

Please check the box next to your answer or follow the directions included with the question. You may be asked to skip some questions that do not apply to you.

BEFORE PREGNANCY

The first questions are about you.

1. What is your date of birth?

<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/> /	<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/> /	<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/>
Month	Day	Year

2. Before you got pregnant, did you...?

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

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

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

3. During the 3 months before you got pregnant with your *new* baby, did you have any of the following health conditions?

For each one, check **No** if you did not have the condition or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes (not gestational diabetes or diabetes that starts during pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

Please tell us:

If you did not have any healthcare visits in the 12 months before you got pregnant, go to Page 2, Question 6.

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| Talk to me about... | | |
| a. My weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regularly checking my blood pressure.... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My desire to have or not have children.... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Birth control methods | <input type="checkbox"/> | <input type="checkbox"/> |
| e. How I could improve my health before a pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sexually transmitted infections such as chlamydia, gonorrhea, syphilis, or HIV..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Ask me... | | |
| g. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I felt depressed or anxious | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about your *health insurance*.

6. During the *month before* you got pregnant with your new baby, what kind of health insurance did you have?

Check ALL that apply

- Private health insurance (paid for by me, someone else, or through a job)
- Apple Health (includes Medicaid and State Children's Health Insurance Program (CHIP))
- TRICARE or other military healthcare
- Indian Health Service and/or Tribal Health Services
- Other health insurance —→ Please tell us:
- I didn't have any health insurance during the *month before* I got pregnant

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

Check ALL that apply

- Private health insurance (paid for by me, someone else, or through a job)
- Apple Health (includes Medicaid and State Children's Health Insurance Program (CHIP))
- TRICARE or other military healthcare
- Indian Health Service and/or Tribal Health Services
- Other health insurance —→ Please tell us:
- I didn't have any health insurance *during* my pregnancy

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

Check ALL that apply

- Private health insurance (paid for by me, someone else, or through a job)
- Apple Health (includes Medicaid and State Children's Health Insurance Program (CHIP))
- TRICARE or other military healthcare
- Indian Health Service and/or Tribal Health Services
- Other health insurance —→ Please tell us:
- I don't have any health insurance *now*

9. Thinking back to *just before* you got pregnant with your new baby, how did you feel about becoming pregnant?

Check ONE answer

- I wanted to be pregnant later
- I wanted to be pregnant sooner
- I wanted to be pregnant then
- I didn't want to be pregnant then or at any time in the future
- I wasn't sure what I wanted

DURING PREGNANCY

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

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

- No
- Yes

Go to Question 13

11. How many weeks or months pregnant were you when you had your first visit for prenatal care?

Write ONE answer

_____ week(s) OR _____ month(s)

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

No Yes

Talk to me about...

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

Ask me...

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

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

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

No Yes

- a. Flu shot
- b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough])
- c. COVID-19 shot

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

For each shot, check ALL that apply:

B for **3 months before** pregnancy

D for **During** pregnancy

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

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

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

- No
 Yes

16. 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, healthcare provider, doula, childbirth educator, social worker, or another person who works for a program that helps you during your pregnancy.

- No → **Go to Question 20**
 Yes

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

Check ALL that apply

- A nurse, nurse's aide, or midwife
 A teacher or health educator
 A doula or childbirth educator
 Someone else → Please tell us:

 I don't know

18. 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

19. 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** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| 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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The importance of getting tested for sexually transmitted infections (STIs)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Breastfeeding my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My emotional well-being..... | <input type="checkbox"/> | <input type="checkbox"/> |

20. Overall, during my pregnancy, I felt...
For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Comfortable asking questions about the prenatal care that I received..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Comfortable declining care if I didn't want it..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Comfortable accepting the options for care that my provider recommended..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was able to choose the care options that I received..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My providers treated me with respect..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Satisfied with the prenatal care that I received..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Gestational diabetes (diabetes that started during <i>this</i> pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that started during <i>this</i> pregnancy), pre-eclampsia, or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |

If you **had** high blood pressure **before** or **during** your pregnancy, go to Question 22. If you **didn't**, go to Question 23.

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

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

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

- No —————→ **Go to Question 25**
- Yes

Go to Question 24

24. During your most recent pregnancy, did you get information about warning signs from any of the following sources?

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. A healthcare provider (such as a doctor, nurse, or midwife) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Websites or social media (such as Facebook, Instagram, or Twitter)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any source of information that used the slogan “ Hear Her ” (such as websites, social media, or paper handouts)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

- No —————→ **Go to Page 6, Question 29**
- Yes

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

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

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

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

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

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

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

- No
 Yes

→ **Go to Question 33**

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

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

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

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

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

- No
 Yes

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

33. During your most recent pregnancy, did you have any alcoholic drinks during...?
 For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. The first 3 months of pregnancy (1 st trimester)? <i>This includes the time before knowing you were pregnant</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2 nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 ^d trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not have any alcoholic drinks during your pregnancy, go to Question 35.

34. During your most recent pregnancy, did you have 4 or more alcoholic drinks in a 2-hour time span during...?
 For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. The first 3 months of pregnancy (1 st trimester)? <i>This includes the time before knowing you were pregnant</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2 nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 ^d trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I got separated or divorced..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was evicted or forced to move | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have a regular place to sleep..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was homeless or had to sleep outside, in a car, or in a shelter..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My spouse, partner, or I lost a job..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My spouse, partner, or I had a cut in work hours or pay..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I had problems paying the rent, mortgage, or other bills..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My spouse or partner went to jail/prison.. | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I went to jail/prison | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Someone close to me had a problem with drinking or drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Someone close to me was very sick or died..... | <input type="checkbox"/> | <input type="checkbox"/> |

36. In the 12 months before you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each one, check **No** or **Yes**.

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

37. During your most recent pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each one, check **No** or **Yes**.

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

38. Did your current, or ex, spouse or partner do any of the following things during your most recent pregnancy?

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Threatened me or made me feel unsafe in some way..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Made me afraid for my safety or my family's safety because of their anger or threats..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. 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. Forced me to take part in touching or any sexual activity when I didn't want to..... | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

39. Overall, during the delivery of my baby, I felt... For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Comfortable asking questions about the labor and delivery care that I received | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Comfortable declining care if I didn't want it..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Comfortable accepting the options for care that my provider recommended | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was able to choose the care options that I received | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My providers treated me with respect..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Satisfied with the labor and delivery care that I received | <input type="checkbox"/> | <input type="checkbox"/> |

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

- Less than 3 days
- 3 to 5 days
- 6 to 14 days
- More than 14 days
- My baby was not born in a hospital
- My baby is still in the hospital → **Go to Question 43**

41. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Question 51**

42. Is your baby living with you now?

- No → **Go to Question 49**
- Yes

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

Check ONE answer

- I didn't breastfeed my baby
- I breastfed my baby for less than 1 week
- I breastfed my baby for:
 week(s) **OR** month(s)
- I'm still breastfeeding or feeding pumped milk to my new baby

If your baby is still in the hospital, go to Question 49.

44. In the past 2 weeks, how did you place your new baby to sleep at night and during naps?

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

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

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

- Always
- Often
- Sometimes
- Rarely
- Never → **Go to Question 47**

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

- No
- Yes

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. In a crib, portable crib, or bassinet | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On a twin or larger mattress or bed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. On a couch, sofa, or armchair | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In an infant car seat | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a swing, rocker, or other inclined sleeper | <input type="checkbox"/> | <input type="checkbox"/> |
| f. In an in-bed sleeper | <input type="checkbox"/> | <input type="checkbox"/> |
| g. In a baby board or cradleboard | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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

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

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

Please tell us:

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, healthcare provider, doula, social worker, or another person who works for a program that helps families with newborns.

- No → **Go to Question 51**
- Yes

50. Who was the home visitor that came to your home since your new baby was born?

Check ALL that apply

- A nurse, nurse's aide, or midwife
- A teacher or health educator
- A doula or childbirth educator
- Someone else → Please tell us:
-
- I don't know

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

- No
- Yes → **Go to Page 10, Question 53**
- I'm pregnant now → **Go to Page 10, Question 54**

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

Check ALL that apply

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

If you're not doing anything to keep from getting pregnant now, go to Page 10, Question 54.

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

Check ALL that apply

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

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

- No _____ → **Go to Question 56**
- Yes

Go to Question 55

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

No Yes

Talk to me about...

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

Ask me...

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

A healthcare provider...

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

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

No Yes

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

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

- No —————→ **Go to Question 64**
- Yes

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

- No
- Yes —————→ **Go to Question 64**

Go to Question 63

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

Check ALL that apply

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

64. Overall, since my new baby was born, I have felt...

For each one, check No or Yes.

No Yes

- a. Comfortable asking questions about the *postpartum care* that I received.....
- b. Comfortable declining care if I didn't want it.....
- c. Comfortable accepting the options for care that my provider recommended
- d. I was able to choose the care options that I received
- e. My providers treated me with respect.....
- f. Satisfied with the *postpartum care* that I received.....

65. Has your current, or ex, spouse or partner done any of the following things *since your new baby was born*?

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Threatened me or made me feel unsafe in some way..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Made me afraid for my safety or my family's safety because of their anger or threats..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. 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. Forced me to take part in touching or any sexual activity when I didn't want to..... | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER EXPERIENCES

The next questions are on a variety of topics.

66. Before you got pregnant with your new baby, did your spouse or partner ever try to keep you from using your birth control so that you would get pregnant when you did not 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
 I didn't have a partner at that time, or I was in a same sex relationship

67. Before you got pregnant with your new baby, did your spouse or partner ever refuse to use a condom when you wanted them to use one to keep from getting pregnant?

- No
 Yes
 I didn't have a partner at that time, or I was in a same sex relationship

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

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

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

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

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

70. Did any of the following things make it hard for you to go to a dentist or dental clinic during your most recent pregnancy?

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

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

71. During any of the following time periods, did you use marijuana or cannabis in any form? Please do not include hemp or CBD-only products. For each time period, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. During the 3 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"/> |

If you did not use marijuana in any form during your pregnancy, go to Question 73.

72. Why did you use marijuana products during pregnancy? For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. To relieve nausea or vomiting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. To relieve stress or anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. To relieve symptoms of a chronic condition | <input type="checkbox"/> | <input type="checkbox"/> |
| d. To help me sleep..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. To relieve pain..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. For fun or to relax | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Some other reason..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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

- No —————→ **Go to Question 76**
- Yes

74. Did you take leave from work after your new baby was born?

Check ALL that apply

- Yes, I took *paid* leave from my job
- Yes, I took *unpaid* leave from my job
- No, I didn't take any leave

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

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I couldn't financially afford to take leave .. | <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 doesn't have paid leave..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My job doesn't offer a flexible work schedule..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I hadn't built up enough leave time to take any or more time off | <input type="checkbox"/> | <input type="checkbox"/> |

76. Did you use doula support during any of the following time periods? A doula is a trained pregnancy and labor companion who gives comfort, emotional support, and information during birth. A doula does not provide medical care. For each time period, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During the birth of my new baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Since my new baby was born | <input type="checkbox"/> | <input type="checkbox"/> |

77. Are any firearms kept in or around your home now?

- No —————→ **Go to Page 14, Question 80**
- Yes
- I don't know → **Go to Page 14, Question 80**

78. Are any of these firearms now loaded?

- No —————→ **Go to Page 14, Question 80**
- Yes
- I don't know → **Go to Page 14, Question 80**

Go to Page 14, Question 79

79. Are any of these loaded firearms also unlocked? Unlocked meaning you do not need a key, combination, or hand/fingerprint to get the gun or to fire it. Do not count a safety as a lock.

- No
- Yes
- I don't know

80. While getting healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?

For each one, check **No** if you did not experience discrimination because of it or **Yes** if you did.

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

Please tell us:

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

- Very often
- Somewhat often
- Not very often
- Never

82. Have you ever been treated unfairly due to your race, ethnicity, or skin color in any of the following situations?

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

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

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

83. During the 12 months before your new baby was born, what was your yearly total household income before taxes? Include your income, your spouse or partner's income, and any other income you may have received. *All information will be kept private and will not affect any services you are getting now.*

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

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

Number of people _____

85. What is today's date?

	/		/	
Month		Day		Year

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

Thanks for answering our questions!

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

