Michigan Department of Health and Human Services
Division of Family and Community Health

Michigan PRAMS

PREGNANCY RISK ASSESSMENT MONITORING SYSTEM

A Survey of the Health of Mothers and Babies in Michigan

For further information, please call or email:

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Maternal and Child Health Epidemiology Section

333 South Grand Ave, Lansing MI 48933

2016

January

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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. 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)	❑	❑
b.	High blood pressure or hypertension	❑	❑
c.	Depression	❑	❑
d.	Asthma	❑	❑
e.	Anemia (poor blood, low iron)	❑	❑
f.	Heart problems	❑	❑
g.	Epilepsy (seizures)	❑	❑
h.	Thyroid problems	❑	❑
i.	PCOS (polycystic ovarian syndrome)	❑	❑
j.	Anxiety	❑	❑

5. 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

6. 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 → **Go to Page 2, Question 9**
- ❑ Yes

Go to Page 2, Question 7

7. 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:

_____

8. 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	❑	❑
b.	Talk to me about maintaining a healthy weight	❑	❑
c.	Talk to me about controlling any medical conditions such as diabetes or high blood pressure	❑	❑
d.	Talk to me about my desire to have or not have children	❑	❑
e.	Talk to me about using birth control to prevent pregnancy	❑	❑
f.	Talk to me about how I could improve my health before a pregnancy	❑	❑
g.	Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis	❑	❑
h.	Ask me if I was smoking cigarettes	❑	❑
i.	Ask me if someone was hurting me emotionally or physically	❑	❑
j.	Ask me if I was feeling down or depressed	❑	❑
k.	Ask me about the kind of work I do	❑	❑
l.	Test me for HIV (the virus that causes AIDS)	❑	❑

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

9. 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 Michigan Health Insurance Marketplace or HealthCare.gov
- ❑ Medicaid
- ❑ Healthy Michigan Plan
- ❑ Plan First!
- ❑ TRICARE or other military health care
- ❑ Indian Health Service (IHS) or other tribal program
- ❑ Other health insurance ⟶ Please tell us:

_____

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

10. 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 11**
- ❑ 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 Michigan Health Insurance Marketplace or HealthCare.gov
- ❑ Medicaid
- ❑ Maternal Outpatient Medical Services (MOMS)
- ❑ TRICARE or other military health care
- ❑ Indian Health Service (IHS) or other tribal program
- ❑ Other health insurance → Please tell us:

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

11. 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 Michigan Health Insurance Marketplace or HealthCare.gov
- ❑ Medicaid
- ❑ Healthy Michigan Plan
- ❑ Plan First!
- ❑ TRICARE or other military health care
- ❑ Indian Health Service (IHS) or other tribal program
- ❑ Other health insurance → Please tell us:

  _____
- ❑ I do not have health insurance *now*

12. 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

13. When you got pregnant with your new baby, were you trying to get pregnant?

- ❑ No
- ❑ Yes → **Go to Page 4, Question 17**

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

- ❑ No
- ❑ Yes → **Go to Page 4, Question 16**

15. What were your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant?

Check ALL that apply

- ❑ I didn't mind if I got pregnant
- ❑ I thought I could not get pregnant at that time
- ❑ I had side effects from the birth control method I was using
- ❑ I had problems getting birth control when I needed it
- ❑ I thought my husband or partner or I was sterile (could not get pregnant at all)
- ❑ My husband or partner didn't want to use anything
- ❑ I forgot to use a birth control method
- ❑ Other → Please tell us:

  _____

If you or your husband or partner was not doing anything to keep from getting pregnant, go to Question 17.

16. What method of birth control were you using when you got pregnant?

Check ALL that apply

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

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.)

17. 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 Question 19**

Go to Question 18

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

- ❑ No
- ❑ Yes → **Go to Question 20**

19. 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	❑	❑
b.	I didn't have enough money or insurance to pay for my visits	❑	❑
c.	I didn't have any transportation to get to the clinic or doctor's office	❑	❑
d.	The doctor or my health plan would not start care as early as I wanted	❑	❑
e.	I had too many other things going on	❑	❑
f.	I couldn't take time off from work or school	❑	❑
g.	I didn't have my Medicaid or MOMS card	❑	❑
h.	I didn't have anyone to take care of my children	❑	❑
i.	I didn't know that I was pregnant	❑	❑
j.	I didn't want anyone else to know I was pregnant	❑	❑
k.	I didn't want prenatal care	❑	❑

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

20. *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	❑	❑
b. If I was taking any prescription medication	❑	❑
c. If I was smoking cigarettes	❑	❑
d. If I was drinking alcohol	❑	❑
e. If someone was hurting me emotionally or physically	❑	❑
f. If I was feeling down or depressed	❑	❑
g. If I was using drugs such as marijuana, cocaine, crack, or meth	❑	❑
h. If I wanted to be tested for HIV (the virus that causes AIDS)	❑	❑
i. If I planned to breastfeed my new baby	❑	❑
j. If I planned to use birth control after my baby was born	❑	❑

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. 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. Kidney or bladder (urinary tract) infection (UTI)	❑	❑
e. ***Severe*** nausea, vomiting, or dehydration that sent me to the doctor or hospital	❑	❑

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

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

- ❑ No → **Go to Page 6, Question 30**
- ❑ Yes

27. 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

28. 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

29. 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.

30. 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	❑	❑
b. Hookah	❑	❑

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 31. Otherwise, go to Question 33.

31. 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

32. 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.

33. 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 Question 35**
- ❑ Yes

34. 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.

35. 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	❑	❑
b.	I got separated or divorced from my husband or partner	❑	❑
c.	I moved to a new address	❑	❑
d.	I was homeless or had to sleep outside, in a car, or in a shelter	❑	❑
e.	My husband or partner lost their job	❑	❑
f.	I lost my job even though I wanted to go on working	❑	❑
g.	My husband, partner, or I had a cut in work hours or pay	❑	❑
h.	I was apart from my husband or partner due to military deployment or extended work-related travel	❑	❑
i.	I argued with my husband or partner more than usual	❑	❑
j.	My husband or partner said they didn't want me to be pregnant	❑	❑
k.	I had problems paying the rent, mortgage, or other bills	❑	❑
l.	My husband, partner, or I went to jail	❑	❑
m.	Someone very close to me had a problem with drinking or drugs	❑	❑
n.	Someone very close to me died	❑	❑
o.	I had to live with a friend or family member	❑	❑

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

		No	Yes
a.	My husband or partner	❑	❑
b.	My ex-husband or ex-partner	❑	❑
c.	Another family member	❑	❑
d.	Someone else	❑	❑

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

		No	Yes
a.	My husband or partner	❑	❑
b.	My ex-husband or ex-partner	❑	❑
c.	Another family member	❑	❑
d.	Someone else	❑	❑

AFTER PREGNANCY

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

38. When was your new baby born?

____ / ____ / 20____

Month Day Year

39. 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 42**

40. Is your baby alive now?

- ❑ No → *We are very sorry for your loss.* **Go to Page 10, Question 55**
- ❑ Yes

41. Is your baby living with you now?

- ❑ No → **Go to Page 10, Question 55**
- ❑ Yes

42. *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	❑	❑
b.	A nurse, midwife, or doula	❑	❑
c.	A breastfeeding or lactation specialist	❑	❑
d.	My baby's doctor or health care provider	❑	❑
e.	A breastfeeding support group	❑	❑
f.	A breastfeeding hotline or toll-free number	❑	❑
g.	Family or friends	❑	❑
h.	Other	❑	❑

Please tell us:

_____

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

- ❑ No
- ❑ Yes → **Go to Question 45**

44. What were your reasons for not breastfeeding your new baby?

Check ALL that apply

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

_____

If you did not breastfeed your new baby, go to Question 50.

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

- ❑ No
- ❑ Yes → **Go to Question 48**

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

- ❑ Less than 1 week

_____ Weeks **OR** _____ Months

47. What were your reasons for stopping breastfeeding?

Check ALL that apply

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

48. Have you used a breast pump to express milk to feed to your new baby?

- ❑ No → **Go to Question 50**
- ❑ Yes

49. Where did you get the breast pump or pumps that you use with your new baby?

Check ALL that apply

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

If your baby is still in the hospital, go to Page 10, Question 55.

50. 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

51. 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 53**

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

- ❑ No
- ❑ Yes

53. 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	❑	❑
b.	On a twin or larger mattress or bed	❑	❑
c.	On a couch, sofa, or armchair	❑	❑
d.	In an infant car seat or swing	❑	❑
e.	In a sleeping sack or wearable blanket	❑	❑
f.	With a blanket	❑	❑
g.	With toys, cushions, or pillows, including nursing pillows	❑	❑
h.	With crib bumper pads (mesh or non-mesh)	❑	❑

54. 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	❑	❑
b. Place my baby to sleep in a crib, bassinet, or pack and play	❑	❑
c. Place my baby's crib or bed in my room	❑	❑
d. What things should and should not go in bed with my baby	❑	❑
e. Place my baby alone to sleep with no other people in the sleep space	❑	❑

55. 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 57**

56. 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 <u>not doing</u> anything to keep from getting pregnant *now*, go to Question 58.

57. 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:

58. *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 → **Go to Question 60**
- ❑ Yes

Go to Question 59

59. *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	❑	❑
b.	Talk to me about healthy eating, exercise, and losing weight gained during pregnancy	❑	❑
c.	Talk to me about how long to wait before getting pregnant again	❑	❑
d.	Talk to me about birth control methods I can use after giving birth	❑	❑
e.	Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms	❑	❑
f.	Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®)	❑	❑
g.	Ask me if I was smoking cigarettes	❑	❑
h.	Ask me if someone was hurting me emotionally or physically	❑	❑
i.	Ask me if I was feeling down or depressed	❑	❑
j.	Test me for diabetes	❑	❑
k.	Ask me if I was taking prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine	❑	❑
l.	Ask me if I was taking any other prescription medications	❑	❑
m.	Ask me if I was drinking alcohol	❑	❑

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

- ❑ Always
- ❑ Often
- ❑ Sometimes
- ❑ Rarely
- ❑ Never

61. *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.

62. During the *12 months before* your new baby was born, how often did you feel that when you went to get health care you were treated worse than people of other races or cultures?

- ❑ Never
- ❑ Sometimes
- ❑ Usually
- ❑ Always
- ❑ I did not get health care then

63. During *your most recent* pregnancy, which of the following statements about basic needs applied to you? For each item, check **No** if it was not true or **Yes** if it was.

		No	Yes
a.	I had affordable, reliable transportation	❑	❑
b.	I skipped meals or ate less because there wasn't enough money for food	❑	❑
c.	I had safe housing	❑	❑
d.	I had consistent and stable housing	❑	❑
e.	My house or apartment was too crowded	❑	❑
f.	I could keep basic utility services on (heat, water, lights)	❑	❑
g.	I had access to a telephone when needed	❑	❑
h.	I had other basic needs that were not met	❑	❑

Please tell us:

_____

If your baby is not alive, is not living with you, or is still in the hospital, go to Question 69.

64. Which of the following people spend time taking care of your new baby when you are at school, work, or appointments?

Check ALL that apply

- ❑ My husband or partner
- ❑ Baby's grandparent
- ❑ Other close family member or relative
- ❑ Friend or neighbor
- ❑ Babysitter, nanny, or other child care provider
- ❑ Staff at day care center
- ❑ Other → Please tell us:

_____

- ❑ My baby is always with me while I am at school, work, or appointments

65. How many hours and minutes in the last week was your new baby in an enclosed space, such as a room or a vehicle, with someone who was smoking?

_____ Hours _____ Minutes

66. What are your plans for vaccinating your new baby?

Check ONE answer

- ❑ My baby will be vaccinated the way my doctor recommends
- ❑ My baby will get every vaccine, but at different times than my doctor recommends
- ❑ My baby will get only some of the recommended vaccines
- ❑ My baby will not get vaccines

67. Please mark each statement as true or false for your baby.

	True	False
a. My baby received breast milk from a source other than me	❑	❑
b. My baby has a doctor, nurse, or medical practice where he or she is seen on a regular basis	❑	❑
c. My baby will see a dentist by his or her first birthday	❑	❑

68. In the *last week*, how much time, on average, did you spend sleeping each night?

- ❑ 0-3 hours
- ❑ 4-6 hours
- ❑ 7-8 hours
- ❑ 9+ hours

69. In the *last week*, how many times, on average, did you wake up each night?

_____ Times

- ❑ I don't know

70. During any of the following time periods, did you use marijuana or hash in any form? For each time period, check **No** if you did not use then or **Yes** if you did.

	No	Yes
a. During the 12 months before I got pregnant	❑	❑
b. During my most recent pregnancy	❑	❑
c. Since my new baby was born	❑	❑

71. During any of the following time periods, did you use prescription pain relievers, such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine? For each time period, check **No** if you did not use then or **Yes** if you did.

	No	Yes
a. During the 12 months before I got pregnant	❑	❑
b. During my most recent pregnancy	❑	❑
c. Since my new baby was born	❑	❑

72. The following statements are about the way you handle life events. Please check all that are true for you most of the time.

- ❑ I tend to bounce back quickly after hard times
- ❑ I have a hard time making it through stressful events
- ❑ It does not take me long to recover from a stressful event
- ❑ It is hard for me to snap back when something bad happens
- ❑ I usually come through a difficult time with little trouble
- ❑ I tend to take a long time to get over set-backs in my life

73. This question is about your husband or partner, who may or may not be the father of your new baby. Please choose the statement that best describes the current living arrangement.

- ❑ My husband or partner lives with me all of the time
- ❑ My husband or partner lives with me some of the time
- ❑ My husband or partner does not live with me
- ❑ I do not have a husband or partner → **Go to Question 75**

Go to Question 74

74. The following statements are about your husband or partner, who may or may not be the father of your baby, and the support they provide you at this time. For each one, check **No** if it is not true most of the time or **Yes** if it is true.

	No	Yes
a. My partner is someone I can count on for financial support if I need it	❑	❑
b. My partner is someone I can talk with about things that are important to me	❑	❑
c. My partner is someone who is affectionate toward me	❑	❑
d. My partner is someone who helps me care for my child(ren)	❑	❑
e. My partner is someone who understands how I am feeling	❑	❑
f. My partner is someone who talks with me and spends time with me	❑	❑
g. My partner is someone whom I can count on	❑	❑
h. My partner is someone who does things with me	❑	❑

75. Some of these things might happen to people during childhood. Childhood experiences may be important. Please tell us if any of these things ever happened to you from the time you were born through age 13.

	No	Yes
a. Most of the time, I had an adult who believed in me and who I could count on to help me	❑	❑
b. A parent or guardian I lived with got divorced or separated	❑	❑
c. We had to move because of problems paying the rent or mortgage	❑	❑
d. Someone in my family or I went hungry because we could not afford enough food	❑	❑
e. A parent or guardian got in trouble with the law or went to jail	❑	❑
f. A parent or guardian I lived with had a serious drinking or drug problem	❑	❑
g. I was in foster care (removed from my home by the court or child welfare agency)	❑	❑

76. Thinking back to your childhood through age 13, how often was it hard for your family to pay for basic needs like food or housing?

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

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

77. 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

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

_____ People

79. What is today's date?

_____ / _____ / 20_____

Month Day Year

A family medical history is a record of health information about a person and his or her close relatives. The following questions are about your family history of ovarian and breast cancer.

C1. Have any of your family members listed below who are related to you by blood had ovarian cancer? For each family member, check **No** if she has not had ovarian cancer, **Yes** if she has, or **DK** if you don't know.

Family member	Had Ovarian Cancer		
	No	Yes	DK
a. My mother	❑	❑	❑
b. My mother's mother	❑	❑	❑
c. My father's mother	❑	❑	❑

C2. Have any of your <u>other</u> family members who are related to you by blood had ovarian cancer? For each family member, check **No** if she has not had ovarian cancer, **Yes** if she has, **DK** if you don't know, or **NA** if the option does not apply to you.

Family member	Had Ovarian Cancer			
	No	Yes	DK	NA
a. Sister(s)	❑	❑	❑	❑
IF YES, how many have had ovarian cancer? _____				
b. Aunt(s)	❑	❑	❑	❑
IF YES, how many have had ovarian cancer? _____				
c. Female cousin(s)	❑	❑	❑	❑
IF YES, how many have had ovarian cancer? _____				

C3. Have any of your family members listed below who are related to you by blood had breast cancer? For each family member, check **No** if they have not had breast cancer, **Yes** if they have, or **DK** if you don't know.

Family member	Had Breast Cancer		
	No	Yes	DK
a. My mother	❑	❑	❑
b. My mother's mother	❑	❑	❑
c. My father's mother	❑	❑	❑
d. My father	❑	❑	❑
e. My mother's father	❑	❑	❑
f. My father's father	❑	❑	❑

C4. Have any of your <u>other</u> family members who are related to you by blood had breast cancer? For each family member, check **No** if they have not had breast cancer, **Yes** if they have, **DK** if you don't know, or **NA** if the option does not apply to you.

Family member	Had Breast Cancer			
	No	Yes	DK	NA
a. Sister(s)	❑	❑	❑	❑
IF YES, how many have had breast cancer? _____				
b. Brother(s)	❑	❑	❑	❑
IF YES, how many have had breast cancer? _____				
c. Aunt(s)	❑	❑	❑	❑
IF YES, how many have had breast cancer? _____				
d. Uncle(s)	❑	❑	❑	❑
IF YES, how many have had breast cancer? _____				
e. Cousin(s)	❑	❑	❑	❑
IF YES, how many have had breast cancer? _____				

C5. Has any woman in your family who is related to you by blood had breast cancer *at age 50 or younger*?

- ❑ No
- ❑ Yes
- ❑ I don't know

C6. Has any woman in your family who is related to you by blood had both breast AND ovarian cancer?

- ❑ No
- ❑ Yes
- ❑ I don't know

C7. Have any of your family members related to you by blood had bilateral breast cancer (breast cancer on both sides)?

- ❑ No
- ❑ Yes
- ❑ I don't know

C8. Do you have Ashkenazi Jewish heritage?

- ❑ No
- ❑ Yes
- ❑ I don't know

The next questions are about talking to a genetic counselor about your cancer risk. A genetic counselor is a trained professional who talks with you about the chances of having a health condition based on your family medical history.

C9. Have you ever talked to a genetic counselor about your risk for cancer based on your family history?

- ❑ No → **Go to Question C12**
- ❑ Yes

Go to Question C10

C10. What was the MAIN reason you talked to a genetic counselor about your risk for cancer?

Check ONE answer

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

C11. Thinking about your MOST RECENT visit to a genetic counselor for cancer risk, what kind of cancer was it for?

Check ALL that apply

- ❑ Breast cancer
- ❑ Ovarian cancer
- ❑ Other → Please tell us:

C12. Have you ever had genetic testing for a gene mutation connected to breast or ovarian cancer? A mutation is a change in a gene that increases the risk for hereditary cancer. Genetic testing is done by taking a sample of your saliva or blood.

- ❑ No
- ❑ Yes
- ❑ I don't know

Thank you for answering these questions!

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 Michigan.

Thanks for answering our questions!

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

For Office Use Only

Received:	___/___/___ By:___ ___ ___
Checks	M ❑ Yes ❑ No
	B ❑ Yes ❑ No
Partial	❑ <25% ❑ 25-75% ❑ >75%
Data Entry	
Data:	___/___/___ By:___ ___ ___
Comments	❑ Yes ❑ No
	___/___/___ By:___ ___ ___
Comment Page	❑ Yes ❑ No
	___/___/___ By:___ ___ ___
Verification	❑ Yes ❑ No
	___/___/___ By:___ ___ ___

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