

## Pregnancy Risk Assessment Monitoring System (PRAMS)

### Phase 5 Standard Questions

**NOTE: Skip A1–A2 if the mother was not trying to get pregnant.**

**A1. Did you receive treatment 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 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<sup>®</sup>, Serophene<sup>®</sup>, Pergonal<sup>®</sup>, 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:

**[BOX]**

**NOTE: Skip A3 if the mother was not trying to get pregnant.**

**A3. How many months had you been trying to get pregnant?**

0 to 3 months

4 to 6 months

7 to 12 months

13 to 24 months

More than 24 months

**NOTE: Skip B1 if infant is not alive or not living with the mother.  
Skip B1 if the mother ever breastfed.  
AFTER B1, insert instruction box that says, "If you did not breastfeed your new baby, go to..."**

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

My baby was sick and could not breastfeed

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 didn't want to be tied down

I was embarrassed to breastfeed

I went back to work or school

I wanted my body back to myself

Other = Please tell us:

**[BOX]**

**NOTE: Skip B2 if infant is not alive or not living with the mother.  
Skip B2 if the mother did not breastfeed or is still breastfeeding.**

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

My baby had difficulty nursing

Breast milk alone did not satisfy my baby

I thought my baby was not gaining enough weight

My baby got sick and could not breastfeed

My nipples were sore, cracked, or bleeding

I thought I was not producing enough milk

I had too many other household duties

I felt it was the right time to stop breastfeeding

I got sick and could not breastfeed

I went back to work or school

I wanted or needed someone else to feed the baby

My baby was jaundiced (yellowing of the skin or whites of the eyes)

Other = Please tell us:

**[BOX]**

**NOTE: Skip B3 if infant is not alive or not living with the mother.  
Skip B3 if infant was not born in a hospital.**

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

	<b>No</b>	<b>Yes</b>
a. Hospital staff gave me information about breastfeeding .....	N	Y
b. My baby stayed in the same room with me at the hospital.....	N	Y
c. I breastfed my baby in the hospital.....	N	Y
d. I breastfed my baby in the first hour after my baby was born .....	N	Y
e. Hospital staff helped me learn how to breastfeed.....	N	Y
f. My baby was fed only breast milk at the hospital .....	N	Y
g. Hospital staff told me to breastfeed whenever my baby wanted .....	N	Y
h. The hospital gave me a gift pack with formula .....	N	Y
i. The hospital gave me a telephone number to call for help with breastfeeding.....	N	Y
j. My baby used a pacifier in the hospital.....	N	Y

**NOTE: Skip B4 if infant is not alive or not living with the mother.**

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

- I knew I would 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.**

**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:
- [BOX]**

**NOTE: Skip B7 if mother was not on WIC during her pregnancy.**

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

No  
Yes

**NOTE: Skip C1–C3 if infant is not alive or not living with the mother.**

**C1. Are you currently in school or working outside the home?**

No ≡ Go to Question ##  
Yes

**C2. Which one of the following people spends the most time taking care of your new baby when you go to work or school? 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:  
[BOX]

**C3. When you leave your new baby to go to work or school, how often do you feel that she or he is well cared for? Check one answer**

Always  
Often  
Sometimes  
Rarely  
Never

**NOTE: Skip D1–D2 if infant is not alive or not living with the mother.**

**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

**NOTE: Skip E1 if mother is not using birth control now.  
BEFORE E1, insert instruction box that says, "If you are not doing anything to keep from getting pregnant *now*, go to...."**

**E1. What kind of birth control are you or your husband or partner using *now* to keep from getting pregnant? Check all that apply**

Tubes tied or closed (female sterilization)  
Vasectomy (male sterilization)  
Pill  
Condoms  
Shot once a month (Lunelle<sup>®</sup>)  
Shot once every 3 months (Depo-Provera<sup>®</sup>)  
Contraceptive patch (OrthoEvra<sup>®</sup>)  
Diaphragm, cervical cap, or sponge  
Cervical ring (NuvaRing<sup>®</sup> or others)  
IUD (including Mirena<sup>®</sup>)  
Rhythm method or natural family planning  
Withdrawal (pulling out)  
Not having sex (abstinence)  
Other ≡ Please tell us:  
**[BOX]**

**E2. After your new baby was born, did a doctor, nurse, or other health care worker talk with you about using birth control?**

No  
Yes

**NOTE: Skip E3 if mother was not using birth control when she got pregnant.  
BEFORE E3, insert instruction box that says, “If you were not doing anything to keep from getting pregnant, go to....”**

**E3. When you got pregnant with your new baby, what were you or your husband or partner doing to keep from getting pregnant? Check all that apply**

Tubes tied or closed (female sterilization)  
 Vasectomy (male sterilization)  
 Pill  
 Condoms  
 Shot once a month (Lunelle<sup>®</sup>)  
 Shot once every 3 months (Depo-Provera<sup>®</sup>)  
 Contraceptive patch (OrthoEvra<sup>®</sup>)  
 Diaphragm, cervical cap, or sponge  
 Cervical ring (NuvaRing<sup>®</sup> or others)  
 IUD (including Mirena<sup>®</sup>)  
 Rhythm method or natural family planning  
 Withdrawal (pulling out)  
 Not having sex (abstinence)  
 Other ≡ Please tell us:  
**[BOX]**

**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 3 days after unprotected sex.

No  
 Yes

**NOTE: Skip F1 if infant is not alive or not living with the mother.**

**F1. How often does your new baby sleep in the same bed with you or anyone else?**

Always  
 Often  
 Sometimes  
 Rarely  
 Never

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

No  
 Yes

**NOTE: Skip G2 if mother has never heard or read about folic acid.**

**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:  
**[BOX]**

**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 a multivitamin or a prenatal vitamin? 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 or nurse 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 or a prenatal vitamin? These are pills that contain many different vitamins and minerals.**

I did not take a multivitamin or a prenatal 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 or a prenatal vitamin? These are pills that contain many different vitamins and minerals.**

I did not take a multivitamin or a prenatal vitamin at all  
1 to 3 times a week  
4 to 6 times a week  
Every day of the week

**G7. During the last 3 months of your most recent pregnancy, about how many servings of fruits or vegetables did you have in a day? Check one answer**

- Less than 1 serving per day
- 1 or 2 servings per day
- 3 or 4 servings per day
- 5 or more servings per day

**NOTE: Skip H1–H2 if infant is not alive or not living with the mother.**

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

- No ≡ **Go to Question ##**
- Yes

**H2. What type of insurance is your new baby covered by? Check all that apply**

- Medicaid (*state program name*)
  - Private insurance or HMO (including insurance from your work or your husband’s work)
  - State-specific*
  - State-specific*
  - Other ≡ Please tell us:
- [BOX]**

**NOTE: Skip H3–H4 if infant is not alive or not living with the mother.**

**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:
- [BOX]**

**NOTE: Skip I2 if mom indicated in I6 that she had been tested before this pregnancy.  
Skip I2–I3 if mom indicated in Core 20 that she was tested during pregnancy or delivery. Do NOT skip these if mom indicated in Core 20 that she “didn’t know” whether she was tested during pregnancy or delivery.**

**I2. Had you been tested for HIV *before* this pregnancy?**

No ≡ **Go to Question ##**

Yes

I don’t know ≡ **Go to Question ##**

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

Less than 6 months before you got pregnant

6 months to 1 year before you got pregnant

More than 1 year before you got pregnant

**NOTE: Skip I2 if mom indicated in I6 that she had been tested before this pregnancy.  
Skip I4–I6 if mom indicated in Core 20 that she was tested during pregnancy or delivery. Do NOT skip these if mom indicated in Core 20 that she “didn’t know” whether she was tested during pregnancy or delivery.**

**I4. Were you *offered* an HIV test during your most recent pregnancy or delivery?**

No ≡ **Go to next section**

Yes

**I5. Did you turn down the HIV test?**

No ≡ **Go to next section**

Yes

**I6. Why did you turn down the HIV test? Check all that apply**

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 ≡ **Go to Question ##** (Skip I2 and answer I3)

Other ≡ Please tell us:

**[BOX]**

**NOTE: Skip I7 if mom indicated in Core 20 that she had not been tested during this pregnancy or delivery.  
Skip I7 if mom indicated in Core 20 that she “didn’t know” whether she was tested during pregnancy or delivery.**

**I7. When was your most recent HIV test? Check one answer**

- During the first 3 months of pregnancy
- During the second 3 months of pregnancy
- During the last 3 months of pregnancy
- Unsure when, but during pregnancy and before delivery
- At labor and delivery
- After delivery but before hospital discharge

**NOTE: Skip K1–K4 if mother has not had a previous infant born alive.**

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

- No ≡ Go to Question ##
- Yes

**K2. How did you expect your *new* baby to be delivered, vaginally (naturally) or by cesarean delivery?**

- Vaginally
- Cesarean delivery ≡ Go to Question ##

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

- Vaginally
- I went into labor but had to have a cesarean delivery
- I didn’t go into labor and had to have a cesarean delivery

**NOTE: Skip K4 if mother did not have prenatal care.**

**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
- He or she didn’t suggest how I deliver my baby

**NOTE: Skip K5 if mother did not have her baby in a hospital.**

**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

**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.**

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

No ≡ **Go to Question ##**  
Yes

**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

**NOTE: All moms that answer L5 should answer L7.**

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

None

1

2

3 or more

**L8. Since your new baby was born, have you had a postpartum checkup for yourself?** (A postpartum checkup is the regular checkup a woman has after she gives birth.)

No  $\equiv$  **Go to Question ##**

Yes

**L9. At that visit, did a doctor, nurse, or other health care worker discuss family planning or birth control with you?**

No

Yes

**L10. Would you say that, in general, your health is—**

Excellent

Very good

Good

Fair

Poor

**L11. During the 3 months before you got pregnant with your new baby, did you have any of the following health problems?** For each one, circle **Y** (Yes) if you had the problem or circle **N** (No) if you did not.

	No	Yes
a. Asthma .....	N	Y
b. High blood pressure (hypertension) .....	N	Y
c. High blood sugar (diabetes) .....	N	Y
d. Anemia (poor blood, low iron) .....	N	Y
e. Heart problems .....	N	Y

**L12. At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker offer you a flu vaccination or tell you to get one?**

No

Yes

**L13. Did you get a flu vaccination during your most recent pregnancy?**

No

Yes ≡ **Go to Question ##**

**L14. What were your reasons for not getting a flu vaccination during your most recent pregnancy?** For each item, circle **Y** (Yes) if it was a reason for you or circle **N** (No) if it was not a reason or did not apply to you.

	<b>No</b>	<b>Yes</b>
a. My doctor didn't mention anything about a flu vaccination during my pregnancy .....	N	Y
b. I was worried about side effects of the flu vaccination for me.....	N	Y
c. I was worried that the flu vaccination might harm my baby .....	N	Y
d. I wasn't pregnant during the flu season (November–February).....	N	Y
e. I was in my first trimester during the flu season (November–February).....	N	Y
f. I don't normally get a flu vaccination .....	N	Y
g. Other.....	N	Y

Please tell us:

**[BOX]**

**L15. Have you ever had a flu vaccination when you were *not* pregnant?**

No

Yes

**NOTE: Skip L16 if mother has not had a postpartum checkup (L8).**

**L16. At that visit, did a doctor, nurse, or other health care worker advise you to take a multivitamin or a prenatal vitamin every day?** These are pills that contain many different vitamins and minerals.

No

Yes

**L17. Before you got pregnant with your new baby, did you talk with a doctor, nurse, or other health care worker to prepare for a healthy pregnancy and baby?**

No

Yes

**M1a. Since your new baby was born, how often have you felt down, depressed, or hopeless?**

- Always
- Often
- Sometimes
- Rarely
- Never

**M1b.** *Since your new baby was born, how often have you had little interest or little pleasure in doing things?*

Always  
Often  
Sometimes  
Rarely  
Never

**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.** *At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker diagnose you with depression?*

No ≡ **Go to Question ##**  
Yes

**M4.** *At any time during your most recent pregnancy, did you seek 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 diagnosed you with depression?*

No ≡ **Go to Question ##**  
Yes

**M6.** *Since your new baby was born, did you seek 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

**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

**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

**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

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

[BOX] Weeks **OR** [BOX] Months

**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

**N4. What types of support would have helped you to stay in bed for the recommended time?** For each item, circle **Y** (Yes) if it was a reason for you or circle **N** (No) if it was not a reason or did not apply to you.

	<b>No</b>	<b>Yes</b>
a. Help with child care .....	N	Y
b. Help with housework .....	N	Y
c. Knowing I wouldn't lose my job.....	N	Y
d. Money to make up for not working.....	N	Y
e. Other.....	N	Y

Please tell us:  
[BOX]

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

No ≡ Go to Question ##  
Yes

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

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

**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:  
[BOX]

**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:  
[BOX]

**P3. When you got pregnant, who lived in the same house with you?** Check all that apply

My husband or partner

Children aged 5 years and under ≡ How many? [BOX]

Children aged 6 years and over ≡ How many? [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:

[BOX]

I lived alone

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

My husband or partner

Children aged 5 years and under ≡ How many? [BOX]

Children aged 6 years and over ≡ How many? [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:

[BOX]

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 with your first baby?**

[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

**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)

**P13a. Which of the following utilities do you have in your house, apartment, or trailer? For each item, circle Y (Yes) if you have the utility or circle N (No) if you do not 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) .....	N	Y
b. Electricity .....	N	Y
c. A telephone from which you can make and receive calls (including cell phones) .....	N	Y

**If you don't have complete plumbing facilities in your home, go to Question ##.**

**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 ##**

**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, circle Y (Yes) if you did it or circle N (No) if you did not.**

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

**The next questions are about the time just before you got pregnant with your new baby.**

**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 wasn't trying to get pregnant or trying to keep from getting 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

He wanted me to get pregnant  
He partly wanted me to get pregnant and partly wanted me not to get pregnant  
He didn't care one way or the other whether I got pregnant  
He didn't especially want me to get pregnant  
He 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**

- He wanted me to be pregnant sooner
- He wanted me to be pregnant later
- He wanted me to be pregnant then
- He 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 mother wanted to be pregnant sooner, then, or not at any time in the future.**

**Q4. How much later did you want to become pregnant?**

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to less than 4 years
- 4 years or more

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

	<b>No</b>	<b>Yes</b>
a. I was worried that I didn't know enough about how to take care of a baby .....	N	Y
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.....	N	Y
c. I looked forward to teaching and caring for a new baby .....	N	Y
d. I looked forward to the new experiences that having a baby would bring .....	N	Y
e. I looked forward to telling my friends that I was pregnant .....	N	Y
f. I was worried that I did not have enough money to take care of a baby .....	N	Y
g. I did not look forward to telling my friends that I was pregnant .....	N	Y
h. I looked forward to buying things for a new baby.....	N	Y

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

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

**NOTE: Skip R1–R15 if mother had no prenatal care.**

**R1. We would like to know how you felt 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, circle **Y** (Yes) if you were satisfied or circle **N** (No) if you were not satisfied.

**Were you satisfied with—**

	<b>No</b>	<b>Yes</b>
a. The amount of time you had to wait after you arrived for your visits .....	N	Y
b. The amount of time the doctor or nurse spent with you during your visits .....	N	Y
c. The advice you got on how to take care of yourself.....	N	Y
d. The understanding and respect that the staff showed toward you as a person.....	N	Y

**R2. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about how much weight you should gain during your pregnancy?**

No  
Yes

**R3. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask if you were smoking cigarettes?**

No  
Yes

**R4. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask if you were drinking alcoholic beverages (beer, wine, wine cooler, or liquor)?**

No  
Yes

**R5. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you—**

	<b>No</b>	<b>Yes</b>
a. How much alcohol you were drinking .....	N	Y
b. If someone was hurting you emotionally or physically .....	N	Y
c. If you were using illegal drugs (marijuana or hash, cocaine, crack, etc.).....	N	Y
d. If you wanted to be tested for HIV (the virus that causes AIDS).....	N	Y
e. If you planned to use birth control after your baby was born.....	N	Y

**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, circle **Y** (Yes) if someone talked with you about it or circle **N** (No) if no one talked with you about it.

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

**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 a multivitamin or a prenatal vitamin *during your pregnancy*?** These are pills that contain many different vitamins and minerals.

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 visits? Do not include visits for WIC. Check one answer**

- Hospital clinic
- Health department clinic
- Private doctor’s office or HMO clinic
- State-specific*
- State-specific*
- Other = Please tell us:
- [BOX]**

**NOTE: Skip S1 if infant is not alive or not living with the mother.**

**S1. Listed below are some statements about safety.** For each one, circle **Y** (Yes) if it applies to you or circle **N** (No) if it does not.

		<b>No</b>	<b>Yes</b>
a.	My infant was brought home from the hospital in an infant car seat .....	N	Y
b.	My baby always or almost always rides in an infant car seat.....	N	Y
c.	My home has a working smoke alarm.....	N	Y
d.	There are <b>loaded</b> guns, rifles, or other firearms in my home .....	N	Y

**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 or not living with the mother.**

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

		<b>True</b>	<b>False</b>
a.	New babies should be in rear-facing car seats.....	T	F
b.	Car seats should not be placed in front of an air bag.....	T	F

**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

<b>NOTE: Skip S6–S9 if infant is not alive or not living with the mother.</b>
---

**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 ##

**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 = Go to Question ## (Skip S9 and then answer S8)

**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 or not living with the mother.**

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

No ≡ **Go to Question ##**

Yes

**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:

**[BOX]**

**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

Someone from a loaner program showed me

A health or safety professional showed me

I figured it out myself

Some other way ≡ Please tell us:

**[BOX]**

**NOTE: Skip S13 if infant is not alive or not living with the mother.**

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

No

Yes

**NOTE: Skip T1–T3 if infant is not alive or not living with the mother.**

**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 ##**

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

- Hospital clinic
- Health department clinic
- Hospital emergency room
- Private doctor's office
- State-specific*
- State-specific*
- Other = Please tell us:
- [BOX]**

**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 or not living with the mother.**

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

- No = Go to Question ##
- Yes

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

- No
- Yes

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

- No
- Yes

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

- No
- Yes

**V1. During your most recent pregnancy, did you get any of these services?** For each one, circle Y (Yes) if you got the service or circle N (No) if you did not get it.

		<b>No</b>	<b>Yes</b>
a.	Childbirth classes .....	N	Y
b.	Parenting classes .....	N	Y
c.	Classes on how to stop smoking.....	N	Y
d.	Visits to your home by a nurse or other health care worker .....	N	Y
e.	Food stamps .....	N	Y

f. TANF (welfare)..... N Y  
**V2. Since your new baby was born, have you used any of these services?** For each one, circle **Y** (Yes) if you used the service or circle **N** (No) if you did not use it.

a. List of services..... **No** **Yes**  
 N Y

**NOTE: Skip V3 if infant is not alive or not living with the mother.**

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

No  
 Yes

**V4. At any time during the last 2 years, have you or any member of your household considered seeking help from the government because your income was low?**

No ≡ **Go to Question ##**  
 Yes

**V5. 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 ##**

**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 want to use up my benefits
- I didn't think I could get help because I am from another country
- Other ≡ Please tell us:

**[BOX]**

**NOTE: Skip V7 if mother did not apply for government assistance.**

**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

**V8. Between the time you got pregnant and now, have you applied for TANF (Temporary Assistance for Needy Families or welfare)?**

No ≡ **Go to Question ##**  
Yes

**V9. Did you get TANF (welfare)?**

No  
Yes ≡ **Go to Question ##**

**V10. Why didn't you get TANF (welfare)? 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:  
**[BOX]**

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

**Did you need—**

	<b>No</b>	<b>Yes</b>
a. Money to buy food, food stamps, or WIC vouchers.....	N	Y
b. Help with an alcohol or drug problem.....	N	Y
c. Help to reduce violence in your home.....	N	Y
d. Counseling information for family and personal problems.....	N	Y
e. Help to quit smoking .....	N	Y
f. Help with or information about breastfeeding.....	N	Y
g. Other.....	N	Y

Please tell us:  
**[BOX]**

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

**Did you receive—**

	<b>No</b>	<b>Yes</b>
a. Money to buy food, food stamps, or WIC vouchers.....	N	Y
b. Help with an alcohol or drug problem.....	N	Y
c. Help to reduce violence in your home.....	N	Y
d. Counseling information for family and personal problems.....	N	Y
e. Help to quit smoking.....	N	Y
f. Help with or information about breastfeeding.....	N	Y
g. Other.....	N	Y

Please tell us:

**[BOX]**

**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

Someone else = Please tell us:

**[BOX]**

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, circle **Y** (Yes) if you would have had it or circle **N** (No) if not.

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

**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

Someone else = Please tell us:

**[BOX]**

No one would help me

**NOTE: Skip W4 if infant is not alive or is not living with the mother.**

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

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

**NOTE: Skip X1–X2 if infant is not alive or is not living with the mother.**

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

No

Yes = Go to Question ##

**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 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 routine care

Other = Please tell us:

[BOX]

**NOTE: Skip X3 if infant is not alive or is not living with the mother.**

**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 is not alive or is not living with the mother.  
Skip X4 if infant has not had a well-baby checkup.**

**X4. When your new baby goes for well-baby checkups, who pays for those visits? Check all that apply**

Medicaid

Personal income (cash, check, or credit card)

Health insurance or HMO (including insurance from your work or your husband's work)

*State-specific*

*State-specific*

Other = Please tell us:

**[BOX]**

**NOTE: Skip X5 if infant is not alive or is not living with the mother.**

**X5. What do you think would be the best time to get information from your doctor or nurse about baby shots? Check one answer**

During prenatal care visits

In the hospital or birthing center after my new baby's delivery

At my new baby's first visit to the doctor

**NOTE: Skip X6 if infant is not alive or is not living with the mother.  
Skip X6 if infant did not have a medical visit during the first week after leaving the hospital.**

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

At home

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

**NOTE: Skip X7–X8 if infant is not alive or is not living with the mother.  
Skip X7–X8 if infant has not had a well-baby checkup.**

**X7. How many times has your new baby been to a doctor or nurse 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

- Hospital clinic
- Health department clinic
- Private doctor’s office or HMO clinic
- State-specific*
- State-specific*
- Other ≡ Please tell us:
- [BOX]

**Y1. This question is about the care of your teeth during your most recent pregnancy.** For each item, circle **Y** (Yes) if it is true or circle **N** (No) if it is not true.

- |   | <b>No</b> | <b>Yes</b> |
|---|-----------|------------|
| a. I needed to see a dentist for a problem .....  | N         | Y          |
| b. I went to a dentist or dental clinic .....   | N         | Y          |
| c. A dental or other health care worker talked with me about how<br>to care for my teeth and gums ..... | N         | Y          |

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

- No ≡ Go to Question ##
- Yes

**Y3. When did you have your teeth cleaned by a dentist or dental hygienist?** For each of the three time periods, circle **Y** (Yes) if you had your teeth cleaned then or circle **N** (No) if you did not have your teeth cleaned then.

- |  | <b>No</b> | <b>Yes</b> |
|--|-----------|------------|
| a. Before my most recent pregnancy ..... | N         | Y          |
| b. During my most recent pregnancy ..... | N         | Y          |
| c. After my most recent pregnancy .....  | N         | Y          |

**Z1. This question is about things that may have happened during your most recent pregnancy.** For each thing, circle **Y** (Yes) if it happened to you or circle **N** (No) if it did not.

**During your most recent pregnancy—**

- |  | <b>No</b> | <b>Yes</b> |
|--|-----------|------------|
| a. Your husband or partner threatened you or made you feel unsafe in some way .....  | N         | Y          |
| b. You were frightened for the safety of yourself or your family because of the<br>anger or threats of your husband or partner.....                      | N         | Y          |
| c. Your husband or partner tried to control your daily activities, for example,<br>controlling who you could talk to or where you could go .....         | N         | Y          |
| d. Your husband or partner forced you to take part in any sexual activity when<br>you did not want to (including touch that made you uncomfortable)..... | N         | Y          |

**Z2. This question is about things that may have happened since your most recent delivery.** For each thing, circle **Y** (Yes) if it happened to you or circle **N** (No) if it did not.

**Since your most recent delivery—**

	<b>No</b>	<b>Yes</b>
a. Your ex-husband or ex-partner pushed, hit, slapped, kicked, choked, or physically hurt you in any other way .....	N	Y
b. Your husband or partner physically hurt you in any way .....	N	Y
c. Your husband or partner threatened you or made you feel unsafe in some way .....	N	Y
d. You were frightened for the safety of yourself or your family because of the anger or threats of your husband or partner.....	N	Y
e. Your husband or partner tried to control your daily activities, for example, controlling who you could talk to or where you could go .....	N	Y
f. Your husband or partner forced you to take part in any sexual activity when you did not want to (including touch that made you uncomfortable) .....	N	Y

**Z3. During the 12 months before you got pregnant, did anyone else physically hurt you in any way?**

No  
Yes

**Z4. During your most recent pregnancy, did anyone else physically hurt you in any way?**

No  
Yes

**NOTE: Skip AA1 if mother did not smoke during the 3 months before she got pregnant.  
Skip AA1 if mother did not have any prenatal care.**

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

No  
Yes

I had quit smoking before my first prenatal care visit

**NOTE: Skip AA2 if mother did not smoke during the 3 months before she got pregnant.**

**AA2. Listed below are some things about smoking.** For each thing, circle **Y** (Yes) if it applied to you during your most recent pregnancy or circle **N** (No) if it did not.

**During your most recent pregnancy, did you—**

		<b>No</b>	<b>Yes</b>
a.	Set a specific date to stop smoking.....	N	Y
b.	Use a nicotine nasal spray or nicotine inhaler .....	N	Y
c.	Take a pill like Zyban <sup>®</sup> (also known as Wellbutrin <sup>®</sup> or Bupropion <sup>®</sup> ) to help you quit .....	N	Y
d.	Use nicotine gum.....	N	Y
e.	Use a nicotine patch .....	N	Y
f.	Attend a class or program to stop smoking .....	N	Y
g.	Use booklets, videos, or other materials to help you quit.....	N	Y
h.	Go to counseling for help with quitting.....	N	Y
i.	Call a national or state quit line.....	N	Y

**NOTE: Skip AA3 if mother did not smoke during the 3 months before she got pregnant.**

**Skip AA3 if mother did not have any prenatal care.**

**Put both of the above instructions in one box on the survey.**

**AA3. Listed below are some things about smoking that a doctor, nurse, or other health care worker might have done during any of your prenatal care visits.** For each thing, circle **Y** (Yes) if it applied to you during any of your prenatal care visits or circle **N** (No) if it did not.

**During any of your prenatal care visits, did a doctor, nurse, or other health care worker—**

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

**AA4. During your most recent pregnancy, about how many hours a day, on average, were you in the same room with another person who was smoking?**

**[BOX]** Hours

Less than 1 hour a day

I was never in the same room with someone who was smoking

**AA5. Which of the following statements best describes the rules about smoking *inside* your home during your most recent pregnancy?** 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 smoked during the last 3 months of pregnancy.**

**AA6. When did you quit smoking?**

Before I found out I was pregnant  
 When I found out I was pregnant  
 Later in my pregnancy

**AA7. Which of the following statements best describes the rules about smoking *inside* your home now?**  
 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

**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

**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.) Do not count exercise you may have done as part of your regular job.

Less than 1 day per week  
 1 to 4 days per week  
 5 or more days per week

**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?** Do not count exercise you may have done as part of your regular job.

Less than 1 day per week

1 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.**

**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

**EE1. During your most recent pregnancy, did a doctor, nurse, or other health care worker tell you that you had a urinary tract infection (UTI), a sexually transmitted disease (STD), or any vaginal infection, including bacterial vaginosis or Group B Strep (Beta Strep)?**

No ≡ Go to Question ##

Yes

**EE2. What disease or infection were you told you had?** Check all that apply

Genital warts (HPV)  
Herpes  
Chlamydia  
Gonorrhea  
Pelvic inflammatory disease (PID)  
Syphilis  
Group B Strep (Beta Strep)  
Bacterial vaginosis  
Trichomoniasis (Trich)  
Yeast infections  
Urinary tract infection (UTI)  
Other ≡ Please tell us:  
**[BOX]**

**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

**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 two questions 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