

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"/> |

9. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk to you about preparing for a pregnancy?

- No → **Go to Question 11**
 Yes

10. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk to you about any of the things listed below about preparing for a pregnancy? *Please count only discussions, not reading materials or videos.* For each item, check **No** if no one talked with you about it or **Yes** if someone did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Getting my vaccines updated before pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Visiting a dentist or dental hygienist before pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Getting counseling for any genetic diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Getting counseling or treatment for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The safety of using prescription or over-the-counter medicines during pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. How smoking during pregnancy can affect a baby | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How drinking alcohol during pregnancy can affect a baby | <input type="checkbox"/> | <input type="checkbox"/> |
| h. How using illegal drugs during pregnancy can affect a baby | <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*.

11. 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 Vermont Health Connect, another state marketplace or HealthCare.gov
- Medicaid or Dr. Dynasaur
- Other health insurance ———> Please tell us:

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

12. 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 13**
- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from Vermont Health Connect, another state marketplace or HealthCare.gov
- Medicaid or Dr. Dynasaur
- Other health insurance ———> Please tell us:

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

13. 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 Vermont Health Connect, another state marketplace or HealthCare.gov
- Medicaid or Dr. Dynasaur
- Other health insurance ———> Please tell us:

- I do not have health insurance *now*

14. 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

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

- No
- Yes

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 20**

17. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos. For each item, check **No** if no one talked with you about it or **Yes** if someone did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Using a seat belt during my pregnancy ... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Doing tests to screen for birth defects or diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The health of my teeth and gums | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Suggest that I go see a dentist..... | <input type="checkbox"/> | <input type="checkbox"/> |

18. 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"/> |

19. During any of your prenatal care visits, did a doctor, nurse, or other health care worker advise you not to drink alcohol while you were pregnant?

- No
 Yes

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I knew it was important to care for my teeth and gums during my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A dental or other health care worker talked with me about how to care for my teeth and gums..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had insurance to cover dental care during my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I <u>needed</u> to see a dentist for a problem .. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I <u>went</u> to a dentist or dental clinic about a problem | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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"/> |

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

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

- No → Go to Page 7, Question 34
 Yes

28. 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

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

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

If you did not smoke at any time in the 3 months before you got pregnant, go to Question 33.

30. During any of your prenatal care visits, did a doctor, nurse, or other health care worker advise you to quit smoking?

- No
 Yes
 I didn't go for prenatal care → **Go to Question 32**

31. Listed below are some things about quitting smoking that a doctor, nurse, or other health care worker might have done during any of your prenatal care visits. For each thing, check **No** if it was not done or **Yes** if it was.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Spend time with me discussing how to quit smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Suggest that I set a specific date to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Suggest I attend a class or program to stop smoking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Provide me with booklets, videos, or other materials to help me quit smoking on my own | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Refer me to counseling for help with quitting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Ask if a family member or friend would support my decision to quit..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Refer me to a national or state quit line (like 802Quits) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Recommend using nicotine gum | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Recommend using a nicotine patch..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Prescribe a nicotine nasal spray or nicotine inhaler | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Prescribe a pill like Zyban® (also known as Wellbutrin® or bupropion) to help me quit..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Prescribe a pill like Chantix® (also known as varenicline) to help me quit | <input type="checkbox"/> | <input type="checkbox"/> |

32. During your most recent pregnancy, did you do any of the following things about quitting smoking? For each thing, check **No** if you did not do it or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Set a specific date to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Use booklets, videos, or other materials to help me quit | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Call a national or state quit line (like 802Quits) or go to a website | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Attend a class or program to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Go to counseling for help with quitting... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Use a nicotine patch, gum, lozenge, nasal spray or inhaler | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Take a pill like Zyban® (also known as Wellbutrin® or bupropion) to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Take a pill like Chantix® (also known as varenicline) to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Try to quit on my own (e.g., cold turkey).. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Use the internet..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Use an "e-cigarette" | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Use a cessation texting program | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Use a cessation application or "app" | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

33. 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.

34. 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. Chewing tobacco, snuff, or snus | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cigars, cigarillos, or little cigars | <input type="checkbox"/> | <input type="checkbox"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 35. Otherwise, go to Question 37.

35. 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

36. 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.

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

- No → **Go to Page 8, Question 41**
- Yes

38. 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 → **Go to Page 8, Question 40**

39. During the *3 months before* you got pregnant, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span?

- 6 or more times
- 4 to 5 times
- 2 to 3 times
- 1 time
- I didn't have 4 drinks or more in a 2 hour time span

40. 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.

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 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"/> |

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 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"/> |

AFTER PREGNANCY

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

43. When was your new baby born?

<input style="width: 40px; height: 25px; border: 1px solid black;" type="text"/> / <input style="width: 40px; height: 25px; border: 1px solid black;" type="text"/> / <input style="width: 40px; height: 25px; border: 1px solid black;" type="text"/> 20
Month Day Year

44. 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 47**

45. Is your baby alive now?

- No → **We are very sorry for your loss. Go to Page 10, Question 58**
- Yes

46. Is your baby living with you now?

- No → **Go to Page 10, 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
- I discussed feeding *only* breast milk to my baby with my health care worker
- I chose 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** 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:

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

- No → **Go to Question 53**
 Yes

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

- No
 Yes → **Go to 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 Page 10, 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 _____ → **Go to Question 63**
- Yes

↓
Go to 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

OTHER EXPERIENCES

The next questions are on a variety of topics.

65. 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, Advil®, Aleve®, or Tylenol® | <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. Heroin (smack, junk, Black Tar) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Amphetamines (uppers, speed, crystal meth, crank, ice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Cocaine (crack, rock, coke, blow, snow) ... | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Over-the-counter pain relievers such as aspirin, Advil®, Aleve®, or Tylenol® | <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. Heroin (smack, junk, Black Tar) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Amphetamines (uppers, speed, crystal meth, crank, ice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Cocaine (crack, rock, coke, blow, snow) ... | <input type="checkbox"/> | <input type="checkbox"/> |

67. During any of the following time periods, did you use Methadone, Suboxone®, or another drug used for maintenance treatment? For each time period, check **No** if you did not use then or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. During the 12 months before I got pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Since my new baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

68. During your *most recent* pregnancy, would you have had the kinds of help listed below if you needed them? For each one, check **No** if you would have not had it or **Yes** if you would have had it.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Someone to loan me \$50..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Someone to help me if I were sick and needed to be in bed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Someone to take me to the clinic or doctor's office if I needed a ride | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone to talk with about my problems..... | <input type="checkbox"/> | <input type="checkbox"/> |

69. Did you experience discrimination by health care providers during your prenatal care, labor, or delivery because of any of the things listed below?

Check ALL that apply

- My race, ethnicity, or culture
- My insurance or Medicaid status
- My weight
- My marital status
- My age
- Prescription use of Suboxone®, Methadone, or other drug addiction treatment
- Other _____ → Please tell us:

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

No —————→ **Go to Question 76**

Yes

71. 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 76**

No, but I will be returning

Yes

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

Check ALL that apply

I took *paid* leave from my job

I took *unpaid* leave from my job

I did not take any leave —————→ **Go to Question 74**

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

_____ Weeks **OR** _____ Months

Less than 1 week

74. How did you feel about the amount of time you were able to take off after the birth of your new baby?

Check ONE answer

Too little time

Just the right amount of time

Too much time

75. 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

b. I was afraid I'd lose my job if I took leave or stayed out longer

c. I had too much work to do to take leave or stay out longer

d. My job does not have paid leave

e. My job does not offer a flexible work schedule.....

f. I had not built up enough leave time to take any or more time off

If your baby is not alive, is not living with you, or is still in the hospital, go to Page 14, Question 82.

76. Since you delivered your new baby, would you have the kinds of help listed below if you needed them? For each one, check **No** if you would not have it or **Yes** if you would.

No Yes

a. Someone to loan me \$50.....

b. Someone to help me if I were sick and needed to be in bed

c. Someone to talk with about my problems.....

d. Someone to take care of my baby.....

e. Someone to help me if I were tired and feeling frustrated with my new baby

77. Do you have an infant car seat(s) that you can use for your new baby?

- No → **Go to Question 80**
 Yes

78. How did you get your new baby's infant car seat(s)?

Check ALL that apply

- I bought a car seat **new**
 I received it new for this baby as a gift
 I had one from another one of my babies
 I bought a car seat **used**
 I borrowed a car seat from a friend or family member
 I borrowed or rented a car seat from a loaner program
 The hospital where my new baby was born gave me a car seat
 A community program gave me a car seat
 Other → Please tell us:

79. How did you learn to install and use your infant car seat(s)?

Check ALL that apply

- I read the instructions
 A friend or family member showed me
 A health or safety professional showed me
 I figured it out myself
 I already knew how to install it because I have other children
 Some other way → Please tell us:

80. When your new baby rides in a car, truck, or van, how often does he or she ride in an infant car seat?

- Always
 Often
 Sometimes
 Rarely
 Never

81. Listed below are some statements about infant car seats. For each one, check **True** if you agree with the statement or **False** if you do not agree.

True False

- a. New babies should be in rear-facing car seats.....
 b. Car seats should not be placed in front of an air bag.....

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

82. 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

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

People

84. 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 Vermont.

Thanks for answering our questions!

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

