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your
story

Michigan PRAMS

Telling the story of Michigan's mothers and babies

your
baby's
story

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The figure displays 12 monthly calendars for the year 2015, arranged in two rows of six. Each calendar shows the days of the month in a grid format, with the day of the week indicated by the column header. The days are numbered 1 through 31, with some days highlighted in green (e.g., 1st, 10th, 19th, 28th) and others in red (e.g., 2nd, 11th, 20th, 29th).

January							February							March							April							May							June						
Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6					1	2	3	3	4	5	6	7	8	9	1	2	3	4	5	6					1	2	3	4	2	3	4	5	6	7	8
7	8	9	10	11	12	13	4	5	6	7	8	9	10	10	11	12	13	14	15	16	7	8	9	10	11	12	13	5	6	7	8	9	10	11	9	10	11	12	13	14	15
14	15	16	17	18	19	20	11	12	13	14	15	16	17	17	18	19	20	21	22	23	14	15	16	17	18	19	20	12	13	14	15	16	17	18	16	17	18	19	20	21	22
21	22	23	24	25	26	27	18	19	20	21	22	23	24	24	25	26	27	28	29	30	21	22	23	24	25	26	27	19	20	21	22	23	24	25	23	24	25	26	27	28	29
28	29	30	31				25	26	27	28	29			31							28	29	30					26	27	28	29	30	31		30						

July							August							September							October							November							December							
Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa	Su	M	Tu	W	Th	F	Sa								
	1	2	3	4	5	6					1	2	3	1	2	3	4	5	6	7				1	2	3	4	5						1	2	1	2	3	4	5	6	7
7	8	9	10	11	12	13	4	5	6	7	8	9	10	8	9	10	11	12	13	14	6	7	8	9	10	11	12	3	4	5	6	7	8	9	8	9	10	11	12	13	14	
14	15	16	17	18	19	20	11	12	13	14	15	16	17	15	16	17	18	19	20	21	13	14	15	16	17	18	19	10	11	12	13	14	15	16	15	16	17	18	19	20	21	
21	22	23	24	25	26	27	18	19	20	21	22	23	24	22	23	24	25	26	27	28	20	21	22	23	24	25	26	17	18	19	20	21	22	23	22	23	24	25	26	27	28	
28	29	30	31				25	26	27	28	29	30	31	29	30						27	28	29	30	31			24	25	26	27	28	29	30	29	30	31					

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The information you are being asked to provide is authorized to be collected under Section 301 of The Public Health Service Act (42 USC 241). Providing this information is voluntary. CDC will use this information as part of the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data is used to inform efforts to improve health among mothers and infants. The information you give us will be kept private and will be protected under the Privacy Act (System of Records Notice 09-20-0136).

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

BEFORE PREGNANCY

The first questions are about *you*.

1. What is *your* date of birth?

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

2. How tall are *you* without shoes?

Write ONE answer

<input type="text"/>	feet	&	<input type="text"/>	inches
OR				
<input type="text"/>	centimeters			

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

Write ONE answer

<input type="text"/>	pounds	OR	<input type="text"/>	kilos
----------------------	--------	----	----------------------	-------

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

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

No Yes

- | | | |
|--|--------------------------|--------------------------|
| a. Have serious difficulty hearing, or are you deaf? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have serious difficulty seeing, even when wearing glasses, or are you blind? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have serious difficulty walking or climbing stairs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have difficulty with dressing or bathing yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

No Yes

- | | | |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes (not gestational diabetes or diabetes that starts during pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Anemia (poor blood, low iron) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| h. PCOS (polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> |

6. In the 12 months before you got pregnant with your new baby, did you have any of the following healthcare visits?
For each one, check **No** or **Yes**.

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

Please tell us:

If you did not have any healthcare visits in the 12 months before you got pregnant, go to Question 8.

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

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

The next questions are about your *health insurance*.

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

Check ALL that apply

☐ Private health insurance (paid for by me, someone else, or through a job)

☐ Medicaid

☐ Healthy Michigan Plan

☐ TRICARE or other military healthcare

☐ Indian Health Service (IHS) or other tribal program

☐ Other health insurance —→ Please tell us:

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

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

Check ALL that apply

- ☐ Private health insurance (paid for by me, someone else, or through a job)
- ☐ Medicaid
- ☐ Maternal Outpatient Medical Services (MOMS)
- ☐ TRICARE or other military healthcare
- ☐ Indian Health Service (IHS) or other tribal program
- ☐ Other health insurance —→ Please tell us:

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

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

Check ALL that apply

- ☐ Private health insurance (paid for by me, someone else, or through a job)
- ☐ Medicaid
- ☐ Healthy Michigan Plan
- ☐ TRICARE or other military healthcare
- ☐ Indian Health Service (IHS) or other tribal program
- ☐ Other health insurance —→ Please tell us:

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

11. 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

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

☐ No

☐ Yes —→

Go to Page 4, Question 16

13. When you got pregnant with your new baby, were you or your spouse or partner doing anything to keep from getting pregnant? This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

☐ No

☐ Yes —→

Go to Page 4, Question 15

14. What were your 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 couldn't get pregnant at that time
- ☐ I didn't want to use birth control
- ☐ I had side effects from the birth control method I was using
- ☐ I had problems getting birth control I wanted
- ☐ I thought my spouse or partner or I was sterile (couldn't get pregnant at all)
- ☐ My spouse or partner didn't want to use condoms
- ☐ My spouse or partner didn't want me to use birth control
- ☐ I forgot to use a birth control method
- ☐ Other —→ Please tell us:

If you were not doing anything to keep from getting pregnant, go to Page 4, Question 16.

15. What kind of birth control were you using when you got pregnant?

Check ALL that apply

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

DURING PREGNANCY

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

16. How many weeks or months pregnant were you when you were *sure* you were pregnant?
For example, you had a pregnancy test, or a healthcare provider said you were pregnant.

Write ONE answer

_____ week(s) **OR** _____ month(s)

- ☐ I don't remember

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

- ☐ No _____ → **Go to Question 20**

☐ Yes

Go to Question 18

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

Write ONE answer

_____ week(s) **OR** _____ month(s)

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

No Yes

Talk to me about...

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

Ask me...

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

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

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Flu shot..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough]) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

For each shot, check ALL that apply:

B for **3 months before** pregnancy

D for **During** pregnancy

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

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

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

- ☐ No
☐ Yes

23. Overall, during my pregnancy, I felt...

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

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

24. During your most recent pregnancy, were you on WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)?

- ☐ No → **Go to Question 26**
☐ Yes

25. When you went for WIC visits during your most recent pregnancy, did you receive information on breastfeeding?

- ☐ No
☐ Yes

26. During your most recent pregnancy, did a healthcare provider tell you that you had any of the following health conditions?
For each one, check **No** or **Yes**.

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

If you had high blood pressure before or during your pregnancy, go to Question 27. If you didn't, go to Page 6, Question 28.

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

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

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

- ☐ No
☐ Yes

→ **Go to Question 30**

29. During your most recent pregnancy, did you get information about warning signs from any of the following sources?
 For each one, check **No** or **Yes**.

No Yes

- a. A healthcare provider (such as a doctor, nurse, or midwife) ☐ ☐
- b. Websites or social media (such as Facebook, Instagram, or Twitter) ☐ ☐
- c. Any source of information that used the slogan “**Hear Her**” (such as websites, social media, or paper handouts) ☐ ☐
- d. Family or friends ☐ ☐

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

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

- ☐ No
☐ Yes

→ **Go to Question 34**

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

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

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

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

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

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

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

- ☐ No
☐ Yes

→ **Go to Question 38**

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

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

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

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

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

- ☐ No
☐ Yes

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

38. During your most recent pregnancy, did you have any alcoholic drinks during...?

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

No Yes

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

If you did not have any alcoholic drinks during your pregnancy, go to Question 40.

39. During your most recent pregnancy, did you have 4 or more alcoholic drinks in a 2-hour time span during...?

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

No Yes

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

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

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

No Yes

- a. I got separated or divorced..... ☐ ☐
- b. I was evicted or forced to move ☐ ☐
- c. I didn't have a regular place to sleep..... ☐ ☐
- d. I was homeless or had to sleep outside, in a car, or in a shelter..... ☐ ☐
- e. My spouse, partner, or I lost a job..... ☐ ☐
- f. My spouse, partner, or I had a cut in work hours or pay..... ☐ ☐
- g. I had problems paying the rent, mortgage, or other bills..... ☐ ☐
- h. My spouse or partner went to jail/prison.. ☐ ☐
- i. I went to jail/prison ☐ ☐
- j. Someone close to me had a problem with drinking or drugs ☐ ☐
- k. Someone close to me was very sick or died ☐ ☐

41. In the 12 months before you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?

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

No Yes

- a. My spouse or partner..... ☐ ☐
- b. My ex-spouse or ex-partner ☐ ☐
- c. Another family member ☐ ☐
- d. Someone else ☐ ☐

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

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

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

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

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

- ☐ Less than 3 days
- ☐ 3 to 5 days
- ☐ 6 to 14 days
- ☐ More than 14 days
- ☐ My baby was not born in a hospital
- ☐ My baby is still in the hospital —————→

Go to Question 47

Go to Question 45

45. Is your baby alive now?

- ☐ No —————→ **We are very sorry for your loss.**
☐ Yes **Go to Page 11, Question 58**

46. Is your baby living with you now?

- ☐ No —————→ **Go to Page 11, Question 58**
☐ Yes

47. Before your new baby was born, did any of the following things happen?

Check ALL that apply

- ☐ Someone answered my questions about breastfeeding
- ☐ I was offered a class on breastfeeding
- ☐ I attended a class on breastfeeding
- ☐ I decided or planned to feed *only* breast milk to my baby
- ☐ I discussed feeding *only* breast milk to my baby with my family/friends
- ☐ I discussed feeding *only* breast milk to my baby with my healthcare provider
- ☐ I decided not to breastfeed my baby

48. 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** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. One of my doctors | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A nurse or midwife..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A doula | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A breastfeeding or lactation specialist | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My baby's doctor or healthcare provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A breastfeeding support group..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. A breastfeeding hotline or toll-free number..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Websites or apps about pregnancy or infant care | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Social media (such as Facebook, Instagram, TikTok)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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

Check ONE answer

- ☐ I didn't breastfeed my baby → **Go to Page 10, Question 51**
- ☐ I breastfed my baby for less than 1 week
- ☐ I breastfed my baby for:
- _____ week(s) OR _____ month(s)
- ☐ I'm still breastfeeding or feeding pumped milk to my new baby → **Go to Page 10, Question 51**

50. What were your reasons for stopping breastfeeding?

Check ALL that apply

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

If your baby was not born in a hospital, go to Question 52.

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Hospital staff talked to me about how to breastfeed (how often and long to breastfeed) | <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. Hospital staff helped me learn how to breastfeed | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I breastfed as soon as possible after my baby was born | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My baby was placed in skin-to-skin contact as soon as possible after birth | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My baby was fed only breast milk at the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Hospital staff helped me recognize when my baby was hungry..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The hospital gave me a gift pack with formula | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The hospital gave me information about who I could contact for breastfeeding support when I left the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is still in the hospital, go to Question 58.

52. In the *past 2 weeks*, how did you place your new baby to sleep at night and during naps? For each one, check **No or **Yes**.**

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

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

- ☐ Always → **Go to Question 55**
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

54. Who does your new baby *usually* sleep with when they are not sleeping alone?

Check ALL that apply

- ☐ Me
☐ My spouse or partner
☐ A grandparent
☐ My baby's twin
☐ An older sibling
☐ Someone else → Please tell us:

If your baby never sleeps alone in their own crib or bed, go to Question 56.

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

- ☐ No
☐ Yes

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

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

57. In the *past 2 weeks*, has your new baby been placed to sleep with the following? For each one, check **No** or **Yes**.

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

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

- ☐ No
☐ Yes
☐ I'm pregnant now

Go to Question 60

Go to Page 12, Question 61

Go to Question 59

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

Check ALL that apply

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

If you're not doing anything to keep from getting pregnant now, go to Page 12, Question 61.

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

Check ALL that apply

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

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

☐ No

☐ Yes

→ **Go to Question 63**

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

Check ALL that apply

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

If you did not have a postpartum checkup, go to Question 64.

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

No Yes

Talk to me about...

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

Ask me...

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

A healthcare provider...

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

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

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

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

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

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

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

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

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

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

No Yes

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

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

For each one, check No or Yes.

No Yes

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

OTHER EXPERIENCES

The next questions are on a variety of topics.

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

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

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

For each one, check No or Yes.

No Yes

- a. Going to medical appointments ☐ ☐
 b. Going to non-medical appointments, meetings, or work ☐ ☐
 c. Doing errands ☐ ☐

72. While getting healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?
For each one, check **No** if you did not experience discrimination because of it or **Yes** if you did.

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

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

☐ Very often
☐ Somewhat often
☐ Not very often
☐ Never

74. Have you ever been treated unfairly due to your race, ethnicity, or skin color in any of the following situations?
For each one, check **No** or **Yes**.

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

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

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

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

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

Number of people

77. 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 safe housing | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I had consistent and stable housing | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My house or apartment was too crowded | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I could keep basic utility services on (heat, water, lights) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had access to a telephone when needed | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I had other basic needs that were not met | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

78. 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 79

Go to Question 80

79. 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"/> |

The next few questions are about environmental contaminants. Your environment is all of the things around you in your daily life, at home or at work. Environmental contaminants are chemicals or pollutants in the environment that do not belong there or are found at levels that may cause harmful health effects.

If your baby is not alive or not living with you, go to Question 82.

80. How concerned are you about risks to your baby's health from environmental contamination?

- ☐ Not at all concerned →
- ☐ Not very concerned
- ☐ Somewhat concerned
- ☐ Very concerned
- ☐ I don't know or I am unsure

Go to Question 82

81. What is the top environmental contamination issue you are concerned may impact your baby's health?

Check ONE answer

- ☐ Chemicals in the air you breathe, either inside or outside
- ☐ Chemicals in your household's drinking water
- ☐ Chemicals in your community, like from nearby industrial sites or dumps
- ☐ Other → Please tell us:

- ☐ I don't know or I am unsure

82. 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

83. 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

84. If you were told that you have high levels of lead in the drinking water at your home, where would you go to first for information about what you could do to protect the people in your household?

Check ONE answer

- ☐ Local or state health department
- ☐ Federal agency, like Centers for Disease Control and Prevention (CDC) or Environmental Protection Agency (EPA)
- ☐ Private business, like a water supply company or water testing lab
- ☐ Doctor or other health care worker
- ☐ Health website, like WebMD
- ☐ Social media, like Facebook or Instagram
- ☐ Other → Please tell us:

- ☐ I don't know or I am unsure

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

- ☐ No
☐ Yes

Go to Question 88

86. During the 12 months before the delivery of your new baby, did a 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 it 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 or nitrites..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Bacteria, E. coli, or coliform | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fluoride | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Copper..... | <input type="checkbox"/> | <input type="checkbox"/> |

87. 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 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 or nitrites..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Bacteria, E. coli, or coliform | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fluoride | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Copper..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

88. 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 (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 in the 12 months before the birth of your new baby go to Question 90.

89. 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:

90. During your *most recent pregnancy*, did a doctor, nurse, or other health care worker test you for Hepatitis C?

- ☐ No
☐ Yes
☐ I don't know

91. During your *last or third trimester of your most recent pregnancy*, did you have a test for syphilis?

☐ No —————→ **Go to Question 93**

☐ Yes

☐ I got tested for syphilis, but I don't remember when

☐ I don't know —————→

**Go to
Question 94**

92. When you got tested for syphilis during your *last or third trimester*, was it the first time you had been tested for syphilis during your most recent pregnancy?

☐ No, I was also tested *earlier* in my pregnancy

☐ Yes, it was the first time I was tested for syphilis *during* my most recent pregnancy

☐ I don't know if it was the first time I was tested

Go to Question 94

93. Why didn't you have a test for syphilis during the last or third trimester of 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 did not think I was at risk for syphilis
- ☐ I was tested *earlier in this pregnancy*, and did not think I needed to be tested again
- ☐ I was tested *before this pregnancy*, and did not think I needed to be tested again
- ☐ Other reason —————→ Please tell us:

94. 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 ☐ ☐

95. 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 ☐ ☐

96. This question is about the 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**..... ☐ ☐

97. 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 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 ☐ ☐

98. During your most recent pregnancy, did a home visitor come to your home to support you in having a healthy pregnancy and preparing 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 supports pregnant and parenting people.

☐ No → **Go to Question 100**

☐ Yes

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

100. Since your new baby was born, did a home visitor come to your home to support you in taking 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 supports pregnant and parenting people and their newborns.

☐ No → **Go to Question 102**

☐ Yes

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

If your baby is not alive or not living with you, go to Question 106.

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

Check ONE answer

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

103. Since your new baby was born, how concerned have you felt about your new baby catching any of the following illnesses? For each illness, check the ONE answer that best describes your level of concern:
N for Not at all concerned
S for Somewhat concerned
V for Very concerned

- | | N | S | V |
|--|--------------------------|--------------------------|--------------------------|
| a. Influenza, or the flu..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Respiratory Syncytial Virus (RSV)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pneumonia..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hand, foot, and mouth disease (HFMD)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

104. Do you currently feel you have enough information to protect your new baby from the following illnesses? For each one, check No or Yes.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Influenza, or the flu | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Respiratory Syncytial Virus (RSV)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pneumonia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hand, foot, and mouth Disease (HFMD) .. | <input type="checkbox"/> | <input type="checkbox"/> |

105. Since your new baby was born, did a doctor, nurse, or other healthcare worker talk to you about how to protect your new baby from the following illnesses? For each one, check No or Yes.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Influenza, or the flu | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Respiratory Syncytial Virus (RSV)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pneumonia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hand, foot, and mouth Disease (HFMD) .. | <input type="checkbox"/> | <input type="checkbox"/> |

106. What is today's date?

 / /

Month

Day

Year

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

Thanks for answering our questions!

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

For Office Use Only

Received: _____ / _____ / _____ By: _____

Checks: M ☐ Yes ☐ No

B ☐ Yes ☐ No

A ☐ Yes ☐ No

Mail Data Entry: _____ / _____ / _____ By: _____

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

DDE: _____ / _____ / _____ By: _____

DDE Supplement: _____ / _____ / _____ By: _____

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