

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

BEFORE PREGNANCY

The first questions are about you.

1. How tall are *you* without shoes?

____ Feet ____ Inches

OR ____ Centimeters

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

____ Pounds OR ____ Kilos

3. What is *your* date of birth?

____ / ____ / ____
Month Day Year

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

4. During the 3 months before you got pregnant with your new baby, did you have any of the following health conditions? For each one, check **No** if you did not have the condition or **Yes** if you did.

No Yes

- a. Type 1 or Type 2 diabetes (**not** gestational diabetes or diabetes that starts during pregnancy)
- b. High blood pressure or hypertension
- c. Depression

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

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"/> |
| m. Test me for Hepatitis B (Hep B) | <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 Health Insurance Marketplace or HealthCare.gov
- Medicaid (LaMoms or Bayou Health)
- LaCHIP
- Take Charge or Take Charge Plus
- Greater New Orleans Health Connection (GNOCHC)
- TRICARE or other military health care
- 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 Health Insurance Marketplace or HealthCare.gov
- Medicaid (LaMoms or Bayou Health)
- LaCHIP
- Take Charge or Take Charge Plus
- Greater New Orleans Health Connection (GNOCHC)
- TRICARE or other military health care
- 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 Health Insurance Marketplace or HealthCare.gov
- Medicaid (LaMoms or Bayou Health)
- LaCHIP
- Take Charge or Take Charge Plus
- Greater New Orleans Health Connection (GNOCHC)
- TRICARE or other military health care
- 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 16**

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:

DURING PREGNANCY

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

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

Weeks **OR** Months
 I didn't go for prenatal care → **Go to Question 18**

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

No
 Yes → **Go to Question 19**

Go to Question 18

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan would not start care as early as I wanted..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid (LaMoms or Bayou Health) 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 20.

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

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

20. 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

21. 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

22. 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

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

- No
 Yes

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 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"/> |

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

- No
 Yes
 I don't know

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

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

- No
 Yes

→ **Go to Question 32**

29. 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

30. 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

31. 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.

32. 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"/> |
| c. Cigarillos or flavored little cigars (Black and Milds, Swisher Sweets, etc)..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 33. Otherwise, go to Question 35.

33. 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

34. 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.

35. 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 38**
- Yes

36. 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

37. During the *last 3 months* of your pregnancy, 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.

38. 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"/> |

39. During the 12 months before your new baby was born, how often did you feel unsafe in the neighborhood where you lived?

- Always
- Often
- Sometimes
- Rarely
- Never

40. In the 12 months before you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

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

41. During your most recent pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

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

AFTER PREGNANCY

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

42. When was your new baby born?

	/		/	20
Month		Day		Year

43. 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 46**

44. Is your baby alive now?

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

45. Is your baby living with you now?

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

46. 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:

47. 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 49

48. 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
 Other _____ Please tell us:

If you did not breastfeed your new baby, go to Page 10, Question 53.

49. After your new baby was born, did you receive the kinds of help with breastfeeding that are listed below? For each one, check No if you did not receive this kind of breastfeeding help or Yes if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Someone to answer my questions | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Help getting my baby positioned correctly | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Help knowing if my baby was getting enough milk | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help with managing pain or bleeding nipples | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Information about where to get a breast pump | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Help using a breast pump | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Information about breastfeeding support groups | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:

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

- No
 Yes

Go to Page 10, Question 52

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

- Less than 1 week

_____ Weeks OR _____ Months

If your baby was not born in a hospital, go to Question 53.

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

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

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

53. 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

54. 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 56

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

- No
 Yes

56. 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"/> |

57. 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"/> |

58. 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 60**

59. 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 61.

60. 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:

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

- No →
 Yes

Go to Page 12, Question 63



Go to Page 12, Question 62

62. 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"/> |

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

- Always
 Often
 Sometimes
 Rarely
 Never

64. 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

65. Since your new baby was born, have any of the following things happened to you? For each thing, check **No** if it did not happen to you or **Yes** if it did.

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

OTHER EXPERIENCES

The next questions are on a variety of topics.

66. Have you ever experienced discrimination (felt like you were treated worse than other people) while getting any type of health or medical care? For each item, check **No** if you have never experienced discrimination because of it or **Yes** if you have.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. My race or skin color..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My immigration status..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My age | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My income..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My sex/gender..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My sexual orientation..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My religion | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Because I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The language I speak..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. My type of health insurance or my lack of health insurance | <input type="checkbox"/> | <input type="checkbox"/> |

67. 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 didn't happen to you or **Yes** if it did. It may help to use the calendar.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I felt that my race or ethnic background contributed to the stress in my life..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I felt emotionally upset (for example, angry, sad, or frustrated) as a result of how I was treated based on my race or ethnic background..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I experienced physical symptoms (for example, a headache, an upset stomach, or a pounding heart) that I felt were related to how I was treated based on my race or ethnic background..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Over-the-counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve® | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Adderall®, Ritalin® or another stimulant... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Marijuana or hash..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Synthetic marijuana (K2, Spice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Methadone, naloxone, subutex, or Suboxone® | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Heroin (smack, junk, Black Tar, Chiva) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Amphetamines (uppers, speed, crystal meth, crank, ice, agua)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cocaine (crack, rock, coke, blow, snow, nieve) | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Tranquilizers (downers, ludes)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing) | <input type="checkbox"/> | <input type="checkbox"/> |

69. During your most recent pregnancy, did you receive any of the following services? For each one, check **No** if you did not receive the service or **Yes** if you received the service.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Food stamps or money to buy food | <input type="checkbox"/> | <input type="checkbox"/> |
| b. WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Counseling for family and personal problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help to quit smoking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help to reduce violence in my home | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:
-

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

- No → **Go to Page 14, Question 75**
- Yes ↓

71. Please tell us about your MAIN job during your most recent pregnancy. What was your job title and what were your usual activities or duties?

Job title:

Job duties:

72. 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 75**
- No, but I will be returning
- Yes

73. 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

74. 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"/> |

75. Do you have a husband or partner who lives with you now?

- No
- Yes

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

76. 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

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

People

78. What is today's date?

/ / 20

Month Day Year

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 Louisiana.

Thanks for answering our questions!

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

