

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 type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Month		Day		Year

2. How would you describe your sexual orientation?

- ☐ Heterosexual or "straight"
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Prefer to self-describe —————> Please tell us:

3. 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.

4. 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"/> |
| f. Anemia (poor blood, low iron) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| h. PCOS (polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> |

5. 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 7.

6. 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.

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

Check ALL that apply

☐ Private health insurance (paid for by me, someone else, or through a job)
☐ Medicaid or BadgerCare Plus (ForwardHealth)
☐ TRICARE or other military healthcare
☐ Indian Health Service or other tribal healthcare
☐ Other health insurance ———> Please tell us:

☐ I didn't have any health insurance during the month before I got pregnant

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

Check ALL that apply

☐ Private health insurance (paid for by me, someone else, or through a job)
☐ Medicaid or BadgerCare Plus (ForwardHealth)
☐ TRICARE or other military healthcare
☐ Indian Health Service or other tribal healthcare
☐ Other health insurance ———> Please tell us:

☐ I didn't have any health insurance *during my pregnancy*

9. What kind of health insurance do you have now?

Check ALL that apply

☐ Private health insurance (paid for by me, someone else, or through a job)
☐ Medicaid or BadgerCare Plus (ForwardHealth)
☐ TRICARE or other military healthcare
☐ Indian Health Service or other tribal healthcare
☐ Other health insurance ———> Please tell us:

☐ I don't have any health insurance *now*

10. 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.)

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

- ☐ No
☐ Yes

Go to Question 13

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

- ☐ No
☐ Yes

Go to Page 4, Question 14

Go to Question 13

13. Did any of these things keep you from getting prenatal care when you wanted it?

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

No Yes

- | | | |
|----------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan wouldn't start care as early as I wanted..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid or BadgerCare Plus (ForwardHealth) card..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't have anyone to take care of my children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I didn't know that I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I didn't want anyone else to know I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I didn't want prenatal care..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. The doctor's office was too far away..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not get prenatal care, go to Page 4, Question 15.

14. 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 ☐ ☐

15. 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..... ☐ ☐
- d. RSV shot (given during pregnancy to protect the baby from respiratory syncytial virus) ☐ ☐

16. 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..... ☐ ☐ ☐
- b. Tdap shot..... ☐ ☐ ☐
- c. COVID-19 shot..... ☐ ☐ ☐
- d. RSV shot ☐ ☐ ☐

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

☐ No

☐ Yes

18. The following statements are about the care of your teeth during your most recent pregnancy. For each one, check **No or **Yes**.**

No Yes

- a. I knew it was important to care for my teeth and gums during my pregnancy ☐ ☐
- b. A dental or other healthcare provider talked with me about how to care for my teeth and gums..... ☐ ☐
- c. I knew it was safe to go to the dentist during pregnancy ☐ ☐
- d. I had insurance to cover dental care during my pregnancy ☐ ☐
- e. I needed to see a dentist for a **problem**.. ☐ ☐
- f. I went to a dentist or dental clinic about a **problem**..... ☐ ☐

19. 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 *this* pregnancy) ☐ ☐
- b. High blood pressure (that **started** during *this* pregnancy), pre-eclampsia, or eclampsia ☐ ☐
- c. Depression ☐ ☐
- d. Anxiety ☐ ☐

If you had high blood pressure before or during your pregnancy, go to Question 20. If you didn't, go to Question 21.

20. 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 ☐ ☐
- b. Tell me to regularly check my blood pressure **during** pregnancy ☐ ☐
- c. Talk to me about getting to a healthy weight **after** pregnancy ☐ ☐
- d. Talk to me about regularly checking my blood pressure **after** pregnancy ☐ ☐
- e. Talk to me about the risk for having high blood pressure (chronic hypertension) and heart disease **after** pregnancy ☐ ☐

21. 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 23**

☐ Yes

Go to Question 22

22. 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) ☐ ☐
- b. Websites or social media (such as Facebook, Instagram, or X/Twitter) ☐ ☐
- c. Any source of information that used the slogan "**Hear Her**" (such as websites, social media, or paper handouts) ☐ ☐
- d. Family or friends ☐ ☐

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

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

☐ No —————→ **Go to Page 6, Question 27**

☐ Yes

24. 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

25. 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

26. 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

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

- ☐ No → **Go to Question 31**
- ☐ Yes

28. 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

29. 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

30. 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.

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

No Yes

- a. The first 3 months of pregnancy (1st trimester)? *This includes the time before knowing you were pregnant*..... ☐ ☐
- b. The second 3 months of pregnancy (2nd trimester)? ☐ ☐
- c. The last 3 months of pregnancy (3rd trimester)? ☐ ☐

If you did not have any alcoholic drinks during your pregnancy, go to Question 33.

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

No Yes

- a. The first 3 months of pregnancy (1st trimester)? *This includes the time before knowing you were pregnant*..... ☐ ☐
- b. The second 3 months of pregnancy (2nd trimester)? ☐ ☐
- c. The last 3 months of pregnancy (3rd trimester)? ☐ ☐

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

33. 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"/> |

34. 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
☐ Never

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

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

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

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

AFTER PREGNANCY

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

37. 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"/> |

38. 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 Page 8, Question 41

39. Is your baby alive now?

- ☐ No
☐ Yes

**We are very sorry for your loss.
Go to Page 9, Question 48**

Go to Page 8, Question 40

40. Is your baby living with you now?

☐ No  **Go to Question 48**

☐ Yes


41. 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 was not born in a hospital, go to Question 43.

42. During your hospital stay after your new baby was born, did any of the following things happen? For each one, check No or Yes.**No Yes**


- a. Hospital staff talked to me about how to breastfeed (how often and long to breastfeed) ☐ ☐
- b. My baby stayed in the same room with me at the hospital..... ☐ ☐
- c. Hospital staff helped me learn how to breastfeed ☐ ☐
- d. I breastfed as soon as possible after my baby was born ☐ ☐
- e. My baby was placed in skin-to-skin contact as soon as possible after birth ☐ ☐
- f. My baby was fed only breast milk at the hospital..... ☐ ☐
- g. Hospital staff helped me recognize when my baby was hungry..... ☐ ☐
- h. The hospital gave me a gift pack with formula ☐ ☐
- i. The hospital gave me information about who I could contact for breastfeeding support when I left the hospital..... ☐ ☐

If your baby is still in the hospital, go to Question 48.

43. 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 ☐ ☐
- b. On their back..... ☐ ☐
- c. On their stomach ☐ ☐

44. 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 46**45. In the *past 2 weeks*, was your baby's crib or bed in the same room where you or another adult slept?**

- ☐ No
☐ Yes

46. 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 ☐ ☐
- b. On a twin or larger mattress or bed ☐ ☐
- c. On a couch, sofa, or armchair..... ☐ ☐
- d. In an infant car seat..... ☐ ☐
- e. In a swing, rocker, or other inclined sleeper ☐ ☐
- f. In an in-bed sleeper ☐ ☐
- g. In a baby board or cradleboard ☐ ☐
- h. Other ☐ ☐

Please tell us:

47. 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:

If your baby was not born in a hospital, go to Question 49.

48. During your hospital stay after your new baby was born, did a healthcare provider do any of the following things?

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

- | | No | Yes |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Talked with me about birth control methods I can use after giving birth | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tied or blocked my tubes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Placed an IUD..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Placed a contraceptive implant in my arm | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Gave me a contraceptive shot/injection .. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Gave me or prescribed a contraceptive method for me to start at a later time (such as birth control pills, patch, ring)..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

- ☐ No
☐ Yes

Go to Question 51

- ☐ I'm pregnant now

Go to Page 10, Question 52

Go to Question 50

50. 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 52.

51. 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:

52. 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

☐ Yes

→ **Go to Question 54**

53. Did any of these things keep you from having a postpartum checkup?

Check ALL that apply

- ☐ I didn't know I needed one
- ☐ I didn't have enough money or insurance to pay for the visit
- ☐ I felt fine and didn't think I needed to have a visit
- ☐ I couldn't get an appointment when I wanted one
- ☐ I didn't have any transportation to get to the clinic or doctor's office
- ☐ I had too many other things going on
- ☐ I couldn't take time off from work or school
- ☐ I didn't have anyone to take care of my children
- ☐ The doctor's office was too far away
- ☐ Other → Please tell us:

If you did not have a postpartum checkup, go to Question 55.

54. 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..... ☐ ☐

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

59. 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 ☐ ☐

60. 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 63**
- ☐ Yes

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

- ☐ No
- ☐ Yes —————→ **Go to Question 63**

Go to Question 62

62. 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:

OTHER EXPERIENCES

The next questions are on a variety of topics.

63. 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

64. 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"/> |

65. During your most recent pregnancy, did you take or use any of the following medications or drugs for any reason? Your answers are strictly confidential.

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

- | | No | Yes |
|--------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Medication for depression..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Medication for anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Adderall®, Ritalin®, or another stimulant .. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Benzodiazepines (Valium®, Ativan®, Xanax®) or Tranquilizers (downers or ludes) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Methadone, Subutex®, Suboxone®, or buprenorphine | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Naloxone..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Marijuana or cannabis in any form (not including hemp or CBD-only products)... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. CBD products | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Synthetic marijuana (K2 or Spice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Kratom | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Fentanyl or heroin (smack, junk, Black Tar or Chiva) | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Amphetamines (uppers, speed, crystal meth, crank, ice or <i>agua</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Cocaine (crack, rock, coke, blow, snow or <i>nieve</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, or bath salts) | <input type="checkbox"/> | <input type="checkbox"/> |

66. During your most recent pregnancy, did you feel you *needed* any of the following services?

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

- | | No | Yes |
|--------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. SNAP (the Supplemental Nutrition Assistance Program) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Counseling for family or personal problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help to quit smoking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help to reduce violence in my home | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Help to quit using drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Assistance with housing or rent | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

67. 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 spouse or partner
- ☐ My mother, father, or in-laws
- ☐ Other family member or relative
- ☐ A friend
- ☐ Religious community
- ☐ Neighbors
- ☐ Someone else —————→ Please tell us:

- ☐ No one would have helped me

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

☐ No —————→ **Go to Question 71**

☐ Yes

69. 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 —————→ **Go to Question 71**

70. How many weeks or months of leave, in total, did you take or will you take?

Write ONE answer

☐ Less than 1 week

week(s) **OR**

month(s)

71. 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 ☐ ☐

b. During the birth of my new baby ☐ ☐

c. Since my new baby was born ☐ ☐

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

☐ Always

☐ Often

☐ Sometimes

☐ Rarely

☐ Never

73. 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 ☐ ☐

b. My disability status ☐ ☐

c. My immigration status ☐ ☐

d. My age ☐ ☐

e. My weight ☐ ☐

f. My income ☐ ☐

g. My sex ☐ ☐

h. My sexual orientation ☐ ☐

i. My religion ☐ ☐

j. My language or accent ☐ ☐

k. My type or lack of health insurance ☐ ☐

l. My use of substances (alcohol, tobacco, or other drugs) ☐ ☐

m. My involvement with the justice system (jail or prison) ☐ ☐

n. Another reason ☐ ☐

Please tell us:

74. 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

75. 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"/> |

76. What is your living situation today?

Check ONE answer

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I'm worried about losing it in the future
- ☐ I don't have a steady place to live (I'm temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

77. The next questions are about things that may have happened to you during your childhood, before your 18th birthday.

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

- | | No | Yes |
|-----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Did you live with someone who was depressed, mentally ill, or suicidal? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did you live with someone who had a problem with alcohol or drug use?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Were you separated from a parent or guardian because they went to jail, prison, or a detention center? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Did your parents or other adults in your home slap, hit, kick, punch, or beat each other up? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Did a parent or other adult in your home hit, beat, kick, or physically hurt you in any way? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Did a parent or other adult in your home swear at you, insult you, or put you down? | <input type="checkbox"/> | <input type="checkbox"/> |

Before your 18th birthday...

No Yes

- g. Did an adult or person at least 5 years older than you ever make you do sexual things that you didn't want to do (such as kissing, touching, or having sexual intercourse)?
- h. Was there an adult in your household who tried hard to make sure your basic needs were met, such as looking after your safety and making sure you had clean clothes and enough to eat?

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

78. 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

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

Number of people _____

80. 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 Wisconsin healthier.

