check ALL that apply**

- Someone answered my questions about breastfeeding
- I was offered a class on breastfeeding
- I attended a class on breastfeeding
- I decided or planned to feed *only* breast milk to my baby
- I discussed feeding *only* breast milk to my baby with my family
- I discussed feeding *only* breast milk to my baby with my health care worker
- I chose not to breastfeed my baby

**NOTE: Skip B9, B10, B11 if infant is not alive or not living with the mother (Core 32 and/or Core 33).**

**Skip B10 if mother said that she did not breastfeed (Core 35).**

**B10. How old was your new baby the first time he or she had liquids other than breast milk (such as formula, water, juice, or cow's milk)?**

[BOX] Weeks OR [BOX] Months

- My baby was less than 1 week old
- My baby has not had any liquids other than breast milk

**B11. How old was your new baby the first time he or she ate food (such as baby cereal, baby food, or any other food)?**

[BOX] Weeks OR [BOX] Months  
 My baby was less than 1 week old  
 My baby has not eaten any foods

**B12. (Phase 7, Core 27) During your most recent pregnancy, were you on WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)?**

No  
 Yes

**NOTE: Skip B13, B14, B15, B16 if mother did not breastfeed (Core 35).**

**B13. (NEW) After your new baby was born, did you receive the kinds of help with breastfeeding that are listed below?** For each one, check **No** if you did not receive this kind of breastfeeding help or **Yes** if you did.

	No	Yes
Someone to answer my questions		
Help getting my baby positioned correctly		
Help knowing if my baby was getting enough milk		
Help with managing pain or bleeding nipples		
Information about where to get a breast pump		
Help using a breast pump		
Information about breastfeeding support groups		
Other → Please tell us: _____		

**B14. (NEW) Have you used a breast pump to express milk to feed to your new baby?**

No → Go to Question X  
 Yes

**NOTE: B15 and B16 require B14, but B14 can be used alone.**

**B15. (NEW) Did your health insurance pay for a breast pump for you to use with your new baby?**

No  
 Yes, but I had to make a co-payment  
 Yes, with no co-payment  
 I did not have health insurance  
 I don't know

**B16. (NEW) Where did you get the breast pump or pumps that you use with your new baby? Check ALL that apply**

From the hospital for free  
 Rented from the hospital or doctor's office  
 Bought new from a hospital or doctor's office  
 Bought new from a store or online website  
 Received new as a gift  
 Bought used or someone gave it to me used  
 I had one from a previous child  
 Other → Please tell us: \_\_\_\_\_

**NOTE: Skip C1–C3 if infant is not alive or not living with the mother or is still in the hospital (Core 32 and/or Core 33, and Core 31).  
C2 and/or C3 need C1. C1 can be used alone. If C1 is used alone, it does not need to be skipped if infant is not alive or not living with the mother, or if the baby is still in the hospital.**

**C1. Are you currently in school or working?**

No, I don't go to school or work → **Go to Question ##**  
 Yes, I go to school or work outside the home  
 Yes, I go to school or work from home

**C2. Which *one* of the following people spends the most time taking care of your new baby when you are at school or work? Check ONE answer**

My husband or partner  
 Baby's grandparent  
 Other close family member or relative  
 Friend or neighbor  
 Babysitter, nanny, or other child care provider  
 Staff at day care center  
 Other → Please tell us: \_\_\_\_\_  
 The baby is with me while I am at school or work → **Go to Question ##**

**NOTE: C3 requires C2, with the skip arrow off of the last answer option. If C3 is not added, remove the skip in C2.**

**C3. While you are away from your new baby for school or work, how often do you feel that he or she is well cared for? Check ONE answer**

Always  
 Often  
 Sometimes  
 Rarely  
 Never

**C4. At any time during *your most recent* pregnancy, did you work at a job for pay?**

No → **Go to Question ##**  
 Yes

**NOTE: C5 and C6 need C4 (skip goes to C11 in this series. If C11 is not used, skip to the next topic).**

**C5. During *your most recent* pregnancy, how many hours did you work per week at your *main* job?**

40 or more hours per week  
 21 – 39 hours per week  
 20 hours per week or less

**C6. Which of the following best describes your work schedule during the *last month* of your most recent pregnancy? Check ONE answer**

- I worked up to the time of delivery with no change in schedule
- I cut back on my work hours
- I took time off before the birth of my baby
- I stopped working due to doctor's orders
- I quit my job → Go to Question ##
- I was laid off or fired from my job → Go to Question ##

**NOTE: C7 requires C4 (skip C7 if C4 is no). If C7 is no and not returning, skip C8-C10 and C14 (mom goes to C11 in this series, if used, or to next topic).**

**C7. Have you returned to the job you had during *your most recent* pregnancy? Check ONE answer**

- No, and I do not plan to return → Go to Question ##
- No, but I will be returning
- Yes

**NOTE: C8 requires C7 (and C4).**

**If a state adds a state-specific option to C8, insert "I took..." for options such as Family Medical Leave and "I took leave and used..." for options such as Temporary/Short-term Disability Insurance.**

**C8. Did you take leave from work *after* your new baby was born? Check ALL that apply**

- I took *paid* leave from my job
- I took *unpaid* leave from my job
- State-specific options (Leave or disability programs)*
- I did not take any leave

**C9. How did you feel about the amount of time you were able to take off *after* the birth of your new baby? Check ONE answer**

- Too little time
- Just the right amount of time
- Too much time

**C10. Did any of the things listed below affect your decision about taking leave from work *after* your new baby was born? For each item, check No if it does not apply to you or Yes if it does.**

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. I could not financially afford to take leave                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was afraid I'd lose my job if I took leave or stayed out longer | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had too much work to do to take leave or stay out longer        | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My job does not have paid leave                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My job does not offer a flexible work schedule                    | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I had not built up enough leave time to take any or more time off | <input type="checkbox"/> | <input type="checkbox"/> |

**C11. Did your baby's father take leave from work *after* your new baby was born? Check ONE answer**

- No, he did not take leave from his job
- Yes, he took *paid* leave from his job
- Yes, he took *unpaid* leave from his job
- Yes, he took *paid and unpaid* leave from his job
- My baby's father was unemployed
- I don't know

**NOTE: C12 and C13 require C4.**

**C12. (NEW) Please tell us about your MAIN job *during your most recent pregnancy*. What was your job title and what were your usual activities or duties?**

- Job title:
- Job duties:

**C13. (NEW) Thinking about your MAIN job *during your most recent pregnancy*, what type of company did you work for (what did the company do or make)?**

- Type of company:
- I don't know

**NOTE: C14 requires C8. Add a skip arrow to C8 response option "I did not take any leave" that goes to C9, (or C10, C11), if used, or to next topic.**

**C14. (NEW) How many weeks *or* months of leave, in total, did you take or will you take?**

- [BOX] Weeks **OR** [BOX] Months
- Less than 1 week

**NOTE: Skip D1–D2 if infant is not alive or not living with the mother (Core 32 and/or Core 33). D2 needs D1, but D1 can be used alone.**

**D1. Is your new baby a boy or a girl?**

- Boy
- Girl →Go to Question ##

**D2. Did you have your new baby boy circumcised?**

- No
- Yes

**E2 added to Core 46**

**NOTE: Skip E3 if mother was not using birth control when she got pregnant (E6).**

**BEFORE E3, insert instruction box that says, “If you or your husband or partner was not doing anything to keep from getting pregnant, go to Question....”**

**E3. What method of birth control were you using when you got pregnant? Check ALL that apply**

- Birth control pills
- Condoms
- Shots or injections (Depo-Provera<sup>®</sup>)
- Contraceptive implant in the arm (Nexplanon<sup>®</sup> or Implanon<sup>®</sup>)
- Contraceptive patch (OrthoEvra<sup>®</sup>) or vaginal ring (NuvaRing<sup>®</sup>)
- IUD (including Mirena<sup>®</sup>, ParaGard<sup>®</sup>, Liletta<sup>®</sup>, or Skyla<sup>®</sup>)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- Other → Please tell us: \_\_\_\_\_

**E4. Before you got pregnant with your new baby, had you ever heard or read about emergency birth control (the “morning-after pill”)? This combination of pills is used to prevent pregnancy up to 5 days after unprotected sex.**

- No
- Yes

**E5. (Phase 7, Core 14) When you got pregnant with your new baby, were you trying to get pregnant?**

- No
- Yes → Go to Question X

**NOTE: E5 is a required filter for E6.**

**E6. (Phase 7, Core 15) When you got pregnant with your new baby, were you or your husband or partner doing anything to keep from getting pregnant? Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.**

- No
- Yes

**NOTE: E6 is a required filter or E7.**

**E7. (Phase 7, Core 16) What were your reasons or your husband’s or partner’s 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 could not get pregnant at that time
- I had side effects from the birth control method I was using
- I had problems getting birth control when I needed it
- I thought my husband or partner or I was sterile (could not get pregnant at all)
- My husband or partner didn’t want to use anything

I forgot to use a birth control method

Other → Please tell us: \_\_\_\_\_

**F1-F3 replaced with Core 39, 40 & 41**

**NOTE: Inserting F4 after Core 39 requires the skip arrow to be changed from “Never” to “Always” so the filter will work properly.**

**AFTER F4 and BEFORE Core 40 insert this instruction box: “If your baby never sleeps alone in his or her own crib or bed, go to Question #.”**

**F4. (NEW) Who does your new baby usually sleep with when he or she is not sleeping alone? Check ALL that apply**

Me

My husband or partner

Someone else → Please tell us: \_\_\_\_\_

**G1. Have you ever heard or read that taking a vitamin with folic acid can help prevent some birth defects?**

No → Go to Question ##

Yes

**NOTE: G1 and G2 can be used alone. However, if they are used together, skip G2 if mother has never heard or read about folic acid (answered No to G1).**

**G2. Have you ever heard about folic acid from any of the following? Check ALL that apply**

Magazine or newspaper article

Radio or television

Doctor, nurse, or other health care worker

Book

Family or friends

Other → Please tell us: \_\_\_\_\_

**G3. Some health experts recommend taking folic acid for which one of the following reasons? Check ONE answer**

To make strong bones

To prevent birth defects

To prevent high blood pressure

I don't know

- G4. Which of the following things would cause *you* to take multivitamins, prenatal vitamins, or folic acid vitamins? Check ALL that apply**

I didn't usually eat the right foods  
 It prevented heart disease  
 It was good for my general health  
 It would help me have a healthy baby someday  
 My family or friends said it was a good idea  
 My doctor, nurse, or other health care worker said it was a good idea

- G5. During the *last 3 months* of your most recent pregnancy, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?**

I did not 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

- G6. During the *past month*, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?**

I did not 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

- G7a. During the *last 3 months* of your most recent pregnancy, about how many servings of *fruit* did you have in a day? Check ONE answer**

Zero servings (none)  
 1 or 2 servings per day  
 3 or 4 servings per day  
 5 or more servings per day

- G7b. During the *last 3 months* of your most recent pregnancy, about how many servings of *vegetables* did you have in a day? Check ONE answer**

Zero servings (none)  
 1 or 2 servings per day  
 3 or 4 servings per day  
 5 or more servings per day

<b>NOTE: Skip G8 if mother took a multivitamin 1 or more times a week (Core 5).</b>
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- G8. During the *month before* you got pregnant with your new baby, what were your reasons for not taking multivitamins, prenatal vitamins, or folic acid vitamins? Check ALL that apply**

I wasn't planning to get pregnant  
 I didn't think I needed to take vitamins  
 I didn't want to take vitamins

The vitamins were too expensive  
 The vitamins gave me side effects (such as nausea or constipation)  
 Other → Please tell us: \_\_\_\_\_

**NOTE: Skip H1–H2 if infant is not alive or not living with the mother (Core 32 and/or Core 33).**

**H1. Do you have health insurance or Medicaid for your new baby?**

No  
 Yes

**H2. What kind of health insurance is your new baby covered by now? Check ALL that apply**

Private health insurance from my job or the job of my husband or partner  
 Private health insurance from my parents  
 Private health insurance from the <State> Health Insurance Marketplace or <state website> or  
 HealthCare.gov  
 Medicaid (required: *state Medicaid name*)  
*State-specific option (Other government plan or program such as SCHIP/CHIP)*  
*State-specific option (Other government plan or program not listed above such as MCH program, indigent  
 program or family planning program)*  
*State-specific option (TRICARE or other military health care)*  
 State-specific option (IHS or tribal) Other health insurance → Please tell us:

\_\_\_\_\_ I do not have any health insurance for my new baby

**NOTE: Skip H3–H4 if infant is not alive or not living with the mother (Core 32 and/or Core 33).  
 H4 must be used with H3, but H3 can be used alone.**

**H3. Is your new baby in the Child Health Insurance Program (CHIP)?**

No  
 Yes → Go to Question ##

**H4. Why didn't you enroll your new baby in CHIP? Check ALL that apply**

I didn't know about the program  
 I already had insurance  
 I didn't think he or she was eligible  
 Other → Please tell us: \_\_\_\_\_

**NOTE: Skip H5–H7 if the baby did not have insurance (H2).  
 If H5, H6 and/or H7 is used, add a skip arrow to the last answer option in H2.**

**H5. Does the cost of health insurance for your new baby cause financial problems for you or your family *now*?**

No  
Yes

**H6. Do you or someone else make regular payments to pay for the health insurance that you have for your new baby *now*, including having money taken out of your paycheck or your husband, partner, or parent's paycheck?**

No  
Yes → About how much per month? \_\_\_\_\_

**H7. Do you have copayments for medical visits when you use your new baby's health insurance *now*?**

No  
Yes

**NOTE: Skip I3 and I9 if mom indicated in I8 that she was tested during pregnancy or delivery. I3 must be used with or I9, but I9 can be used alone.**

**BEFORE I3, include instruction box stating "If you did not have an HIV test *before* this pregnancy, go to Question x."**

**I3. When were you tested *before* this pregnancy? Check ONE answer**

Less than 6 months before I got pregnant  
6 months to 1 year before I got pregnant  
More than 1 year before I got pregnant

**I4-I6 replaced with I9**

**I8. (Phase 7, Core 20) At any time during *your most recent* pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)?**

No  
Yes → Go to Question x  
I don't know → Go to Question x

**I9. Why didn't you have an HIV test during your most recent pregnancy or delivery? Check ALL that apply**

I was not offered the test  
I did not want to have the test  
I already knew my HIV status  
I did not think I was at risk for HIV  
I did not want people to think I was at risk for HIV  
I was afraid of getting the result  
I was tested *before* this pregnancy, and did not think I needed to be tested again  
Other reason → Please tell us: \_\_\_\_\_

**J1 replaced with modified version is now Phase 8 Core 47**

**NOTE: Skip J2 if mom has not had a postpartum checkup.**

**J2. (NEW) Where did you go for your postpartum checkup?**

- My family doctor's office
- My OB/GYN's office
- Hospital clinic
- Health department clinic
- State-specific option*
- State-specific option*
- Other → Please tell us: \_\_\_\_\_

**NOTE: Skip J3 if mom had a postpartum checkup.**

**If J3 is added, the skip arrow on Core 46 should be switched from "no" to "yes"; (J2 and) Core 47 will need an instruction to skip.**

**AFTER J3, add: "If you did not have a postpartum checkup, go to Question #..."**

**J3. (NEW) Did any of these things keep you from having a postpartum checkup? Check ALL that apply**

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

**NOTE: Skip J4 if mom has not had a postpartum checkup.**

**J4. (NEW) How did you feel about the care you got during your postpartum checkup? For each item, check No if you were not satisfied or Yes if you were satisfied.**

- |    |  | <b>No</b>                | <b>Yes</b>               |
|----|--|--------------------------|--------------------------|
| a. | The amount of time you had to wait   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | The amount of time the doctor, nurse, or health care worker spent with you | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | The advice you got on how to take care of yourself                         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | The understanding and respect shown toward you as a person                 | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: Skip J5 if mom had a routine care visit.  
If J5 is added, the skip arrow on Core 6 should be switched from “no” to “yes” and Core 7 will need an instructional skip.  
AFTER J5, add: “If you did not have any health care visits, go to Question #...”.**

**J5. (NEW) Why didn't you have any health care visits in the 12 months before you got pregnant with your new baby? Check ALL that apply**

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

**NOTE: Skip K1 if mother has not had a previous infant born alive (FF5 is a required filter).**

**K1. Before you had your new baby, did you ever have a baby by cesarean delivery or c-section (when a doctor cuts through the mother's belly to bring out the baby)?**

- No
- Yes

**K3. How was your new baby delivered?**

- Vaginally
- Cesarean delivery (c-section)

**NOTE: Skip K4 if mother did not have prenatal care (Core 13).**

**K4. How did the doctor, nurse, or other health care worker who provided your prenatal care suggest you deliver your new baby? Check ONE answer**

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

**NOTE: If using K5 with K14, drop the last answer option (I didn't have my baby in the hospital) and add a skip arrow to K14's last answer option.**

**K5. After you were *admitted* to the hospital to deliver your new baby, were you transferred to another hospital *before* your baby was born?**

- No
- Yes
- I didn't have my baby in the hospital

**NOTE: Skip K6 and K7 if the mother did not have a cesarean delivery for her new baby (K3). K6 and K7 must be used with K3, but K3 may be used alone.**

**K6. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)? Check ONE answer**

- My health care provider recommended a cesarean delivery *before* I went into labor
- My health care provider recommended a cesarean delivery while I was in labor
- I asked for the cesarean delivery

**K7. What was the reason that your new baby was born by cesarean delivery (c-section)? Check ALL that apply**

- I had a previous cesarean delivery (c-section)
- My baby was in the wrong position (such as breech)
- I was past my due date
- My health care provider worried that my baby was too big
- I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)
- I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)
- My health care provider tried to induce my labor, but it didn't work
- Labor was taking too long
- The fetal monitor showed that my baby was having problems before or during labor (fetal distress)
- I wanted to schedule my delivery
- I didn't want to have my baby vaginally
- Other → Please tell us: \_\_\_\_\_

**K8. Did you plan or schedule a cesarean delivery (c-section) at least one week before your new baby was born?**

- No
- Yes

**NOTE: K10 needs K9, but K9 can be used alone.**

**K9. Did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)?**

- No → Go to Question ##
- Yes
- I don't know → Go to Question ##

**K10. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)? Check ALL that apply**

- My water broke and there was a fear of infection
- I was past my due date
- My health care provider worried about the size of the baby
- My baby was not doing well and needed to be born
- I had a complication in my pregnancy (such as low amniotic fluid or pre-eclampsia)
- I wanted to schedule my delivery
- I wanted to give birth with a specific health care provider
- Other → Please tell us: \_\_\_\_\_

**NOTE: Skip K11-K12 if the baby was not born in the hospital (Core 31).  
Add a skip arrow to Core 31 response option “My baby was not born in a hospital” if K11 and/or K12 is inserted.**

**K11. After your baby was born, was he or she transferred to another hospital?**

- No
- Yes

**K12. After your baby was born, were you transferred to another hospital?**

- No
- Yes

**K13. When was your baby due?**

[BOX]      / [BOX]      /20\_\_ [BOX]  
Month      Day      Year

**K14. When did you go into the hospital to have your baby?**

[BOX]      / [BOX]      /20\_\_ [BOX]  
Month      Day      Year

I didn't have my baby in a hospital

**K15. When were you discharged from the hospital after your baby was born?**

[BOX]      / [BOX]      /20\_\_ [BOX]  
Month      Day      Year

I didn't have my baby in a hospital

**K16. (Phase 7, Core 41) After your baby was delivered, was he or she put in an intensive care unit (NICU)?**

- No
- Yes
- I don't know

**L1. Other than prenatal vitamins, did you take any over-the-counter or prescribed medicine during pregnancy, even for a short period of time?**

- No
- Yes

**L2. Have you ever had German measles (rubella) or been vaccinated for German measles?**

- No
- Yes

**L3. Have you ever had chickenpox (varicella) or been vaccinated for chickenpox?**

- No
- Yes

**L4. Have you ever taken medicine on a regular basis to control seizures or epilepsy?**

- No → Go to Question ##
- Yes

**NOTE: Skip L5–L7 if mother has never taken medicine to control seizures or epilepsy (L4). L5-L7 need L4, but L4 can be used alone.**

**L5. During *your most recent* pregnancy, did you take medicine on a regular basis to control seizures or epilepsy?**

- No → Go to Question ##
- Yes

**NOTE: L6 and L7 need L5, but L5 can be used alone.**

**L6. When did you start taking the medicine?**

- I started taking the medicine during my pregnancy
- I started taking the medicine in the year before I got pregnant
- I started taking the medicine more than a year before I got pregnant

**L7. How many seizures did you experience during *your most recent* pregnancy?**

- None
- 1
- 2
- 3 or more

**NOTE: Skip L9 if mother has not had a postpartum checkup (Core 53).**

**L9 is part of Phase 8, Core 47**

**L10. Before you got pregnant, would you say that, in general, your health was—**

- Excellent
- Very good
- Good
- Fair
- Poor

**Response options for L11 will now be added directly to Core 4 if this question is selected. Recommended minimum grouping for selecting L11 includes options a, e, & f.**

**L11. 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. | Asthma.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Anemia (poor blood, low iron) .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Heart problems .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | Epilepsy (seizures).....                | <input type="checkbox"/> | <input type="checkbox"/> |
| e. | Thyroid problems .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. | PCOS (polycystic ovarian syndrome)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. | Anxiety .....                           | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: Skip L14 if mother got a flu shot (Core 16).**

**Add skip arrows to both “yes” response options on Core 16 if L14 is inserted.**

**L14. What were your reasons for not getting a flu shot during the 12 months before the birth of your new baby?** For each item, check **No** if it was not a reason for you or **Yes** if it was.

- |    |  | No                       | Yes                      |
|----|--|--------------------------|--------------------------|
| a. | My doctor didn’t mention anything about a flu shot.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | I was worried about side effects of the flu shot for me..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | I was worried that the flu shot might harm my baby.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | I was not worried about getting sick with the flu.....       | <input type="checkbox"/> | <input type="checkbox"/> |
| e. | I do not think the flu shot works.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| f. | I don’t normally get a flu shot .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| g. | Other.....   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | Please tell us: _____  |                          |                          |

**L15. Have you ever had a flu shot?**

- No
- Yes

**L16 is part of Phase 8, Core 47**

**NOTE: Skip L18 if health care worker didn't talk with mother about preparing for pregnancy (L27). L27 must be used before L18.**

**L17 was incorporated into Core 8 for Phase 8; a modified version to serve as a filter for L18 was developed and named L27.**

**L18.** *Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk with you about any of the things listed below about preparing for a pregnancy? Please count only discussions, not reading materials or videos. For each item, check No if no one talked with you about it or Yes if someone did.*

	<b>No</b>	<b>Yes</b>
a. Getting my vaccines updated before pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
b. Visiting a dentist or dental hygienist before pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
c. Getting counseling for any genetic diseases that run in my family	<input type="checkbox"/>	<input type="checkbox"/>
d. Getting counseling or treatment for depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>
e. The safety of using prescription or over-the-counter medicines during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
f. How smoking during pregnancy can affect a baby	<input type="checkbox"/>	<input type="checkbox"/>
g. How drinking alcohol during pregnancy can affect a baby	<input type="checkbox"/>	<input type="checkbox"/>
h. How using illegal drugs during pregnancy can affect a baby	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE: Skip L19 if mother did not get a flu shot (Core 16).**

**L19.** **Where did you get your flu shot? Check ONE answer**

- My obstetrician or gynecologist's office
- My family doctor or other doctor's office
- A health department or community clinic
- A hospital
- A pharmacy, drug store, or grocery store
- My work place or school
- Other → Please tell us: \_\_\_\_\_

**L20.** **At any time during *your most recent* pregnancy, were you sick with a fever?**

- No
- Yes

**L21.** **At any time during *your most recent* pregnancy, did a doctor, nurse, or other health care worker tell you that you had the flu?**

- No → Go to Question ##
- Yes

**NOTE: Skip L22 and L23 if mother was not told by a health care worker that she had the flu (L21).**

- L22. Were you hospitalized for the flu during *your most recent* pregnancy?**  
 No  
 Yes
- L23. Did you take a medicine prescribed by your doctor or other health care worker called Tamiflu® or oseltamivir, or an inhaled medicine called Relenza® or zanamivir *during* your pregnancy to treat the flu?**  
 No  
 Yes
- L24. (Modified). During *your most recent* pregnancy, did you get a Tdap shot or vaccination? A Tdap vaccination is a tetanus booster shot that also protects against pertussis (whooping cough).**  
 No  
 Yes  
 I don't know
- L26. (Phase 7, Core 7) At any time during the *12 months before* you got pregnant with your new baby, did you do any of the following things? For each item, check **No** if you did not do it or **Yes** if you did it.**
- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. I was dieting (changing my eating habits) to lose weight                          | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was exercising 3 or more days of the week for fitness outside of my regular job | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I was regularly taking prescription medicines other than birth control            | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A health care worker checked me for diabetes                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I talked to a health care worker about my family medical history                  | <input type="checkbox"/> | <input type="checkbox"/> |
- L27. (Modified L17) Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk to you about preparing for a pregnancy?**  
 No  
 Yes
- L28. (NEW) Since your new baby was born, have you been told that you have thyroid problems by a doctor, nurse, or other health care worker?**  
 No → Go to Question x  
 Yes
- L29. (NEW) What kind of thyroid problem do you have? Check ONE answer**  
 Hypothyroidism (underactive thyroid)  
 Hyperthyroidism (overactive thyroid)  
 Both hypothyroidism and hyperthyroidism  
 Other → Please tell us: \_\_\_\_\_  
 I don't know

**L30. (NEW) Have you ever experienced any of the following health problems?** For each condition, check **No** if you have not experienced it or **Yes** if you have.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Irregular periods (menstruation).....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skin condition that causes pimples (acne) .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Increased hair growth on the face, chest, or other parts of the<br>body..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Being overweight or obese.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**L31. (NEW) Have you ever been told that you have Polycystic Ovarian Syndrome or PCOS by a doctor, nurse, or other health care worker?**

- No → Go to Question x  
 Yes  
 I don't know → Go to Question x

**L32. (NEW) How did your doctor, nurse, or other health care worker find out that you had Polycystic Ovarian Syndrome, or PCOS? Check ALL that apply**

- Ultrasound of my abdomen and pelvis
- Blood tests (including measurements of hormones)
- Because of my irregular periods
- Because of my skin condition or acne
- Because of the increased hair growth on my body
- Because of my weight
- Other → Please tell us: \_\_\_\_\_

**M2. At any time during *your most recent* pregnancy or after delivery, did a doctor, nurse, or other health care worker talk with you about “baby blues” or postpartum depression?**

- No  
 Yes

**M3 added to Core 18**

**Note: Skip M4 if mom does not indicate she had depression in Core 18 (Q18, item c).**  
**BEFORE M4, add instruction: “If you had depression during your most recent pregnancy, go to Question #\*. Otherwise, go to Question #.” (\*this being the next question inserted—M4)**

**M4. At any time during *your most recent* pregnancy, did you *ask for help* for depression from a doctor, nurse, or other health care worker?**

- No  
 Yes

**M5. *Since your new baby was born*, has a doctor, nurse, or other health care worker *told you that you had* depression?**

- No → Go to Question ##  
 Yes

**M6.** *Since your new baby was born, have you asked for help for depression from a doctor, nurse, or other health care worker?*

No  
Yes

**M7.** **How would you describe the time during *your most recent* pregnancy? Check ONE answer**

One of the happiest times of my life  
A happy time with few problems  
A moderately hard time  
A very hard time  
One of the worst times of my life

**Note: Skip M8 and M9 if mom does not indicate she had depression in Core 18 (Q18, item c).**

**BEFORE M9/M8, add instruction: “If you had depression during your most recent pregnancy, go to Question #\*. Otherwise, go to Question #.” (\*this being the next question inserted—M9 or M8)**

**M8.** *At any time during *your most recent* pregnancy, did you take prescription medicine for your depression?*

No  
Yes

**M9.** *At any time during *your most recent* pregnancy, did you get counseling for your depression?*

No  
Yes

**Note: M10 and M11 need M5, but M5 can be used alone. Skip M10 and M11 if M5 is no.**

**M10.** *Since your new baby was born, have you taken prescription medicine for your depression?*

No  
Yes

**M11.** *Since your new baby was born, have you gotten counseling for your depression?*

No  
Yes

**Note: M12 and M21 must be used together.**

**M12.** *Since your new baby was born, how often have you felt panicky?*

Always  
Often  
Sometimes  
Rarely  
Never

**M13.** *At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker tell you that you had anxiety?*

No → Go to Question ##  
Yes

**M14.** *At any time during your most recent pregnancy, did you ask for help for anxiety from a doctor, nurse, or other health care worker?*

No  
Yes

**M15.** *Since your new baby was born, has a doctor, nurse, or other health care worker told you that you had anxiety?*

No → Go to Question ##  
Yes

**M16.** *Since your new baby was born, have you asked for help for anxiety from a doctor, nurse, or other health care worker?*

No  
Yes

**Note:** M17 and M18 need M13, but M13 can be used alone.

**M17.** *At any time during your most recent pregnancy, did you take prescription medicine for your anxiety?*

No  
Yes

**M18.** *At any time during your most recent pregnancy, did you get counseling for your anxiety?*

No  
Yes

**Note:** M19 and M20 need M15, but M15 can be used alone.

**M19.** *Since your new baby was born, have you taken prescription medicine for your anxiety?*

No  
Yes

**M20.** *Since your new baby was born, have you gotten counseling for your anxiety?*

- No
- Yes

**Note: M21 must be used with M12.**

**M21.** *Since your new baby was born, how often have you felt restless?*

- Always
- Often
- Sometimes
- Rarely
- Never

**N1.** *At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker tell you to stay in bed for at least 1 week?*

- No → Go to Question ##
- Yes

**NOTE: N2 needs N1, but N1 can be used alone.**

**N2.** *How many weeks or months pregnant were you when you were told to stay in bed?*

[BOX] Weeks OR [BOX] Months

**NOTE: N3 needs N1, but N1 can be used alone.**

**N3.** *How often were you able to follow your provider's instruction to stay in bed?*

- Always → Go to Question ##
- Often → Go to Question ##
- Sometimes
- Rarely
- Never

**NOTE: N4 needs N3, but N3 can be used alone.**

**N4. What types of support would have helped you to stay in bed for the recommended time?** For each item, check **No** if it would not have helped or did not apply to you or **Yes** if it would have helped you.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Help with child care.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Help with housework .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Knowing I wouldn't lose my job .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Money to make up for not working ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other .....                            | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us: \_\_\_\_\_

**N5. During your most recent pregnancy, did a doctor, nurse, or other health care worker give you a series of weekly shots of a medicine called progesterone, Makena®, or 17P (17 alpha-hydroxyprogesterone) to try to keep your new baby from being born too early?**

- No  
 Yes  
 I don't know

**NOTE: Skip N6-N7 if the mother did not have gestational diabetes during this pregnancy (Core 18, item a). BEFORE N6/N7, add instruction that says, "If you had gestational diabetes during your most recent pregnancy, go to Question #\*. Otherwise, go to Question #." (\*being the next question inserted—N6 or N7)**

**N6. During your most recent pregnancy, when you were told that you had gestational diabetes, did the doctor, nurse, or other health care worker tell you to make an appointment with a different doctor because of your gestational diabetes?**

- No  
 Yes

**N7. During your most recent pregnancy, when you were told that you had gestational diabetes, did a doctor, nurse, or other health care worker do any of the things listed below?** For each item, check **No** if it was not done or **Yes** if it was.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Refer me to a nutritionist .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about the importance of exercise.....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about getting to and staying at a healthy weight after delivery..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Suggest that I breastfeed my new baby.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about my risk for Type 2 diabetes .....                              | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: Skip N8 if mother did not have any problems during this pregnancy (N9), so N8 needs N9 but N9 can be used alone.**

**BEFORE N8, insert instruction box that says, "If you did not have any of the problems listed above, go to Question ##."**

**N8b. Did you go to the hospital or emergency room because of any of the problems listed above?**

No → Go to Question xx  
Yes

**N8c. How many times did you go to the hospital or emergency room because of the problem(s)?**

1 time  
2 times  
3 times  
4 or more times

**N9. Did you have any of the following problems during *your most recent* pregnancy? For each item, check No if you did not have the problem or Yes if you did.**

	No	Yes
a. Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
b. Kidney or bladder (urinary tract) infection (UTI)	<input type="checkbox"/>	<input type="checkbox"/>
c. <i>Severe</i> nausea, vomiting, or dehydration that sent me to the doctor or hospital	<input type="checkbox"/>	<input type="checkbox"/>
d. Cervix had to be sewn shut (cerclage for incompetent cervix)	<input type="checkbox"/>	<input type="checkbox"/>
e. Problems with the placenta (such as abruptio placentae or placenta previa)	<input type="checkbox"/>	<input type="checkbox"/>
f. Labor pains more than 3 weeks before my baby was due (preterm or early labor)	<input type="checkbox"/>	<input type="checkbox"/>
g. Water broke more than 3 weeks before my baby was due (preterm premature rupture of membranes [PPROM])		<input checked="" type="checkbox"/> <input type="checkbox"/>
h. I had to have a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
i. I was hurt in a car accident	<input type="checkbox"/>	<input type="checkbox"/>

**O1. Since your new baby was born, have you had any medical problems that caused you to go to the hospital and stay overnight?**

No → Go to Question ##  
Yes

**NOTE: O2 and O3 need O1, but O1 can be used alone.**

**O2.** When was the *first* time you had to go into the hospital and stay overnight after your new baby was born?

[BOX] / [BOX] / [BOX]  
Month Day Year

I don't know

**O3.** What kind of medical problem caused you to go into the hospital? Check ALL that apply

Vaginal bleeding

Fever or infection

Other → Please tell us: \_\_\_\_\_

**O4.** *Since your new baby was born, have you been tested for diabetes or high blood sugar?*

No → Go to Question ##

Yes

**NOTE: O5 needs O4, but O4 can be used alone.**

**O5.** *Since your new baby was born, did a doctor, nurse, or other health care worker tell you that you had diabetes?*

No

Yes → Go to Question ##

**NOTE: O6 needs both O4 and O5.**

**O6.** Did a doctor, nurse, or other health care worker tell you that you had prediabetes, borderline diabetes or high blood sugar?

No

Yes

**P1.** When you got pregnant, did your new baby's father live with you?

No

Yes

**P2.** When you got pregnant, what relationship did you have with your new baby's father? Check ONE answer

He was my husband (legally married)

He was my partner (not legally married)

He was my boyfriend

He was a friend

Other → Please tell us: \_\_\_\_\_

**P3. When you got pregnant with your new baby, who lived in the same house with you? Check ALL that apply**

- My husband or partner
- Children aged less than 12 months → How many children? [BOX]
- Children aged 1 year to 5 years → How many children? [BOX]
- Children aged 6 years and over → How many children? [BOX]
- My mother
- My father
- My husband's or partner's parent(s)
- Friend or roommate
- Other family member or relative
- Other → Please tell us: \_\_\_\_\_
- I lived alone

**P4. Who lives in the same house with you now? Check ALL that apply**

- My husband or partner
- Children aged less than 12 months → How many children? [BOX]
- Children aged 1 year to 5 years → How many children? [BOX]
- Children aged 6 years and over → How many children? [BOX]
- My mother
- My father
- My husband's or partner's parent(s)
- Friend or roommate
- Other family member or relative
- Other → Please tell us: \_\_\_\_\_
- I live alone

**P5. Do you have a husband or partner who lives with you now?**

- No
- Yes

**P6. When you got pregnant, how old was your new baby's father?**

[BOX] Years old

I don't know

**P7. How old were you when you had your first menstrual period?**

[BOX] Years old

**P8. How old were you when you got pregnant for the first time?**

[BOX] Years old

**P9. Do you have a telephone in your home that has been working (in service) for the *past month*?**

No → **Go to Question ##**

Yes

<b>Note: P10 needs P9, but P9 can be used alone.</b>
--

**P10. Is your telephone number listed in the most recent telephone book under your last name and current address?**

Yes

Telephone unlisted

Telephone listed under another name or address

**P11. Which rooms are in the house, apartment, or trailer where you live? Check ALL that apply**

Living room

Separate dining room

Kitchen

Bathroom(s)

Recreation room, den, or family room

Finished basement

Bedrooms → How many? **[BOX]**

**P12. Counting yourself, how many people live in your house, apartment, or trailer?**

**[BOX]** Adults (people aged 18 years or older)

**[BOX]** Babies, children, or teenagers (people aged 17 years or younger)

**NOTE: P13a and P13b do not have to be used together.**

**BEFORE P13b, insert instruction box that says, “If you don’t have complete plumbing facilities in your home, go to Question ##.”**

**P13a. Which of the following utilities do you have in your house, apartment, or trailer?** For each item, check **No** if you do not have the utility or **Yes** if you have the utility.

- |  | <b>No</b> | <b>Yes</b> |
|--|-----------|------------|
| a. Complete plumbing facilities (including hot and cold running water, a flush toilet, and a bathtub or shower)..... | □         | □          |
| b. Electricity.....  | □         | □          |
| c. A telephone from which you can make and receive calls (including cell phones).....                                | □         | □          |

**P13b. Do you get the water you use in your house, apartment, or trailer from a city or county water supply or from a private well?**

- City or county water supply
- Private well

**P14. During the 12 months before your new baby was born, did you ever eat less than you felt you should because there wasn’t enough money to buy food?**

- No
- Yes

**P15. During the 12 months before your new baby was born, how often did you feel unsafe in the neighborhood where you lived?**

- Always
- Often
- Sometimes
- Rarely → Go to Question ##
- Never → Go to Question ##

**Note: P16 needs P15, but P15 can be used alone.**

**P16. During the 12 months before your new baby was born, did you do any of the following things because you felt it was unsafe to leave or return to the neighborhood where you lived?** For each item, check **No** if you did not do it or **Yes** if you did.

- |   | <b>No</b> | <b>Yes</b> |
|---|-----------|------------|
| a. I missed doctor or other appointments.....         | □         | □          |
| b. I limited grocery or other shopping.....           | □         | □          |
| c. I stayed with other family members or friends..... | □         | □          |

**P17. During the 12 months before your new baby was born, did you ever get emergency food from a church, a food pantry, or a food bank, or eat in a food kitchen?**

- No
- Yes

**P18. During the 12 months before your new baby was born, what were the sources of your household's income? Check ALL that apply**

- Money from family or friends
- Money from a business, fees, dividends, or rental income
- Paycheck or money from a job
- Food stamps or WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)
- Aid such as Temporary Assistance for Needy Families (TANF), welfare, public assistance, general assistance, or Supplemental Security Income (SSI)
- Unemployment benefits
- Child support or alimony
- Social security, workers' compensation, disability, veteran benefits, or pensions
- Other → Please tell us: \_\_\_\_\_

**P19. (Phase 7, Core 36) This question is about things that may have happened during the 12 months before your new baby was born. For each item, check No if it did not happen to you or Yes if it did. (It may help to look at the calendar when you answer these questions.)**

	<b>No</b>	<b>Yes</b>
a. A close family member was very sick and had to go into the hospital	<input type="checkbox"/>	<input type="checkbox"/>
b. I got separated or divorced from my husband or partner	<input type="checkbox"/>	<input type="checkbox"/>
c. I moved to a new address	<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 husband or partner lost their job	<input type="checkbox"/>	<input type="checkbox"/>
f. I lost my job even though I wanted to go on working	<input type="checkbox"/>	<input type="checkbox"/>
g. My husband, partner, or I had a cut in work hours or pay.	<input type="checkbox"/>	<input type="checkbox"/>
h. I was apart from my husband or partner due to military deployment or extended work-related travel	<input type="checkbox"/>	<input type="checkbox"/>
i. I argued with my husband or partner more than usual	<input type="checkbox"/>	<input type="checkbox"/>
j. My husband or partner said they didn't want me to be pregnant	<input type="checkbox"/>	<input type="checkbox"/>
k. I had problems paying the rent, mortgage, or other bills	<input type="checkbox"/>	<input type="checkbox"/>
l. My husband, partner, or I went to jail	<input type="checkbox"/>	<input type="checkbox"/>
m. Someone very close to me had a problem with drinking or drugs	<input type="checkbox"/>	<input type="checkbox"/>
n. Someone very close to me died	<input type="checkbox"/>	<input type="checkbox"/>

**Q1. Which of the following statements best describes you during the 3 months before you got pregnant? Check ONE answer**

- I was trying to get pregnant
- I was trying to keep from getting pregnant but was not trying very hard
- I was trying hard to keep from getting pregnant

**Q2. Which of the following statements best describes your husband or partner during the 3 months before you got pregnant? Check ONE answer**

- Wanted me to get pregnant
- Partly wanted me to get pregnant and partly wanted me not to get pregnant
- Didn't care one way or the other whether I got pregnant
- Didn't especially want me to get pregnant
- Wanted very much for me not to get pregnant

**Q3. Thinking back to just before you got pregnant with your new baby, how did your husband or partner feel about your becoming pregnant? Check ONE answer**

- Wanted me to be pregnant sooner
- Wanted me to be pregnant later
- Wanted me to be pregnant then
- Didn't want me to be pregnant then or at any time in the future
- I don't know
- I didn't have a husband or partner

NOTE: Skip Q4 if mom wanted to be pregnant sooner, then, not then or any time in future, or if she wasn't sure (Core 12). Add a skip arrow to Core Q12 for the last four responses.

**Q4. (Phase 7, Core 13) How much longer did you want to wait to become pregnant?**

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to 5 years
- More than 5 years

**Q5. This question asks about feelings and concerns women sometimes have about becoming pregnant.**  
For each item, check **No** if it did not apply to you when you found out you were pregnant with your new baby or **Yes** if it did.

	<b>No</b>	<b>Yes</b>
a. I was worried that I didn't know enough about how to take care of a baby .....	<input type="checkbox"/>	<input type="checkbox"/>
b. I thought a new baby would keep me from doing the things I was used to doing, like working, going to school, or going out.....	<input type="checkbox"/>	<input type="checkbox"/>
c. I looked forward to teaching and caring for a new baby .....	<input type="checkbox"/>	<input type="checkbox"/>
d. I looked forward to the new experiences that having a baby would bring .....	<input type="checkbox"/>	<input type="checkbox"/>
e. I looked forward to telling my friends that I was pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>
f. I was worried that I did not have enough money to take care of a baby.....	<input type="checkbox"/>	<input type="checkbox"/>
g. I did not look forward to telling my friends that I was pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>
h. I looked forward to buying things for a new baby .....	<input type="checkbox"/>	<input type="checkbox"/>

**Q6. How did you feel when you found out you were pregnant with your new baby?**

- Very unhappy to be pregnant
- Unhappy to be pregnant
- Not sure
- Happy to be pregnant
- Very happy to be pregnant

**NOTE: Skip Q7 if mother was not trying to get pregnant (E5).**

**AFTER Q7, insert instruction box that says, “If you were trying to get pregnant when you got pregnant with your new baby, go to Question ##.”**

- Q7. How many months were you trying to get pregnant?** Do not count long periods of time when you and your partner were apart or not having sex.
- 0 to 3 months
  - 4 to 6 months
  - 7 to 12 months
  - 13 to 24 months
  - More than 24 months

**NOTE: Skip R1–R18 if mother had no prenatal care (Core 13).**

- R1. How did you feel about the prenatal care you got during *your most recent* pregnancy?** If you went to more than one place for prenatal care, answer for the place where you got *most* of your care. For each item, check **No** if you were not satisfied or **Yes** if you were satisfied.

	<b>No</b>	<b>Yes</b>
a. The amount of time I had to wait.....	<input type="checkbox"/>	<input type="checkbox"/>
b. The amount of time the doctor, nurse, or midwife spent with me.....	<input type="checkbox"/>	<input type="checkbox"/>
c. The advice I got on how to take care of myself.....	<input type="checkbox"/>	<input type="checkbox"/>
d. The understanding and respect shown toward me as a person.....	<input type="checkbox"/>	<input type="checkbox"/>

**R2 is combined with Core 14.**

**R3-R5 combined and promoted to core.**

- R6. Have you ever heard of the bacteria Group B Strep (Beta Strep) that mothers can pass to their newborns during birth?**

No  
Yes

- R7. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about the bacteria Group B Strep (Beta Strep)?**

No  
Yes

- R8. At any time during *your most recent* pregnancy, did you get tested for the bacteria Group B Strep (Beta Strep)?**

No  
Yes  
I don't know

**R9. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about getting your blood tested for the disease called toxoplasmosis?**

- No
- Yes

**R10. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos. For each item, check No if no one talked with you about it or Yes if someone did.**

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Not touching your mouth or eyes while handling raw meat .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cooking meat to “well done” .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Washing hands and utensils after handling raw meat.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Washing hands after contact with soil, sand, litter, or any other material that may be contaminated with cat feces..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Not feeding cats raw or undercooked meat.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**R11. At any time during your most recent pregnancy, did you have a blood test for the disease called toxoplasmosis?**

- No
- Yes
- I don't know

**R12. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about taking multivitamins, prenatal vitamins, or folic acid vitamins during your pregnancy?**

- No
- Yes

**R13. At any time during your most recent pregnancy, did your regular prenatal care provider ask you to see a specialist doctor for help with any health problem(s)?**

- No
- Yes

**R14. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about how eating fish containing high levels of mercury could affect your baby?**

- No
- Yes

**R15. Where did you go *most of the time* for your prenatal care visits? Do not include visits for WIC. Check ONE answer**

- Private doctor's office  
 Hospital clinic  
 Health department clinic  
*State-specific option*  
*State-specific option*  
 Other → Please tell us: \_\_\_\_\_

**R16. During your most recent pregnancy, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos. For each one, check No if no one talked with you about it or Yes if someone did.**

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Foods that are good to eat during pregnancy                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Exercise during pregnancy   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Programs or resources to help me gain the right amount of weight during pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Programs or resources to help me lose weight after pregnancy                      | <input type="checkbox"/> | <input type="checkbox"/> |

**BEFORE R17, insert instruction box that says, "If a doctor, nurse, or other health care worker did not tell you how much weight you should gain during your most recent pregnancy, go to Question ...."**

**R17. How much weight did your doctor, nurse, or other health care worker tell you to gain during your most recent pregnancy? Check ONE answer and fill in blank if needed.**

Between [BOX] Pounds and [BOX] Pounds

Between [BOX] Kilos and [BOX] Kilos

Exactly [BOX] Pounds OR [BOX] Kilos

I don't remember

**R18. During any of your prenatal care visits, did a doctor, nurse, or other health care worker advise you not to drink alcohol while you were pregnant?**

- No  
 Yes

**R19. How many weeks or months pregnant were you when you were sure you were pregnant? For example, you had a pregnancy test or a doctor, nurse, or other health care worker said you were pregnant.**

- [BOX] Weeks OR [BOX] Months  
 I don't remember

**Note: If R20 is used without R21, insert instruction box that says, “If you did not get prenatal care, go to Question...”**

**R20. Did you get prenatal care as early in your pregnancy as you wanted?**

No

Yes → Go to Question ##

**NOTE: R21 needs R20, but R20 can be used alone.**

**AFTER R21, insert instruction box that says, “If you did not get prenatal care, go to Question...”**

**R21. Did any of these things keep you from getting prenatal care when you wanted it?** For each item, check **No** if it did not keep you from getting prenatal care or **Yes** if it did.

	<b>No</b>	<b>Yes</b>
a. I couldn't get an appointment when I wanted one	<input type="checkbox"/>	<input type="checkbox"/>
b. I didn't have enough money or insurance to pay for my visits	<input type="checkbox"/>	<input type="checkbox"/>
c. I didn't have any transportation to get to the clinic or doctor's office	<input type="checkbox"/>	<input type="checkbox"/>
d. The doctor or my health plan would not start care as early as I wanted	<input type="checkbox"/>	<input type="checkbox"/>
e. I had too many other things going on	<input type="checkbox"/>	<input type="checkbox"/>
f. I couldn't take time off from work or school	<input type="checkbox"/>	<input type="checkbox"/>
g. I didn't have my Medicaid <or <i>state Medicaid name</i> > card	<input type="checkbox"/>	<input type="checkbox"/>
h. I didn't have anyone to take care of my children	<input type="checkbox"/>	<input type="checkbox"/>
i. I didn't know that I was pregnant	<input type="checkbox"/>	<input type="checkbox"/>
j. I didn't want anyone else to know I was pregnant	<input type="checkbox"/>	<input type="checkbox"/>
k. I didn't want prenatal care	<input type="checkbox"/>	<input type="checkbox"/>

**R22. (Phase 7 Core#19). During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos.** For each item, check **No** if no one talked with you about it or **Yes** if someone did.

	<b>No</b>	<b>Yes</b>
a. How smoking during pregnancy could affect my baby	<input type="checkbox"/>	<input type="checkbox"/>
b. Breastfeeding my baby	<input type="checkbox"/>	<input type="checkbox"/>
c. How drinking alcohol during pregnancy could affect my baby	<input type="checkbox"/>	<input type="checkbox"/>
d. Using a seat belt during my pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
e. Medicines that are safe to take during my pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
f. How using illegal drugs could affect my baby	<input type="checkbox"/>	<input type="checkbox"/>
g. Doing tests to screen for birth defects or diseases that run in my family	<input type="checkbox"/>	<input type="checkbox"/>
h. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)	<input type="checkbox"/>	<input type="checkbox"/>
i. What to do if I feel depressed during my pregnancy or after my baby is born	<input type="checkbox"/>	<input type="checkbox"/>
j. Physical abuse to women by their husbands or partners	<input type="checkbox"/>	<input type="checkbox"/>

**R23. (Phase 7 Core #25) During your most recent pregnancy, did you take a class or classes to prepare for childbirth and learn what to expect during labor and delivery?**

No

Yes

**NOTE: Skip S1 if infant is not alive or not living with the mother (Core 32 and/or Core 33). Do not use S16-S17 if you use S1.**

**S1. Listed below are some statements about safety.** For each one, check **No** if it does not apply to you or **Yes** if it does.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. I always used a seatbelt during my most recent pregnancy .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My home has a working smoke alarm.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. There are <b>loaded</b> guns, rifles, or other firearms in my home.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I have received information about infant products that should be taken off the market (product recalls) since my new baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

**S2. Did you worry that wearing your seat belt during pregnancy would hurt your new baby?**

- No
- Yes

**NOTE: Skip S3 if infant is not alive, not living with the mother, or is still in the hospital (Core 31, 32, Core 33).**

**S3. Listed below are some statements about infant car seats.** For each one, check **True** if you agree with the statement or **False** if you do not agree.

- |   | <b>True</b>              | <b>False</b>             |
|---|--------------------------|--------------------------|
| a. New babies should be in rear-facing car seats .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Car seats should not be placed in front of an air bag..... | <input type="checkbox"/> | <input type="checkbox"/> |

**S4. During the *last 3 months* of your most recent pregnancy, how often did you wear a seat belt when you drove or rode in a car?**

- Always
- Often
- Sometimes
- Rarely
- Never

**S5. *Since your new baby was born*, how often do you wear a seat belt when you drive or ride in a car?**

- Always
- Often
- Sometimes
- Rarely
- Never

**NOTE: Skip S6–S9 if infant is not alive, is not living with the mother, or is still in the hospital (Core 32, Core 33, or Core 31).**

**S6. When your new baby rides in a car, truck, or van, how often does he or she ride in an infant car seat?**

- Always
- Often
- Sometimes
- Rarely
- Never → Go to Question ##

**NOTE: Skip S7–S9 if infant never rides in an infant car seat (S6). S7, S8, and S9 need S6, but S6 can be used alone.**

**S7. When your new baby rides in an infant car seat, is he or she *usually* in the front or back seat of the car, truck, or van?**

- Front seat
- Back seat

**S8. When your new baby rides in an infant car seat, is he or she *usually* facing forward or facing the rear of the car, truck, or van?**

- Facing forward
- Facing the rear

**S9. Does the car, truck, or van that your new baby *usually* rides in have an airbag on the passenger side?**

- No
- Yes

**NOTE: Skip S10–S12 if infant is not alive, is not living with the mother, or is still in the hospital (Core 32, Core 33, or Core 31).**

**S10. Do you have an infant car seat(s) that you can use for your new baby?**

- No → Go to Question ##
- Yes

**Note: S11 and S12 need S10, but S10 can be used alone.**

**S11. How did you get your new baby's infant car seat(s)? Check ALL that apply**

- I bought a car seat *new*
- I received it new for this baby as a gift
- I had one from another one of my babies
- I bought a car seat *used*
- I borrowed a car seat from a friend or family member
- I borrowed or rented a car seat from a loaner program
- The hospital where my new baby was born gave me a car seat
- A community program gave me a car seat
- Other → Please tell us: \_\_\_\_\_

**S12. How did you learn to install and use your infant car seat(s)? Check ALL that apply**

- I read the instructions
- A friend or family member showed me
- A health or safety professional showed me
- I figured it out myself
- I already knew how to install it because I have other children
- Some other way → Please tell us: \_\_\_\_\_

**NOTE: Skip S13 if infant is not alive or is not living with the mother (Core 32 or Core 33).**

**S13. Have you ever heard or read about what can happen if a baby is shaken?**

- No
- Yes

**S14. Was the house or apartment you live in now built after 1977?**

- No
- Yes → Go to Question ##
- I don't know → Go to Question ##

**S15. Listed below are some things that may have happened since you moved into your house or apartment. For each one, check No if it does not apply to you or Yes if it does.**

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. I have had the home tested for lead  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I have made changes to the home to remove paint or other things that have lead in them | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The home was remodeled before I moved in   | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: Skip S16-S17 if infant is not alive or not living with the mother (Core 32 and/or Core 33). Do not use S1 if you use S16-S17. S17 requires S16, but S16 can be used alone.**

**S16. Since your new baby was born, have you received information about infant products (such as cribs, medicines, toys) that should be taken off the market (product recalls)?**

No → **Go to Question ##**  
Yes

**S17. Where did you receive information about infant product recalls? Check ALL that apply**

Product manufacturers  
Doctor, nurses, or other health care worker  
Newspaper, radio, TV, internet  
Friends or family members  
In-store recall notices  
Other source → Please tell us: \_\_\_\_\_

**S18. Does the house or apartment you live in now have a carbon monoxide detector?**

No  
Yes  
I don't know

**S19. Has the house or apartment you live in now ever been tested for radon?**

No  
Yes  
I don't know

**NOTE: Skip T1–T3 if infant is not alive, is not living with the mother, or is still in the hospital (Core 32, Core 33, or Core 31).**

**T1. How many times has your new baby gone for care when he or she was sick?**

[BOX] Times

None → **Go to Question ##**  
My baby has not been sick → **Go to Question ##**  
My baby is still in the hospital → **Go to Question ##**

**Note: T2 and T3 need T1, but T1 can be used alone.**

**T2. Where have you taken your new baby when he or she was sick and needed care? Check ALL that apply**

Private doctor's office  
Hospital emergency room  
Hospital clinic  
Health department clinic  
*State-specific option*  
*State-specific option*  
Other → Please tell us: \_\_\_\_\_

**T3. Has your new baby gone for care as many times as you wanted when he or she was sick?**

No  
Yes

**NOTE: Skip T4–T5 if infant is not alive, is not living with the mother or is still in the hospital (Core 32 and Core 33 and Core 31.).**

**T4. Was your new baby jaundiced (yellowing of the skin or whites of the eyes)?**

No → Go to Question ##  
Yes

**NOTE: T5 needs T4, T4 can be used alone.**

**T5. Was your new baby readmitted to the hospital because of jaundice?**

No  
Yes

**NOTE: Skip T6–T7 if infant is not alive, is not living with the mother, or is still in the hospital (Core 32, Core 33, or Core 31).**

**T6. How many times has your new baby gone to the hospital emergency room about his or her health?**  
Please include emergency room visits that resulted in a hospital admission.

\_\_\_\_\_ Times

None → Go to Question ##  
I don't know → Go to Question ##

**NOTE: Insert instruction box BEFORE T7 that says “If your new baby has never been to the hospital emergency room about his or her health, go to Question ...” This skip applies if T6=0.**

**T7. How many of these visits were because of an accident, injury, or poisoning?**

\_\_\_\_\_ Visits

None  
I don't know

**NOTE: T8 requires T3.**

**T8. (NEW) Did any of these things keep you from taking your baby for care when he or she was sick? Check ALL that apply**

I didn't have health insurance to pay for the visit  
I couldn't get an appointment  
I didn't have a regular doctor for my baby

I had no way to get my baby to the clinic or doctor's office  
 I didn't have anyone to take care of my other children  
 Other → Please tell us: \_\_\_\_\_

**NOTE: U1 and U2 need AA7, but AA7 can be used alone. Skip U1 and U2 if no one is allowed to smoke inside the house at any time (AA7).**

**U1. Does your husband or partner smoke inside your home?**

No  
 Yes

**U2. Not including yourself or your husband or partner, does anyone else smoke cigarettes inside your home?**

No  
 Yes

**DRUG2. During the *month before* you got pregnant, did you take or use any of the following drugs for any reason?** Your answers are strictly confidential. For each item, check **No** if you did not use it or **Yes** if did.

- |  | No | Yes |
|--|----|-----|
| a. Over the counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve®                  |    |     |
| b. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine |    |     |
| c. Adderall®, Ritalin® or another stimulant  |    |     |
| d. Marijuana or hash   |    |     |
| e. Synthetic marijuana (K2, Spice)   |    |     |
| f. Methadone, naloxone, subutex, or Suboxone®  |    |     |
| g. Heroin (smack, junk, Black Tar, <i>Chiva</i> )  |    |     |
| h. Amphetamines (uppers, speed, crystal meth, crank, ice, <i>agua</i> )                          |    |     |
| i. Cocaine (crack, rock, coke, blow, snow, <i>nieve</i> )  |    |     |
| j. Tranquilizers (downers, ludes)  |    |     |
| k. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)               |    |     |
| l. Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing)                   |    |     |

**DRUG3. During your *most recent* pregnancy, did you take or use any of the following drugs for any reason?** Your answers are strictly confidential. For each item, check **No** if you did not use it or **Yes** if did.

- |  | No | Yes |
|--|----|-----|
| a. Over the counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve®                  |    |     |
| b. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine |    |     |
| c. Adderall®, Ritalin® or another stimulant  |    |     |
| d. Marijuana or hash   |    |     |
| e. Synthetic marijuana (K2, Spice)   |    |     |

- f. Methadone, naloxone, subutex, or Suboxone®
- g. Heroin (smack, junk, Black Tar, *Chiva*)
- h. Amphetamines (uppers, speed, crystal meth, crank, ice, *agua*)
- i. Cocaine (crack, rock, coke, blow, snow, *nieve*)
- j. Tranquilizers (downers, ludes)
- k. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)
- l. Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing)

**NOTE: If DRUG2 or DRUG3 is not used, add a transition statement before LL17 that reads: “The next questions are about using different drugs around the time of pregnancy. Your answers are strictly confidential.”**

**U5 cannot be used if DRUG3 is used.**

**Skip U6 if the mother did not use prescription pain relievers (DRUG3). Before U6 add instruction that reads “ If you did not use prescription pain relievers during your most recent pregnancy, go to Question XX”**

**U5. During *your most recent* pregnancy, did you use prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine?**

No → Go to Question #  
Yes

**U6. How would you describe the way you got the prescription pain relievers that you used during your most recent pregnancy? Check ALL that apply**

I had a current prescription  
I had pain relievers left over from an old prescription  
I got the pain relievers without a prescription

**U7. During *your most recent* pregnancy, did you use heroin, cocaine, amphetamines, or barbiturates such as phenobarbital?**

No  
Yes

**U8. During *your most recent* pregnancy, did you take prescription antidepressants or selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, or Lexapro?**

No  
Yes

**U9. During *any of your prenatal care visits*, did a doctor, nurse, or other health care worker refer you to treatment because of drug use (prescribed or non-prescribed drugs)?**

No  
Yes  
I did not use any drugs (or only used over-the-counter pain relievers) during my pregnancy  
I didn't go for prenatal care

**U10. After your baby was born, did a doctor, nurse, or other healthcare worker tell you that your baby had drug withdrawal or neonatal abstinence syndrome?**

- No
- Yes

**V1. During your most recent pregnancy, did you get any of these services?** For each one, check **No** if you did not get the service and **Yes** if you did.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. Parenting classes.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Counseling for depression or anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: Skip V2 and V3 if infant is not alive or not living with the mother (Core 32 and/or Core 33). BEFORE V2/V3 insert an instruction that says; “If your baby is not alive or is not living with you, go to Question #.”**

**V2. Since your new baby was born, have you used any of these services?** For each one, check **No** if you did not use the service or **Yes** if you did.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. Parenting classes.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Counseling for depression or anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |

**V3. Since your new baby was born, have you used WIC services for yourself or your new baby?**

- No
- Yes, only I am using WIC services
- Yes, both my new baby and I use WIC services
- Yes, only my new baby uses WIC services

**V4. During the 12 months before your new baby was born, did you or any member of your household consider seeking help from the government because your income was low?**

- No
- Yes

**V5. During the 12 months before your new baby was born, did you or any member of your household apply for government payments such as welfare, TANF (Temporary Assistance for Needy Families), or other public assistance?**

- No
- Yes → Go to Question ##

**Note: V6, V7, and V9 need V5, but V5 can be used alone.**

**V6. Did any of these things keep you from applying for government help? Check ALL that apply**

- I didn't think I could get help because my household made too much money
- I didn't know how to apply
- There was too much paperwork
- I didn't think I could get help because I am from another country
- Other → Please tell us:

**NOTE: If V6 is used, add an instruction box BEFORE V7 that says, "If you or any member of your household did not apply for government payments, go to Question ..."**

**V7. Did any of these happen to you when you applied for government assistance? Check ALL that apply**

- I received assistance
- I was told I made too much money to get assistance
- I was told I shouldn't apply because I might need my benefits later
- I was told I couldn't get assistance because I am from another country

**NOTE: V10 needs V9 and V9 needs V5**

**V9. Did you get welfare, TANF (Temporary Assistance for Needy Families), or other public assistance?**

- No
- Yes → Go to Question ##

**V10. Why didn't you get welfare, TANF (Temporary Assistance for Needy Families), or other public assistance? Check ALL that apply**

- I was ineligible because of my income
- I had reached my time limit
- I had to fulfill work or other requirements
- I had to return on another day to apply
- I had previously lost TANF for another reason (administrative reasons, sanctions, etc.)
- I am not a U.S. citizen
- Other → Please tell us: \_\_\_\_\_

**V11. During your most recent pregnancy, did you feel you needed any of the following services?** For each one, check **No** if you did not feel you needed the service or **Yes** if you felt you needed the service.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. Food stamps or money to buy food.....  | <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 and personal problems .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help to quitsmoking.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help to reduce violence in my home   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other.....   |                          |                          |
- Please tell us: \_\_\_\_\_

**V12. During your most recent pregnancy, did you receive any of the following services?** For each one, check **No** if you did not receive the service or **Yes** if you received the service.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. Food stamps or money to buy food.....  | <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 and personal problems .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help to quitsmoking.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help to reduce violence in my home   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other  | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us: \_\_\_\_\_

**NOTE: Skip V13, V14, V15, V20, if the mother did not have a home visitor (V21).**

**V13. Who was the home visitor that came to your home during your most recent pregnancy?**

- A nurse or nurse’s aide
- A teacher or health educator
- A doula or midwife
- State option (Someone from the <Healthy Start or other Program Name>)
- Someone else → Please tell us: \_\_\_\_\_
- I don’t know

**V14. During your most recent pregnancy, how many times did the home visitor come to your home to help you learn how to prepare for your new baby?**

- 1 time
- 2 to 4 times
- 5 or more times

**V15. During your most recent pregnancy, did the home visitor who came to your home talk with you about any of the things listed below?** For each one, check **No** if they did not talk with you about it or **Yes** if they did.

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

**NOTE: Skip V16, V17, V18, and V19 if the mother did not have a postpartum home visitor (V22).**

**V16. What kind of home visitor has come to your home *since your new baby was born*?**

- A nurse or nurse’s aide
- A teacher or health educator
- A doula or midwife
- State option (Someone from the <Healthy Start or other Program Name>)
- Someone else → Please tell us: \_\_\_\_\_
- I don’t know

**V17. *Since your new baby was born*, how many times has a home visitor come to your home to help you learn how to take care of yourself or your new baby?**

- 1 time
- 2 to 4 times
- 5 or more times

**V18. *Since your new baby was born*, did the home visitor who came to your home talk with you about any of the things listed below? For each one, check No if they did not talk with you about it or Yes if they did.**

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

**V19. (NEW) How did you feel about the care you got from the home visitor *since your new baby was born*? For each item, check No if you were not satisfied or Yes if you were satisfied.**

	No	Yes
a. The amount of time the home visitor spent with me.....	<input type="checkbox"/>	<input type="checkbox"/>
b. The advice I got on how to take care of myself and my baby .....	<input type="checkbox"/>	<input type="checkbox"/>
c. The understanding and respect shown toward me as a person.....	<input type="checkbox"/>	<input type="checkbox"/>

**V20. (NEW) How did you feel about the care you got from the home visitor during your most recent pregnancy? For each item, check No if you were not satisfied or Yes if you were satisfied.**

	No	Yes
a. The amount of time the home visitor spent with me.....	<input type="checkbox"/>	<input type="checkbox"/>
b. The advice I got on how to take care of myself.....	<input type="checkbox"/>	<input type="checkbox"/>
c. The understanding and respect shown toward me as a person.....	<input type="checkbox"/>	<input type="checkbox"/>

**V21. (Phase 7, Core 26) During your most recent pregnancy, did a home visitor come to your home to help you prepare for your new baby?** A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps pregnant women.

No → Go to Question x  
Yes

NOTE: Skip V22 if the baby is not alive. DO NOT skip if the baby is not living with the mom or is still in the hospital (Core 33 and Core 31).  
Skip arrow for Core 33 should go to V22 and the instruction box before Core Q38 should go to V22 if V22 is inserted.

**V22. (Phase 7, Core 49) Since your new baby was born, has a home visitor come to your home to help you learn how to take care of yourself or your new baby?** A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps mothers of newborns.

No → Go to Question x  
Yes

**W1. During your most recent pregnancy, who would have helped you if a problem had come up?** For example, who would have helped you if you needed to borrow \$50 or if you got sick and had to be in bed for several weeks? **Check ALL that apply**

- My husband or partner
- My mother, father, or in-laws
- Other family member or relative
- A friend
- Religious community
- Someone else → Please tell us: \_\_\_\_\_
- No one would have helped me

**W2. During your most recent pregnancy, would you have had the kinds of help listed below if you needed them?** For each one, check **No** if you would not have had it or **Yes** if you would have had it.

	No	Yes
a. Someone to loan me \$50 .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Someone to help me if I were sick and needed to be in bed .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Someone to take me to the clinic or doctor’s office if I needed a ride.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Someone to talk with about my problems .....	<input type="checkbox"/>	<input type="checkbox"/>

**W3. Since you delivered your new baby, who would help you if a problem came up?** For example, who would help you if you needed to borrow \$50 or if you got sick and had to be in bed for several weeks? **Check ALL that apply**

- My husband or partner
- My mother, father, or in-laws
- Other family member or relative
- A friend
- Religious community
- Someone else → Please tell us: \_\_\_\_\_
- No one would help me

**NOTE: Skip W4 if infant is not alive, is not living with the mother, or if baby is still in the hospital (Core 32, Core 33, or Core 31).  
BEFORE W4, add a skip instruction: “If your baby is not alive, is not living with you, or is still in the hospital, go to Question #.”**

**W4. Since you delivered your new baby, would you have the kinds of help listed below if you needed them?**  
For each one, check **No** if you would not have it or **Yes** if you would.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Someone to loan me \$50.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Someone to help me if I were sick and needed to be in bed.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Someone to talk with about my problems.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone to take care of my baby .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Someone to help me if I were tired and feeling frustrated with my new baby ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: Skip X1–X12 if infant is not alive, is not living with the mother, or is still in the hospital (Core 32, Core 33, or Core 31).  
X1-X2, X4, X7, and X8 need X9, but X9 can be used alone.**

**X1. Has your new baby gone as many times as you wanted for a well-baby checkup?**

- No  
Yes → **Go to Question ##**

**NOTE: X2 can be used without X1.**

**X2. Did any of these things keep your baby from having a well-baby checkup? Check ALL that apply**

- I didn't have enough money or insurance to pay for it
- I had no way to get my baby to the clinic or doctor's office
- I didn't have anyone to take care of my other children
- I couldn't get an appointment
- My baby was too sick to go for a well-baby checkup
- Other → Please tell us: \_\_\_\_\_
- [

**X3. Did your new baby have any well-baby shots or vaccinations before he or she was 3 months old? Do not count shots or vaccinations given in the hospital right after birth.**

- No  
Yes  
My child has not had any well-baby shots, but he or she is not 3 months old yet

**NOTE: Skip X4 if infant has not had a well-baby checkup; therefore, X4 needs the well-baby checkup question (X9).**

**X4. Did you have health insurance to pay for your baby's well-baby checkups?**

No  
Yes

**X5. What do you think would be the best time to get information from your doctor, nurse, or other health care worker about baby shots? Check ONE answer**

During prenatal care visits  
In the hospital or birthing center after my baby's delivery  
At my baby's first visit to the doctor

**NOTE: Skip X6 if infant did not have a one week checkup after he or she was born; therefore, X6 needs X10.**

**X6. Was your new baby seen at home or at a health care facility?**

At home  
At a doctor's office, clinic, or other health care facility

**NOTE: Skip X7–X8 if infant has not had a well-baby checkup (X9); therefore, X7 and X8 need X9.**

**X7. How many times has your new baby been to a doctor, nurse, or other health care worker for a well-baby checkup? (It may help to use the calendar.)**

[BOX] Times

**X8. Where do you *usually* take your new baby for well-baby checkups? Check ONE answer**

Private doctor's office  
Hospital clinic  
Health department clinic  
*State-specific option*  
*State-specific option*  
Other → Please tell us: \_\_\_\_\_

**X9. Has your new baby had a well-baby checkup? A well-baby checkup is a regular health visit for your baby usually at 1, 2, 4, and 6 months of age.**

No → Go to Question ##  
Yes

**X10. Was your new baby seen by a doctor, nurse, or other health care worker for a *one week checkup* after he or she was born?**

- No
- Yes
- My baby was still in the hospital at that time

**X11. *Since your new baby was born*, how often have you been frustrated when you tried to get health care services for him or her?**

- Always
- Often
- Sometimes
- Rarely → Go to Question ##
- Never → Go to Question ##
- I haven't tried to get health care services for my new baby → Go to Question ##

**X12. Why have you felt frustrated when you tried to get health care services for your new baby? Check ALL that apply**

- The services that my baby needed were not available in my area
- There were waiting lists or other problems getting an appointment
- My health insurance would not pay for the services that my baby needed
- Other → Please tell us: \_\_\_\_\_

**NOTE: Skip Y2 if mom had teeth cleaned 12 months before or during pregnancy (Core 7, Core 17). BEFORE Y2, add an instruction that says: "If you had your teeth cleaned by a dentist or dental hygienist in the 12 months before your got pregnant or during your pregnancy, go to Question #."**

**Y2. Have you ever had your teeth cleaned by a dentist or dental hygienist?**

- No
- Yes

**Y3. *Since your new baby was born*, have you had your teeth cleaned by a dentist or dental hygienist?**

- No
- Yes

**Y4 deleted because information now captured in Core 7 & Core 17**

**NOTE: Skip Y5 and Y8 if mom did not have teeth or gum problems. BEFORE Y5 and Y8 add an instruction box that says: If you did not have any problems with your teeth or gums during your pregnancy, go to Question ##.**

**Y5 and Y8 require Y7 but Y7 can be used alone**

**Y5. During your most recent pregnancy, what kind of problem did you have with your teeth or gums?**  
For each item, check **No** if you did not have this problem during pregnancy or **Yes** if you did.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. I had cavities that needed to be filled        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I had painful, red, or swollen gums            | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had a toothache                              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I needed to have a tooth pulled                | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had an injury to my mouth, teeth ,or gums    | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I had some other problem with my teeth or gums | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us: \_\_\_\_\_

**Y6. Did any of the following things make it hard for you to go to a dentist or dental clinic during your most recent pregnancy?** For each item, check **No** if it was not something that made it hard for you or **Yes** if it was.

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

**Y7. (Phase 7, Core 24). This question is about other care of your teeth during your most recent pregnancy.**  
For each item, check **No** if it is not true or does not apply to you or **Yes** if it is true.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. I knew it was important to care for my teeth and gums during my pregnancy                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A dental or other health care worker talked with me about how to care for my teeth and gums | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had insurance to cover dental care during my pregnancy                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I <u>needed</u> to see a dentist for a <b>problem</b>                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I <u>went</u> to a dentist or dental clinic about a <b>problem</b>                          | <input type="checkbox"/> | <input type="checkbox"/> |

**Y8. (NEW) Did you get treatment from a dentist or another doctor for the problem that you were having during your pregnancy? Check ONE answer**

- No
- Yes, I got treatment during my pregnancy
- Yes, I got treatment after my pregnancy
- Yes, I got treatment both during and after my pregnancy

**Z1. (wording modification from Phase 7) During your most recent pregnancy, did any of the following things happen to you?** For each thing, check **No** if it did not happen to you or **Yes** if it did.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. My husband or partner threatened me or made me feel unsafe in some way .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was frightened for my safety or my family’s safety because of the anger or threats of my husband or partner.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My husband or partner tried to control my daily activities, for example, controlling who I could talk to or where I could go..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My husband or partner forced me to take part in touching or any sexual activity when I did not want to.....                       | <input type="checkbox"/> | <input type="checkbox"/> |

**Z2. (wording modification) Since your new baby was born, have any of the following things happened to you?**

For each thing, check **No** if it did not happen to you or **Yes** if it did.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. My husband or partner threatened me or made me feel unsafe in some way .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was frightened for my safety or my family’s safety because of the anger or threats of my husband or partner.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My husband or partner tried to control my daily activities, for example, controlling who I could talk to or where I could go..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My husband or partner forced me to take part in touching or any sexual activity when I did not want to.....                       | <input type="checkbox"/> | <input type="checkbox"/> |

**Z3 – Z6 now are combined with Core 28-29**

**Z7. During the 12 months before your new baby was born, did you miss any doctor appointments because you were worried about what your partner would do if you went?**

- No
- Yes

**Z8. Before you got pregnant with your new baby, did your husband or partner ever try to keep you from using your birth control so that you would get pregnant when you didn’t want to?** For example, did they hide your birth control, throw it away or do anything else to keep you from using it?

- No
- Yes

**Z9. During any of the following time periods, did your husband or partner threaten you, limit your activities against your will, or make you feel unsafe in any other way?** For each time period, check **No** if it did not happen then or **Yes** if it did.

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

**Z10 –Z12 Combined in new question Z13**

**Z13. Since your new baby was born, have any of the following people pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?** For each person, check **No** they have not hurt you during this time or **Yes** if they have.

- |   | <b>No</b> | <b>Yes</b> |
|---|-----------|------------|
| a. My husband or partner                      |           |            |
| b. My ex-husband or ex-partner                |           |            |
| c. State-added option (Another family member) |           |            |
| d. State-added option (Someone else)          |           |            |

**Z14. (NEW) During the 12 months before you got pregnant with your new baby, did any of the following things happen to you?** For each thing, check **No** if it did not happen to you or **Yes** if it did.

- |   | <b>No</b> | <b>Yes</b> |
|---|-----------|------------|
| a. My husband or partner threatened me or made me feel unsafe in some way .....   | □         | □          |
| b. I was frightened for my safety or my family's safety because of the<br>anger or threats of my husband or partner.....                | □         | □          |
| c. My husband or partner tried to control my daily activities, for example,<br>controlling who I could talk to or where I could go..... | □         | □          |
| d. My husband or partner forced me to take part in touching or any sexual activity when<br>I did not want to.....                       | □         | □          |

**NOTE: Skip AA1, AA2, and AA3 if mother did not smoke during the 3 months before she got pregnant (Core 20).**

**BEFORE AA1, AA2, and AA3, insert instruction box that says, "If you did not smoke at any time in the 3 months before you got pregnant, go to Question ..."**

**AA1. During any of your prenatal care visits, did a doctor, nurse, or other health care worker advise you to quit smoking?**

No

Yes

I didn't go for prenatal care

**AA2. During your most recent pregnancy, did you do any of the following things about quitting smoking?** For each thing, check **No** if you did not do it or **Yes** if you did.

	No	Yes
a. Set a specific date to stop smoking.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Use booklets, videos, or other materials to help me quit.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Call a national or state quit line or go to a website.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Attend a class or program to stop smoking.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Go to counseling for help with quitting.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Use a nicotine patch, gum, lozenge, nasal spray or inhaler.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Take a pill like Zyban® (also known as Wellbutrin® or bupropion) to stop smoking ....	<input type="checkbox"/>	<input type="checkbox"/>
h. Take a pill like Chantix® (also known as varenicline) to stop smoking.....	<input type="checkbox"/>	<input type="checkbox"/>
i. Try to quit on my own (e.g., cold turkey).....	<input type="checkbox"/>	<input type="checkbox"/>
j. Other: .....	<input type="checkbox"/>	<input type="checkbox"/>

Please tell us: \_\_\_\_\_

**NOTE: Skip AA3 if mother did not have any prenatal care (AA1). AA3 requires AA1.**

**Add skip arrow to AA1 off the “I didn’t go for prenatal care” option.**

**AA3. Listed below are some things about quitting smoking that a doctor, nurse, or other health care worker might have done during any of your prenatal care visits.** For each thing, check **No** if it was not done or **Yes** if it was.

	No	Yes
a. Spend time with me discussing how to quit smoking.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Suggest that I set a specific date to stop smoking .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Suggest I attend a class or program to stop smoking .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Provide me with booklets, videos, or other materials to help me quit smoking on my own .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Refer me to counseling for help with quitting.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Ask if a family member or friend would support my decision to quit.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Refer me to a national or state quit line .....	<input type="checkbox"/>	<input type="checkbox"/>
h. Recommend using nicotine gum.....	<input type="checkbox"/>	<input type="checkbox"/>
i. Recommend using a nicotine patch.....	<input type="checkbox"/>	<input type="checkbox"/>
j. Prescribe a nicotine nasal spray or nicotine inhaler.....	<input type="checkbox"/>	<input type="checkbox"/>
k. Prescribe a pill like Zyban® (also known as Wellbutrin® or bupropion) to help me quit ...	<input type="checkbox"/>	<input type="checkbox"/>
l. Prescribe a pill like Chantix® (also known as varenicline) to help me quit.....	<input type="checkbox"/>	<input type="checkbox"/>

**AA4 Deleted – not valid measure**

**AA5. Which of the following statements best describes the rules about smoking inside your home during your most recent pregnancy, even if no one who lived in your home was a smoker? Check ONE answer**

- No one was allowed to smoke anywhere inside my home
- Smoking was allowed in some rooms or at some times
- Smoking was permitted anywhere inside my home

**NOTE: Skip AA6 if mother did not smoke during the 3 months before pregnancy (Core 20).  
BEFORE AA6, insert instruction box that says, “If you did not smoke at any time in the 3 months before you got pregnant, go to Question ...”**

**AA6. Did you quit smoking around the time of *your most recent* pregnancy? Check ONE answer**

- No
- No, but I cut back
- Yes, I quit before I found out I was pregnant
- Yes, I quit when I found out I was pregnant
- Yes, I quit later in my pregnancy

**AA7. Which of the following statements best describes the rules about smoking *inside* your home *now*, even if no one who lives in your home is a smoker? Check ONE answer**

- No one is allowed to smoke anywhere inside my home
- Smoking is allowed in some rooms or at some times
- Smoking is permitted anywhere inside my home

**AA8. How many cigarette smokers, not including yourself, lived in your home during *your most recent* pregnancy?**

[BOX] Number of smokers

**AA9. How many cigarette smokers, not including yourself, live in your home *now*?**

[BOX] Number of smokers

**NOTE: AA10 must be used with AA6.**  
**Skip AA10 and AA12 if the mother did not smoke 3 months before she got pregnant (Core 20).**  
**BEFORE AA12, insert instruction box that says, “If you did not smoke at any time in the 3 months before you got pregnant, go to Question ...”**

**AA10. Listed below are some things that can make it hard for some people to quit smoking.** For each item, check **No** if it is not something that might make it hard for you or **Yes** if it is.

	No	Yes
a. Cost of medicines or products to help with quitting	<input type="checkbox"/>	<input type="checkbox"/>
b. Cost of classes to help with quitting.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Fear of gaining weight.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Loss of a way to handle stress.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Other people smoking around me.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Cravings for a cigarette .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Lack of support from others to quit.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Worsening depression .....	<input type="checkbox"/>	<input type="checkbox"/>
i. Worsening anxiety .....	<input type="checkbox"/>	<input type="checkbox"/>
j. Some other reason .....	<input type="checkbox"/>	<input type="checkbox"/>
Please tell us: _____		

**AA11 deleted – not valid measure**

**AA12. (NEW) During *your most recent* pregnancy, did your health insurance pay for medications or any other services to help you quit smoking? Check ONE answer**

- No, my insurance did not pay
- Yes, but I had to make a co-payment
- Yes, with no co-payment
- I wasn't trying to quit smoking
- I didn't have health insurance
- I don't know

**NOTE: Skip AA13 and AA14 if the mother never used hookah (Core 23).**  
**BEFORE AA13 and AA14, insert instruction box that says, “If you used hookah in the *past 2 years*, go to Question <AA13>. Otherwise go to Question #.”**

**AA13. (NEW) In the 3 months before you got pregnant, on average, how often did you smoke hookah?**

- Daily
- 2-3 times per week
- Once a week
- 2-3 times per month
- Once a month
- I did not smoke hookah then

**AA14. (NEW) In the last 3 months of your pregnancy, on average, how often did you smoke hookah?**

- Daily
- 2-3 times per week
- Once a week

2-3 times per month  
 Once a month  
 I did not smoke hookah then

**BB1.** During the *12 months before* your new baby was born, did you feel emotionally upset (for example, angry, sad, or frustrated) as a result of how you were treated *based on your race*?

No  
 Yes

**BB2.** Deleted due to evaluation results

**BB3.** *Since your new baby was born*, how often would you say you have been worried or stressed about having enough money to pay your bills?

Always  
 Often  
 Sometimes  
 Rarely  
 Never

**CC1.** During the *3 months before* you got pregnant with your new baby, how often did you participate in any physical activities or exercise for 30 minutes or more? For example, walking for exercise, swimming, cycling, dancing, or gardening.

Less than 1 day per week  
 1 to 2 days per week  
 3 to 4 days per week  
 5 or more days per week  
 I was told by a doctor, nurse, or other health care worker not to exercise

**NOTE:** If state doesn't choose CC1 with CC2, the list of examples will need to be added for CC2.

**CC2.** During the *last 3 months* of your most recent pregnancy, how often did you participate in any physical activities or exercise for 30 minutes or more?

Less than 1 day per week  
 1 to 2 days per week  
 3 to 4 days per week  
 5 or more days per week  
 I was told by a doctor, nurse, or other health care worker not to exercise

**NOTE:** Skip DD1–DD3 if mother was on Medicaid before she got pregnant (Core 9). DD2 and DD3 need DD1, but DD1 can be used alone. DD2 and DD3 do not need to be used together. BEFORE DD1, insert instruction box that says, “If you were on Medicaid (or state Medicaid name) before you got pregnant, go to Question ...”

**DD1. Did you try to get Medicaid coverage during *your most recent* pregnancy?**

No → Go to Question ##  
Yes

**DD2. Did you have any problems getting Medicaid during *your most recent* pregnancy?**

No  
Yes

**DD3. When did Medicaid coverage begin during *your most recent* pregnancy?**

During the first 3 months of my pregnancy  
During the second 3 months of my pregnancy  
During the last 3 months of my pregnancy  
I did not get Medicaid during my pregnancy

**NOTE: Skip DD4, DD5, and DD6 if mother was not insured during the month before she got pregnant (Core 9).**

**BEFORE DD4, DD5, and/or DD6, insert instruction box that says, “If the mother did not have health insurance during the *month before* she got pregnant with her new baby, go to Question ...”**

**DD4. Did you or someone else make regular payments for your health insurance *before* you got pregnant, including having money taken out of your paycheck or your husband, partner, or parent’s paycheck?**

No  
Yes → About how much per month? \_\_\_\_\_

**DD5. Did you have copayments for medical visits when you used your health insurance *before* you got pregnant?**

No  
Yes

**DD6. Did the cost of health insurance cause financial problems for you or your family *before* you got pregnant?**

No  
Yes

**NOTE: Skip DD7 if mother was insured during the month before she got pregnant (Core 9).**

**BEFORE DD7, insert instruction box that says, “If you did not have health insurance during the *month before* you got pregnant, go to Question x. Otherwise, go to Question y”**

**DD7. What was the reason that you did not have any health insurance during the *month before* you got pregnant with your new baby? Check ALL that apply**

Health insurance was too expensive

I could not get health insurance from my job or the job of my husband or partner

I applied for health insurance, but was waiting to get it

I had problems with the health insurance application or website

My income was too high to qualify for Medicaid

My income was too high to qualify for a tax credit from the <State> Health Insurance Marketplace or HealthCare.gov

I didn't know how to get health insurance

*State-specific (I am not a US citizen or I don't have the right residency documents)*

Other → Please tell us: \_\_\_\_\_

**NOTE: Skip DD8, DD9, and DD10 if mother did not have health insurance to pay for prenatal care or did not get prenatal care (Core 10).**

**If DD8, DD9, DD10, or DD11 are inserted, Core 10 skip arrow off “no prenatal care” will go to DD12-DD16 or Core 11.**

**BEFORE DD8, DD9, and/or DD10, insert instruction box that says, “If you had health insurance for your prenatal care, go to Question X. Otherwise, go to Question Y (DD11 or DD12 or Core 11)...”**

**DD8. Did you or someone else make regular payments for the health insurance that you used to pay for your *prenatal care*, including having money taken out of your paycheck or your husband, partner, or parent's paycheck?**

No

Yes → About how much permonth? \_\_\_\_\_

**DD9. Did you have copayments for medical visits when you used your health insurance for *prenatal care*?**

No

Yes

**DD10. Did the cost of health insurance for your *prenatal care* cause financial problems for you or your family?**

No

Yes

**NOTE: Skip DD11 if the mom did not have prenatal care.**

**Skip DD11 if mother had health insurance to pay for prenatal care (Core 10).**

**DD11. What was the reason that you did not have any health insurance for your *prenatal care*? Check ALL that apply**

Health insurance was too expensive

I could not get health insurance from my job or the job of my husband or partner

I applied for health insurance, but was waiting to get it

I had problems with the health insurance application or website  
 My income was too high to qualify for Medicaid  
 My income was too high to qualify for a tax credit from the <State> Health Insurance Marketplace or HealthCare.gov  
 I didn't know how to get health insurance  
*State-specific (I am not a US citizen or I don't have the right residency documents)*  
 Other → Please tell us: \_\_\_\_\_

**NOTE: If DD12 is inserted, the skip arrow off of Core 10 "I did not get prenatal care" should be changed from Core 11 to DD12.**

**DD12. What kind of health insurance did you have to pay for your *delivery*? Check ALL that apply**

Private health insurance from my job or the job of my husband or partner  
 Private health insurance from my parents  
 Private health insurance from the <State> Health Insurance Marketplace or <state website> or HealthCare.gov  
 Medicaid (required: *state Medicaid name*)  
*State-specific option (Other government plan or program such as SCHIP/CHIP)*  
*State-specific option (Other government plan or program not listed above such as MCH program, indigent program or family planning program)*  
*State-specific option (TRICARE or other military health care)*  
*State-specific option (IHS or tribal)* Other health insurance → Please tell us:

\_\_\_\_\_ I did not have any health insurance to pay for my *delivery*

**NOTE: Skip DD13, DD14, and DD15 if mother did not have health insurance to pay for her delivery (DD12). Add a skip arrow to "I did not have health insurance..." response option.**

**DD13. Did you or someone else make regular payments for the health insurance that you used to pay for your *delivery*, including having money taken out of your paycheck or your husband, partner, or parent's paycheck?**

No  
 Yes → About how much per month? \_\_\_\_\_

**DD14. Did you have copayments for medical visits when you used your health insurance for your *delivery*?**

No  
 Yes

**DD15. Did the cost of health insurance at the time of your *delivery* cause financial problems for you or your family?**

No  
 Yes

**NOTE: Skip DD16 if mother had health insurance to pay for her delivery (DD12).**

**BEFORE DD16, insert instruction box that says, “If you did not have health insurance to pay for your delivery, go to Question x. Otherwise, go to Question y”**

**DD16. What was the reason that you did not have any health insurance for your *delivery*? Check ALL that apply**

Health insurance was too expensive

I could not get health insurance from my job or the job of my husband or partner

I applied for health insurance, but was waiting to get it

I had problems with the health insurance application or website

My income was too high to qualify for Medicaid

My income was too high to qualify for a tax credit from the <State> Health Insurance Marketplace or HealthCare.gov

I didn't know how to get health insurance

*State-specific (I am not a US citizen or I don't have the right residency documents)*

Other → Please tell us: \_\_\_\_\_

**NOTE: Skip DD17, DD18, and DD19 if mother does not have health insurance now (Core 11).**

**BEFORE DD17, DD18, and/or DD19, insert instruction box that says, “If the mother does not have health insurance *now*, go to Question...”**

**DD17. Do you or someone else make regular payments for the health insurance that you have *now*, including having money taken out of your paycheck or your husband, partner, or parent's paycheck?**

No

Yes → About how much per month? \_\_\_\_\_

**DD18. Do you have copayments for medical visits when you use your health insurance *now*?**

No

Yes

**DD19. Does the cost of health insurance cause financial problems for you or your family *now*?**

No

Yes

**NOTE: Skip DD20 if mother has health insurance now (Core 11).**

**BEFORE DD20, insert instruction box that says, “If you do not have health insurance now, go to Question x. Otherwise go to Question y”**

**DD20. What is the reason that you do not have any health insurance *now*? Check ALL that apply**

- Health insurance is too expensive
- I cannot get health insurance from my job or the job of my husband or partner
- I applied for health insurance, but I am 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 <State> Health Insurance Marketplace or HealthCare.gov
- I don't know how to get health insurance
- State-specific (I am not a US citizen or I don't have the right residency documents)*
- Other → Please tell us: \_\_\_\_\_

**DD21. In the *past 12 months*, has the cost of health insurance caused financial problems for you or your family?**

- No
- Yes
- I have not had health insurance

**DD22. (NEW) In the *12 months before* you got pregnant, how often did you feel frustrated when you tried to get health care services for yourself?**

- Never → Go to Question ##
- Rarely → Go to Question ##
- Sometimes
- Often
- Always
- I did not try to get health care services then

**DD23. (NEW) Why did you feel frustrated when you tried to get health care services for yourself? Check ALL that apply**

- The services that I needed were not available in my area
- There were waiting lists or other problems getting an appointment
- My health insurance would not pay for the services that I needed
- Other → Please tell us: \_\_\_\_\_

**Replaces EE1 & EE2**

**EE3. (Modified DE74). During *your most recent* pregnancy, did a doctor, nurse, or other health care worker tell you that you had any of the following infections? For each item, check **No** if you were not told that you had the infection or **Yes** if you were.**

	<b>No</b>	<b>Yes</b>
Genital warts (HPV)	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic inflammatory disease (PID)	<input type="checkbox"/>	<input type="checkbox"/>

Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Group B Strep (Beta Strep)	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial vaginosis	<input type="checkbox"/>	<input type="checkbox"/>
Trichomoniasis (Trich)	<input type="checkbox"/>	<input type="checkbox"/>
Yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection (UTI)	<input type="checkbox"/>	<input type="checkbox"/>
Other → Please tell us: _____	<input type="checkbox"/>	<input type="checkbox"/>

**FF1. During the 12 months before you got pregnant with your new baby, did you have a miscarriage, fetal death (baby died before being born), or stillbirth?**

No → Go to Question ##  
Yes

**NOTE: FF2 and FF3 need FF1, but FF1 can be used alone. FF2 and FF3 do not need to be used together.**

**NOTE: In the instruction text below, remove the “(s)” if only one question is used; if both FF2 and FF3 are used, then “question” should be made plural (i.e., ...the next questions...).**

**If you had more than one miscarriage, fetal death, or stillbirth during the 12 months before you got pregnant with your new baby, please answer the next question(s) for the most recent one.**

**FF2. How long did that pregnancy last?**

Less than 20 weeks (less than 4 months)  
20 to 28 weeks (4 to 6 months)  
More than 28 weeks (more than 6 months)

**FF3. How long ago did that pregnancy end?**

Less than 6 months before getting pregnant with my new baby  
6 to 12 months before getting pregnant with my new baby

**NOTE: FF5 must be used with FF4. Skip FF4 if mother has not had a previous infant born alive (FF5).**

**FF4. What is the age difference between your new baby and the child you delivered just before your new one?**

0 to 12 months  
13 to 18 months  
19 to 24 months  
More than 2 years but less than 3 years  
3 to 5 years  
More than 5 years

**FF5. (Phase 7, Core 4) Before you got pregnant with your new baby, did you ever have any other babies who were born alive?**

No → Go to Question x

Yes

<b>NOTE: FF5 must be used with FF6 and FF7.</b>
---

**FF6. (Phase 7, Core 5) Did the baby born *just before* your new one weigh 5 pounds, 8 ounces (2.5 kilos) or less at birth?**

No

Yes

**FF7. (Phase 7, Core 6) Was the baby *just before* your new one born *earlier* than 3 weeks before his or her due date?**

No

Yes

**GG1. Does anyone in your family have sickle cell disease or sickle cell trait?**

No → Go to Question ##

Yes

I don't know → Go to Question ##

<b>NOTE: Skip GG2 if no one in the family has sickle cell disease or trait (GG1).</b>
---

**GG2. During *your most recent* pregnancy, did you receive counseling or were you informed about sickle cell disease?**

No

Yes

**HH1. (modified) Have any of your close family members who are related to you by blood (mother, father, sisters, or brothers) had any of the conditions listed below? For each item, check **No** if no one in your family has the condition, **Yes** if someone in your family has the condition, or **Don't Know** if you don't know.**

	<b>No</b>	<b>Yes</b>	<b>Don't Know</b>
a. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart attack before age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. High blood pressure (hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Breast cancer before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HH2a. Have any of your close family members who are related to you by blood (grandparents, parents, sisters, or brothers) ever been told by a doctor, nurse, or other health care worker that they had *diabetes*?**

No → Go to Question ##

Yes

**HH2b. Who was told by a doctor, nurse, or other health care worker that they had *diabetes*?**

My father

My father's mother

My father's father

My mother

My mother's mother

My mother's father

My sister(s) or brother(s)

Other →

Please tell us: (uncles, aunts, cousins, children, etc.) \_\_\_\_\_

**HH3a. Have any of your close family members who are related to you by blood (grandparents, parents, sisters, or brothers) ever been told by a doctor, nurse, or other health care worker that they had *heart problems*?**

No → Go to Question ##

Yes

**HH3b. Who was told by a doctor, nurse, or other health care worker that they had *heart problems*?**

My father

My father's mother

My father's father

My mother

My mother's mother

My mother's father

My sister(s) or brother(s)

Other →

Please tell us: (uncles, aunts, cousins, children, etc.) \_\_\_\_\_

**HH4a. Have any of your close family members who are related to you by blood (grandparents, parents, sisters, or brothers) ever been told by a doctor, nurse, or other health care worker that they had *high blood pressure (hypertension)*?**

No → Go to Question ##

Yes

**HH4b. Who was told by a doctor, nurse, or other health care worker that they had *high blood pressure (hypertension)*?**

My father

My father's mother

My father's father

My mother

My mother's mother

My mother's father

My sister(s) or brother(s)

Other →

Please tell us: (uncles, aunts, cousins, children, etc.) \_\_\_\_\_

**HH5a. Have any of your close family members who are related to you by blood (grandparents, parents, sisters, or brothers) ever been told by a doctor, nurse, or other health care worker that they had *depression*?**

No → **Go to Question ##**

Yes

**HH5b. Who was told by a doctor, nurse, or other health care worker that they had *depression*?**

My father

My father's mother

My father's father

My mother

My mother's mother

My mother's father

My sister(s) or brother(s)

Other →

Please tell us: (uncles, aunts, cousins, children, etc.) \_\_\_\_\_

**HH6a. Have any of your close family members who are related to you by blood (grandmother, mother, or sisters) ever been told by a doctor, nurse, or other health care worker that they had *postpartum depression*?**

No → **Go to Question ##**

Yes

**HH6b. Who was told by a doctor, nurse, or other health care worker that they had *postpartum depression*?**

My father's mother

My mother

My mother's mother

My sister(s)

Other →

Please tell us: (aunts, cousins, children, etc.) \_\_\_\_\_

**HH7a. Have any of your close family members who are related to you by blood (grandparents, parents, sisters, or brothers) ever been told by a doctor, nurse, or other health care worker that they had *anxiety*?**

No → **Go to Question ##**

Yes

**HH7b. Who was told by a doctor, nurse, or other health care worker that they had *anxiety*?**

My father

My father's mother

My father's father

My mother

My mother's mother

My mother's father

My sister(s) or brother(s)

Other →

Please tell us: (uncles, aunts, cousins, children, etc.) \_\_\_\_\_

**HH8. Did your mother or any sister who is related to you by blood have any of the following problems during any pregnancy?** For each item, check **No** if no one in your family had the problem during pregnancy, **Yes** if someone had the problem during pregnancy, or **Don't Know** if you don't know.

	<b>No</b>	<b>Yes</b>	<b>Don't Know</b>
a. A baby that was born more than 3 weeks before the due date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Gestational diabetes (diabetes that started during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. High blood pressure during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### CANCER SUPPLEMENT

**NOTE: Add the following transition statement and definition before HH9: "A family medical history is a record of health information about a person and his or her close relatives. The following questions are about your family history of ovarian and breast cancer."**

**HH9. Have any of your family members listed below who are related to you by blood had ovarian cancer?** For each family member, check **No** if she has not had ovarian cancer, **Yes** if she has, or **Don't Know** if you don't know.

	<b>Family member</b>	<b>Had Ovarian Cancer</b>		
		<b>No</b>	<b>Yes</b>	<b>Don't know</b>
a.	My mother			
b.	My mother's mother			
c.	My father's mother			

**HH10. Have any of your other family members who are related to you by blood had ovarian cancer?** For each family member, check **No** if she has not had ovarian cancer, **Yes** if she has, **Don't Know** if you don't know, or **Not Applicable** if the option does not apply to you.

	<b>Family Member</b>	<b>Had Ovarian Cancer</b>			
		<b>No</b>	<b>Yes</b>	<b>Don't know</b>	<b>Not Applicable</b>
a.	Sister(s) IF YES, how many have had ovarian cancer?				
b.	Aunt(s) IF YES, how many have had ovarian cancer?				
c.	Female cousin(s) IF YES, how many have had ovarian cancer?				

**HH11. Have any of your family members listed below who are related to you by blood had breast cancer?** For each family member, check **No** if they have not had ovarian cancer, **Yes** if they have, or **Don't Know** if you don't know.

Family member	Had Breast Cancer		
	No	Yes	Don't know
My mother			
My mother's mother			
My father's mother			
My father			
My mother's father			
My father's father			

**HH12. Have any of your other family members who are related to you by blood had breast cancer?** For each family member, check **No** if they have not had breast cancer, **Yes** if they have, **Don't Know** if you don't know, or **Not Applicable** if the option does not apply to you.

	Family Member	Had Breast Cancer			
		No	Yes	Don't know	Not applicable
a.	Sister(s) IF YES, how many have had breast cancer? _____				
b.	Brother(s) IF YES, how many have had breast cancer? _____				
c.	Aunt(s) IF YES, how many have had breast cancer? _____				
d.	Uncle(s) IF YES, how many have had breast cancer? _____				
e.	Cousin(s) IF YES, how many have had breast cancer? _____				

**If no one in the mom's family has had breast cancer, go to Question XX.**

**HH13. Has any woman in your family who is related to you by blood had breast cancer at age 50 or younger?**

- No
- Yes
- I don't know

**HH14. Has any woman in your family who is related to you by blood had both breast AND ovarian cancer?**

- No
- Yes
- I don't know

**HH15. Have any of your family members related to you by blood had bilateral breast cancer or breast cancer on both sides?**

- No
- Yes
- I don't know

**HH16. Do you have Ashkenazi Jewish heritage?**

- No
- Yes
- I don't know

**NOTE: Add the following transition statement and definition before HH17: "The next questions are about talking to a genetic counselor about your cancer risk. A genetic counselor is a trained professional who talks with you about the chances of having a health condition based on your family medical history."**

**HH17. Have you ever talked to a genetic counselor about your risk for cancer based on your family history?**

- No → Go to end of cancer series
- Yes

**HH18. What was the MAIN reason you talked to a genetic counselor about your risk for cancer? Check ONE answer**

- My doctor recommended it
- I requested it
- A family member suggested it
- I heard or read about it in the news
- Other → Please tell us: \_\_\_\_\_

**HH19. Thinking about your MOST RECENT visit to a genetic counselor for cancer risk, what kind of cancer was it for? Check ALL that apply**

- Breast cancer
- Ovarian cancer
- Other → Please tell us: \_\_\_\_\_

**END OF CANCER SERIES**

**III. (Phase 7, Core 40, modified) How much weight did you gain during *your most recent pregnancy*? Check ONE answer and fill in blank if needed**

- I gained \_\_\_\_\_ pounds **OR** \_\_\_\_\_ kilos
- I didn't gain any weight during my pregnancy
- I don't know

**NOTE: Skip JJ1 if mother did not drink during the 3 months before she got pregnant (Core 27).**

**JJ1.** During the *3 months before* you got pregnant, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span? Check ONE answer

- 6 or more times
- 4 to 5 times
- 2 to 3 times
- 1 time
- I didn't have 4 drinks or more in a 2 hour time span

**NOTE: Skip JJ2 if mother did not drink during the last 3 months of her pregnancy (JJ3).**

**JJ2.** During the *last 3 months* of your pregnancy, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span? Check ONE answer

- 6 or more times
- 4 to 5 times
- 2 to 3 times
- 1 time
- I didn't have 4 drinks or more in a 2 hour time span

**JJ3. (Phase 7, Core 35)** During the *last 3 months* of your pregnancy, how many alcoholic drinks did you have in an average week? Check ONE answer

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

**KK1.** Do you currently have an emergency plan for your family in case of disaster? For example, you and your family have talked about how to be safe if a disaster happened.

- No
- Yes

**KK2.** During *your most recent* pregnancy, did you have an emergency plan for your family in case of disaster? For example, you and your family talked about how to be safe if a disaster happened.

- No
- Yes

**KK3.** How often do you worry about the possibility of a disaster happening to you or your family? Check ONE answer

- Always
- Sometimes
- Never

**KK4.** Below is a list of things that some people do to prepare for a disaster. For each item, check **No** if it is not something you have done to prepare for a disaster or **Yes** if it is.

- |  | <b>No</b> | <b>Yes</b> |
|--|-----------|------------|
| a. I have an emergency meeting place for family members (other than my home)   |           |            |
| b. My family and I have practiced what to do in case of a disaster   |           |            |
| c. I have a plan for how my family and I would keep in touch if we were separated  |           |            |
| d. I have an evacuation plan if I need to leave my home and community  |           |            |
| e. I have an evacuation plan for my child or children in case of a disaster (permission for day care or school to release my child to another adult) |           |            |
| f. I have copies of important documents like birth certificates and insurance policies in a safe place outside my home                               |           |            |
| g. I have emergency supplies in my home for my family such as enough extra water, food, and medicine to last for at least three days                 |           |            |
| h. I have emergency supplies that I keep in my car, at work, or at home to take with me if I have to leave quickly                                   |           |            |