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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) | <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. Heart problems | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| i. PCOS (polycystic ovarian syndrome)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |

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... | <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.

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..... | <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 MOMS 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.

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..... | <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"/> |

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 <i>this</i> pregnancy)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that started during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Kidney or bladder (urinary tract) infection (UTI)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Severe nausea, vomiting, or dehydration that sent me to the doctor or hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |

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
 Yes

Go to Page 6, Question 30

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..... | <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 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..... | <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"/> |
| o. I had to live with a friend or family member..... | <input type="checkbox"/> | <input type="checkbox"/> |

36. In the 12 months *before* you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each 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. Another family member..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone else..... | <input type="checkbox"/> | <input type="checkbox"/> |

37. During your most *recent* pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each 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. Another family member..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone else..... | <input type="checkbox"/> | <input type="checkbox"/> |

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.*
- Yes → **Go to Page 10, Question 55**

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..... | <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:

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 | <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"/> |

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 | <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"/> |
| e. Place my baby alone to sleep with no other people in the sleep space | <input type="checkbox"/> | <input type="checkbox"/> |

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 not doing 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
 Yes

→ **Go to Question 60**

↓
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 ... | <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"/> |
| k. Ask me if I was taking prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Ask me if I was taking any other prescription medications | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Ask me if I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |

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 .. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I skipped meals or ate less because there wasn't enough money for food | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had safe housing | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I had consistent and stable housing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My house or apartment was too crowded..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I could keep basic utility services on (heat, water, lights)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I had access to a telephone when needed | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I had other basic needs that were not met..... | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Since my new baby was born | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My partner is someone I can talk with about things that are important to me | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My partner is someone who is affectionate toward me | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My partner is someone who helps me care for my child(ren) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My partner is someone who understands how I am feeling | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My partner is someone who talks with me and spends time with me | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My partner is someone whom I can count on | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My partner is someone who does things with me | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A parent or guardian I lived with got divorced or separated | <input type="checkbox"/> | <input type="checkbox"/> |
| c. We had to move because of problems paying the rent or mortgage..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone in my family or I went hungry because we could not afford enough food..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A parent or guardian got in trouble with the law or went to jail..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A parent or guardian I lived with had a serious drinking or drug problem | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I was in foster care (removed from my home by the court or child welfare agency)..... | <input type="checkbox"/> | <input type="checkbox"/> |

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 next 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.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My mother's mother.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My father's mother.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C2. Have any of your other 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, how many have had ovarian cancer?	_____			
b. Aunt(s).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, how many have had ovarian cancer?	_____			
c. Female cousin(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My mother's mother.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My father's mother.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My father.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. My mother's father.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My father's father.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C4. Have any of your other 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, how many have had breast cancer?	_____			
b. Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, how many have had breast cancer?	_____			
c. Aunt(s).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, how many have had breast cancer?	_____			
d. Uncle(s).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, how many have had breast cancer?	_____			
e. Cousin(s).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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

The next questions are about your ability to do different activities.

D1. Do you have difficulty seeing, even when wearing glasses or contact lenses?

- No difficulty
 Some difficulty
 A lot of difficulty
 I cannot do this at all

D2. Do you have difficulty hearing, even if using a hearing aid(s)?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D3. Do you have difficulty walking or climbing steps?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D4. Do you have difficulty remembering or concentrating?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D5. Do you have difficulty with self care, such as washing all over or dressing?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

D6. Using your usual language, do you have difficulty communicating, for example, understanding or being understood?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

These final questions are about a variety of topics from around the time of pregnancy.

E1. 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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A dental or other health care worker talked with me about how to care for my teeth and gums..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had insurance to cover dental care during my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I <u>needed</u> to see a dentist for a problem .. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I <u>went</u> to a dentist or dental clinic about a problem | <input type="checkbox"/> | <input type="checkbox"/> |

E2. 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 or **Yes** if it was.

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

E3. Which of the following do you think is the most common cause of lead poisoning in children?

Check ONE answer

- Drinking water
- Paint
- Soil
- Dust
- Food
- Toys
- I don't know or I am unsure

E4. At any time during your most recent pregnancy, did you work at a job for pay?

- No → **Go to Question E8**
- Yes

E5. 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 Question E8**
- No, but I will be returning
- Yes

E6. 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

E7. 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"/> |

E8. During the 12 months before the delivery of your new baby, did you get your household tap water from a private well?

- No → **Go to Page 19, Question E11**
- Yes

E9. During the 12 months before the delivery of your new baby, did your doctor, nurse, or other health care worker talk to you about getting your household well water tested for any of the following things? For each one, check **No** if they did not talk to you about it or **Yes** if they did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Arsenic..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Lead | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Per- and polyfluoroalkyl substances (known as PFAS, pronounced pee-fas)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nitrates and / or nitrites | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Bacteria and E. Coli | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fluoride..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Copper..... | <input type="checkbox"/> | <input type="checkbox"/> |

E10. During the 12 months before the delivery of your new baby, did you have your household well water tested for any of the following things? For each one, check **No** if your water was not tested for it or **Yes** if it was.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Arsenic..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Lead | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Per- and polyfluoroalkyl substances (known as PFAS, pronounced pee-fas)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nitrates and / or nitrites | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Bacteria and E. Coli | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fluoride..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Copper..... | <input type="checkbox"/> | <input type="checkbox"/> |

E11. 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 E13**

Yes ↓

E12. During your most recent pregnancy, did the home visitor who came to your home talk with you about any of the things listed below? For each one, check **No** if they did not talk with you about it or **Yes** if they did.

No Yes

- a. How smoking during pregnancy could affect my baby
- b. How drinking alcohol during pregnancy could affect my baby
- c. Doing tests to screen for birth defects or diseases that run in my family.....
- d. The importance of getting tested for HIV or other sexually transmitted infections..
- e. Physical or emotional abuse to women by their husbands or partners.....
- f. Breastfeeding my baby.....
- g. My emotional well-being.....

E13. 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 Page 20, Question E15**

Yes ↓

E14. Since your new baby was born, did the home visitor who came to your home talk with you about any of the things listed below? For each one, check **No** if they did not talk with you about it or **Yes** if they did.

No Yes

- a. Breastfeeding my baby.....
- b. How long to wait before getting pregnant again
- c. Family planning services or using contraception.....
- d. Postpartum depression
- e. Resources in my community to support new parents.....
- f. Getting to and staying at a healthy weight after delivery
- g. How to quit or keep from smoking.....
- h. How to get the health care that my baby or I need

E15. Did you receive a Tdap vaccination before, during, or after your most recent pregnancy?

A Tdap vaccination is a shot that protects against tetanus, diphtheria, and pertussis (or whooping cough). Tdap was new in 2005.

Check ONE answer

- No
- Yes, I received Tdap *before* my pregnancy
- Yes, I received Tdap *during* my pregnancy
- Yes, I received Tdap *after* my pregnancy
- I don't know

If you had a flu shot during the 12 months before the birth of your new baby, go to question E17.

E16. What were your reasons for not getting a flu shot during the 12 months before the birth of your new baby? For each item, check **No** if it was not a reason for you or **Yes** if it was.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. My doctor didn't mention anything about a flu shot | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was worried about side effects of the flu shot for me | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I was worried that the flu shot might harm my baby | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was not worried about getting sick with the flu | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I do not think the flu shot works | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I don't normally get a flu shot | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

E17. Were you offered two HIV tests during your most recent pregnancy or delivery?

- No, I wasn't offered any HIV tests
- No, I was just offered 1 test
- Yes, I was offered 2 tests

E18. At any point during your most recent pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)?

- No
- Yes
- I don't know

Go to Question E20

E19. Why didn't you have an HIV test during your most recent pregnancy or delivery?

Check ALL that apply

- I was not offered the test
- I did not want to have the test
- I already knew my HIV status
- I did not think I was at risk for HIV
- I did not want people to think I was at risk for HIV
- I was afraid of getting the result
- I was tested *before* this pregnancy, and did not think I needed to be tested again
- Other reason _____ → Please tell us:

E20. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about how eating fish containing high levels of mercury could affect your baby?

- No
- Yes

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

A Yes No _____

Main Data Entry: ___ / ___ / ___ By: _____

Supplement Data Entry: ___ / ___ / ___ By: _____

DDE: ___ / ___ / ___ By: _____

Verification: ___ / ___ / ___ By: _____

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