

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. How tall are you without shoes?

Feet Inches

OR Centimeters

2. Just before you got pregnant with your new baby, how much did you weigh?

Pounds OR Kilos

3. What is your date of birth?

/ /
Month Day Year

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

4. Before you got pregnant with your new baby, did you ever have any other babies who were born alive?

No Yes

Go to Question 6

5. Was the baby just before your new one born earlier than 3 weeks before his or her due date?

No
 Yes

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

- Excellent
 Very good
 Good
 Fair
 Poor

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

8. During the month before you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

- I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the month before I got pregnant
 1 to 3 times a week
 4 to 6 times a week
 Every day of the week

9. In the 12 months before you got pregnant with your new baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?

No Yes

Go to Page 2, Question 12

Go to Page 2, Question 10

10. What type of health care visit did you have in the 12 months before you got pregnant with your new baby?

Check ALL that apply

- Regular checkup at my family doctor's office
- Regular checkup at my OB/GYN's office
- Visit for an illness or chronic condition
- Visit for an injury
- Visit for family planning or birth control
- Visit for depression or anxiety
- Visit to have my teeth cleaned by a dentist or dental hygienist
- Other _____ → Please tell us:

11. During any of your health care visits in the 12 months before you got pregnant, did a doctor, nurse, or other health care worker do any of the following things? For each item, check **No if they did not or **Yes** if they did.**

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Talk to me about how I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about your health insurance coverage before, during, and after your pregnancy with your new baby.

12. 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 from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid or BadgerCare Plus (ForwardHealth)
- TRICARE or other military health care
- Indian Health Service or other tribal health care
- Other health insurance → Please tell us:

- I did not have any health insurance during the *month before* I got pregnant

13. During your *most recent pregnancy*, what kind of health insurance did you have for your prenatal care?

Check ALL that apply

- I did not go for prenatal care → **Go to Question 14**
- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid or BadgerCare Plus (ForwardHealth)
- TRICARE or other military health care
- Indian Health Service or other tribal health care
- Other health insurance → Please tell us:

- I did not have any health insurance for my *prenatal care*

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

Check ALL that apply

- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid or BadgerCare Plus (ForwardHealth)
- TRICARE or other military health care
- Indian Health Service or other tribal health care
- Other health insurance —→ Please tell us:

- I do not have health insurance *now*

15. 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 the prenatal care you received during your most recent pregnancy. Prenatal care includes visits to a doctor, nurse, or other health care worker before your baby was born to get checkups and advice about pregnancy. (It may help to look at the calendar when you answer these questions.)

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

{ Weeks OR Months

- I didn't go for prenatal care —→

Go to Page 4, Question 18

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

- No
- Yes —→

Go to Page 4, Question 19

Go to Page 4, Question 18

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

- | | 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 would not start care as early as I wanted..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid or 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"/> |

If you did not get prenatal care, go to Question 21.

19. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the things listed below? For each item, check **No** if they did not ask you about it or **Yes** if they did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. If I knew how much weight I should gain during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If I was taking any prescription medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. If I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was using drugs such as marijuana, cocaine, crack, or meth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I wanted to be tested for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I planned to breastfeed my new baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If I planned to use birth control after my baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

21. During the 12 months before the *delivery* of your new baby, did a doctor, nurse, or other health care worker offer you a flu shot or tell you to get one?

- No
 Yes

22. During the 12 months *before the delivery* of your new baby, did you get a flu shot?

Check ONE answer

- No
 Yes, before my pregnancy
 Yes, during my pregnancy

23. During your most recent pregnancy, did you get a Tdap shot or vaccination? A Tdap vaccination is a tetanus booster shot that also protects against pertussis (whooping cough).

- No
 Yes
 I don't know

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

- No
 Yes

25. This question is about other care of your teeth *during your most recent pregnancy*. For each item, check **No** if it is not true or does not apply to you or **Yes** if it is true.

No Yes

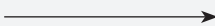
- a. I knew it was important to care for my teeth and gums during my pregnancy.....
- b. A dental or other health care worker talked with me about how to care for my teeth and gums.....
- c. I had insurance to cover dental care during my pregnancy.....
- d. I needed to see a dentist for a **problem**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

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

No Yes

- a. I could not find a dentist or dental clinic that would take pregnant patients
- b. I could not find a dentist or dental clinic that would take Medicaid patients
- c. I did not think it was safe to go to the dentist during pregnancy.....
- d. I could not afford to go to the dentist or dental clinic.....

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

- No  **Go to Question 29**
 Yes

28. 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

29. During your most recent pregnancy, 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. Gestational diabetes (diabetes that **started** during *this* pregnancy)
- b. High blood pressure (that **started** during *this* pregnancy), pre-eclampsia or eclampsia.....
- c. Depression
- d. Anemia

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

- No
 Yes
 I don't know

The next questions are about smoking cigarettes around the time of pregnancy (before, during, and after).

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

- No —————> **Go to Question 37**
 Yes

32. In the *3 months before* you got pregnant, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- 41 cigarettes or more
 21 to 40 cigarettes
 11 to 20 cigarettes
 6 to 10 cigarettes
 1 to 5 cigarettes
 Less than 1 cigarette
 I didn't smoke then

33. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- 41 cigarettes or more
 21 to 40 cigarettes
 11 to 20 cigarettes
 6 to 10 cigarettes
 1 to 5 cigarettes
 Less than 1 cigarette
 I didn't smoke then

If you did not smoke at any time in the *3 months before* you got pregnant, go to Question 36.

34. Did you quit smoking around the time of *your most recent pregnancy*?

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

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

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

Please tell us:

36. How many cigarettes do you smoke on an average day *now*? A pack has 20 cigarettes.

- 41 cigarettes or more
 21 to 40 cigarettes
 11 to 20 cigarettes
 6 to 10 cigarettes
 1 to 5 cigarettes
 Less than 1 cigarette
 I don't smoke now

The next questions are about using other tobacco products around the time of pregnancy.

E-cigarettes (electronic cigarettes) and other electronic nicotine products (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.

A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

37. Have you used any of the following products in the *past 2 years*? For each item, check **No** if you did not use it or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. E-cigarettes or other electronic nicotine products..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hookah..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 38. Otherwise, go to Question 40.

38. During the 3 months before you got pregnant, on average, how often did you use e-cigarettes or other electronic nicotine products?

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

39. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes or other electronic nicotine products?

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

The next questions are about drinking alcohol around the time of pregnancy.

40. Have you had any alcoholic drinks in the *past 2 years*? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

- No → **Go to Page 8, Question 42**

Yes

41. During the 3 months before you got pregnant, how many alcoholic drinks did you have in an average week?

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

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

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

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

43. 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

44. 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

45. 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

46. 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 person, check **No** if they did not hurt you during this time or **Yes** if they did.

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

47. 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 person, check **No** if they did not hurt you during this time or **Yes** if they did.

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

48. During your most recent pregnancy, did any of the following things happen to you? For each thing, check **No** if it did not happen to you or **Yes** if it did.

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

AFTER PREGNANCY

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

49. When was your new baby born?

	/		/	20
Month		Day		Year

50. After your baby was delivered, how long did he or she stay in the hospital?

- Less than 24 hours (less than 1 day)
- 24 to 48 hours (1 to 2 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 53

51. Is your baby alive now?

- No → We are very sorry for your loss. Go to Page 11, Question 65
- Yes

Go to Question 52

52. Is your baby living with you now?

- No → Go to Page 11, Question 63
- Yes

53. Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources? For each one, check **No** if you did not receive information from this source or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. My doctor | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A nurse, midwife, or doula | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A breastfeeding or lactation specialist | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My baby's doctor or health care provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A breastfeeding support group..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A breastfeeding hotline or toll-free number..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:

54. Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time?

- No → Go to Page 10, Question 58
- Yes

55. Are you currently breastfeeding or feeding pumped milk to your new baby?

- No
- Yes → Go to Page 10, Question 57

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

- Less than 1 week
- Weeks **OR** Months

If your baby was not born in a hospital, go to Question 58.

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

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

If your baby is still in the hospital, go to Question 63.

58. In which *one* position do you *most often* lay your baby down to sleep now?

Check ONE answer

- On his or her side
 On his or her back
 On his or her stomach

59. In the *past 2 weeks*, how often has your new baby slept alone in his or her own crib or bed?

- Always
 Often
 Sometimes
 Rarely
 Never

Go to Question 61

60. When your new baby sleeps alone, is his or her crib or bed in the same room where *you* sleep?

- No
 Yes

61. Listed below are some more things about how babies sleep. How did your new baby *usually* sleep in the *past 2 weeks*? For each item, check **No** if your baby did not *usually* sleep like this or **Yes** if he or she did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. In a crib, bassinet, or pack and play | <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 or swing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a sleeping sack or wearable blanket.... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. With a blanket..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. With toys, cushions, or pillows, including nursing pillows | <input type="checkbox"/> | <input type="checkbox"/> |
| h. With crib bumper pads (mesh or non-mesh) | <input type="checkbox"/> | <input type="checkbox"/> |

62. Did a doctor, nurse, or other health care worker tell you any of the following things?

For each thing, check **No** if they did not tell you or **Yes** if they did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Place my baby on his or her back to sleep | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Place my baby to sleep in a crib, bassinet, or pack and play | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Place my baby's crib or bed in my room .. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What things should and should not go in bed with my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

- No —————→ **Go to Question 65**
 Yes



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

- 1 time
 2 to 4 times
 5 or more times

65. Are you or your husband or partner doing anything now to keep from getting pregnant?

Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- No
 Yes —————→ **Go to Question 67**



66. What are your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant now?

Check ALL that apply

- I want to get pregnant
 I am pregnant now
 I had my tubes tied or blocked
 I don't want to use birth control
 I am worried about side effects from birth control
 I am not having sex
 My husband or partner doesn't want to use anything
 I have problems paying for birth control
 Other —————→ Please tell us:

If you or your husband or partner is not doing anything to keep from getting pregnant now, go to Question 68.

67. 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 blocked (female sterilization or Essure®)
 Vasectomy (male sterilization)
 Birth control pills
 Condoms
 Shots or injections (Depo-Provera®)
 Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
 IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
 Contraceptive implant in the arm (Nexplanon® or Implanon®)
 Natural family planning (including rhythm method)
 Withdrawal (pulling out)
 Not having sex (abstinence)
 Other —————→ Please tell us:

68. Since your new baby was born, have you had a postpartum checkup for yourself? A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.

- No
 Yes —————→ **Go to Page 12, Question 70**

Go to Page 12, Question 69

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

Check ALL that apply

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

If you did not have a postpartum checkup, go to Question 71.

70. During your postpartum checkup, did a doctor, nurse, or other health care worker do any of the following things? For each item, check **No if they did not do it or **Yes** if they did.**

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid ... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about healthy eating, exercise, and losing weight gained during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about how long to wait before getting pregnant again | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about birth control methods I can use after giving birth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Ask me if I was smoking cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if I was feeling down or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Test me for diabetes | <input type="checkbox"/> | <input type="checkbox"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

OTHER EXPERIENCES

The next questions are on a variety of topics.

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Over-the-counter pain relievers such as aspirin, acetaminophen, Tylenol®, Advil®, or Aleve® | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Marijuana or hash..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Methadone, naloxone, subutex, or Suboxone® | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heroin (smack, junk, Black Tar) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Amphetamines (uppers, speed, crystal meth, crank, ice, <i>agua</i>)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Cocaine (crack, rock, coke, blow, snow, <i>nieve</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Tranquilizers (downers, ludes) | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Over-the-counter pain relievers such as aspirin, acetaminophen, Tylenol®, Advil®, or Aleve® | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Marijuana or hash..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Methadone, naloxone, subutex, or Suboxone® | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heroin (smack, junk, Black Tar) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Amphetamines (uppers, speed, crystal meth, crank, ice, <i>agua</i>)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Cocaine (crack, rock, coke, blow, snow, <i>nieve</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Tranquilizers (downers, ludes)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

Check ALL that apply

- My husband or partner
- My mother, father, or in-laws
- Other family member or relative
- A friend
- Religious community
- Someone else _____ → Please tell us:

- No one would have helped me

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

Check ALL that apply

- My husband or partner
- My mother, father, or in-laws
- Other family member or relative
- A friend
- Religious community
- Someone else _____ → Please tell us:

- No one would help me

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

- No _____ → **Go to Page 14, Question 82**
- Yes

78. Have you returned to the job you had during your most recent pregnancy?

Check ONE answer

- No, and I do not plan to return _____ → **Go to Page 14, Question 82**
- No, but I will be returning
- Yes

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

Check ALL that apply

- I took *paid* leave from my job
- I took *unpaid* leave from my job
- I did not take any leave _____ → **Go to Page 14, Question 81**

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

- Weeks **OR** Months
 Less than 1 week

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

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

82. Did your baby's father take leave from work *after* your new baby was born?

Check ONE answer

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

83. 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

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

84. During the 12 months before your new baby was born, what was your yearly total household income before taxes? Include your income, your husband's 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 now getting.*

- \$0 to \$16,000
 \$16,001 to \$20,000
 \$20,001 to \$24,000
 \$24,001 to \$28,000
 \$28,001 to \$32,000
 \$32,001 to \$40,000
 \$40,001 to \$48,000
 \$48,001 to \$57,000
 \$57,001 to \$60,000
 \$60,001 to \$73,000
 \$73,001 to \$85,000
 \$85,001 or more

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

People

86. What is today's date?

/ / 20
 Month Day Year

These last questions are about you.

S1. 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 am worried about losing it in the future
- I do not have a steady place to live (I am 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)

S2. During the last 12 months, was there a time when you were not able to pay your mortgage, rent, or utility bills?

- No
- Yes

S3. During the last 12 months, how often did the food that you bought not last, and you didn't have money to get more? Was that...

- Always
- Usually
- Sometimes
- Rarely
- Never

S4. During the last 12 months, how often were you unable to afford to eat balanced meals?

A balanced meal includes all the types of food that you think should be in a healthy meal. For example, a starch like potatoes or rice, vegetables or fruit, and some protein like meat, fish, cheese, or eggs.

- Always
- Usually
- Sometimes
- Rarely
- Never

S5. During the last 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

- No
- Yes

S6. During the last 12 months, how often did your doctors, nurses, or other health providers explain things about your health in a way that was easy to understand?

- Always
- Usually
- Sometimes
- Rarely
- Never

S7. Since your new baby was born, have you felt that you have 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 Page 16, Question S10
- Yes

S8. Were you able to get the mental health services that you needed?

- No
- Yes → Go to Page 16, Question S10

Go to Page 16, Question S9

S9. 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
- My health insurance does not cover any type of mental health treatment or counseling
- My health insurance does not pay enough for mental health treatment or counseling
- I did not know where to go to get services
- I was concerned that the information I gave the counselor 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 job, childcare, or other commitments)
- Some other reason —————> Please tell us:

S10. During your life, how often have you felt that you were treated badly or unfairly because of your race or ethnicity?

- Always
- Usually
- Sometimes
- Rarely
- Never

S11. During the last 12 months, how often would you say you get the social and emotional support you need?

- Always
- Usually
- Sometimes
- Rarely
- Never

S12. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because their mind is troubled all the time.

Within the last 30 days, how often have you felt this kind of stress?

- Always
- Usually
- Sometimes
- Rarely
- Never

Please use this space for any additional comments you would like to make about your experiences around the time of your pregnancy or the health of mothers and babies in Wisconsin.

Thanks for answering our questions!

Your answers will help us work to keep mothers and babies in Wisconsin healthy.

