

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

BEFORE PREGNANCY

The first questions are about you.

1. How tall are *you* without shoes?

Feet Inches

OR Centimeters

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

Pounds OR Kilos

3. What is *your* date of birth?

/ /
Month Day Year

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

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

No Yes

- a. Type 1 or Type 2 diabetes (**not** gestational diabetes or diabetes that starts during pregnancy)
- b. High blood pressure or hypertension
- c. Depression
- d. Asthma
- e. Thyroid problems
- f. PCOS (polycystic ovarian syndrome)

5. During the *month before* you got pregnant with your *new* baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

- I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the *month before* I got pregnant
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week

6. In the *12 months before* you got pregnant with your *new* baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?

- No → **Go to Page 2, Question 9**
- Yes

↓
Go to Page 2, Question 7

7. What type of health care visit did you have in the 12 months before you got pregnant with your new baby?

Check ALL that apply

- Regular checkup at my family doctor's office
- Regular checkup at my OB/GYN's office
- Visit for an illness or chronic condition
- Visit for an injury
- Visit for family planning or birth control
- Visit for depression or anxiety
- Visit to have my teeth cleaned by a dentist or dental hygienist
- Other _____ → Please tell us:

8. During any of your health care visits in the 12 months before you got pregnant, did a doctor, nurse, or other health care worker do any of the following things? For each item, check **No if they did not or **Yes** if they did.**

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Talk to me about how I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

Check ALL that apply

- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid or MaineCare
- 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 or MaineCare
- 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 or MaineCare
- 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 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 Question 16

Go to Question 15

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 were *sure* you were pregnant?

For example, you had a pregnancy test or a doctor, nurse, or other health care worker said you were pregnant.

_____ Weeks **OR** _____ Months

- I don't remember

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

Weeks **OR** Months
 I didn't go for prenatal care → **Go to Question 20**

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

- No
 Yes

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 have your teeth cleaned by a dentist or dental hygienist?

- No
 Yes

23. 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"/> |

24. During your most recent pregnancy, did you have any of the following health conditions?

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

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

25. 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).

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

- No → **Go to Page 6, Question 32**
 Yes

27. In the *3 months before* you got pregnant, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

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

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

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

If you did not smoke at any time during the *3 months before* you got pregnant, go to Page 6, Question 31.

29. 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 Page 6, Question 31

30. 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 ... | <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"/> |

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

32. Which of the following statements best describes the rules about smoking *inside* your home now, even if no one who lives in your home is a smoker?

Check ONE answer

- No one is allowed to smoke anywhere inside my home
- Smoking is allowed in some rooms or at some times
- Smoking is permitted anywhere inside my home

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.

33. Have you used any of the following products in the *past 2 years*? For each item, check **No** if you did not use it or **Yes** if you did.

No Yes

- a. E-cigarettes or other electronic nicotine products.....
- b. Hookah

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 34. Otherwise, go to Question 36.

34. 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

35. 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.

36. 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 40**
 Yes

37. 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 Question 39**

38. 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

39. 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.

40. 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"/> |

41. During the *12 months before* your new baby was born, did you ever eat less than you felt you should because there wasn't enough money to buy food?

- No
 Yes

42. During the 12 months before your new baby was born, did you ever get emergency food from a church, a food pantry, or a food bank, or eat in a food kitchen?

- No
 Yes

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

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

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

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

AFTER PREGNANCY

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

45. When was your new baby born?

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

46. Did you plan or schedule a cesarean delivery (c-section) at least one week before your new baby was born?

- No
 Yes

47. How was your new baby delivered?

- Vaginally Go to Question 50
 Cesarean delivery (c-section)

48. What was the reason that your new baby was born by cesarean delivery (c-section)?

Check ALL that apply

- I had a previous cesarean delivery (c-section)
 My baby was in the wrong position (such as breech)
 I was past my due date
 My health care provider worried that my baby was too big
 I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)
 I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)
 My health care provider tried to induce my labor, but it didn't work
 Labor was taking too long
 The fetal monitor showed that my baby was having problems before or during labor (fetal distress)
 I wanted to schedule my delivery
 I didn't want to have my baby vaginally
 Other Please tell us:

49. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)?

Check ONE answer

- My health care provider recommended a cesarean delivery **before** I went into labor
 My health care provider recommended a cesarean delivery while I was in labor
 I asked for the cesarean delivery

50. 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 53**

51. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 11, Question 68**

52. Is your baby living with you now?

- No → **Go to Page 11, Question 68**
- Yes

53. 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:

54. 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 56**

55. 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 62.

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

- No
- Yes → **Go to Page 10, Question 59**

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

- Less than 1 week

Weeks **OR** Months

58. What were your reasons for stopping breastfeeding?

Check ALL that apply

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

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

- No _____ → **Go to Question 61**
- Yes

60. Did your health insurance pay for a breast pump for you to use with your *new* baby?

- No
- Yes, but I had to make a co-payment
- Yes, with no co-payment
- I did not have health insurance
- I don't know

If your baby was not born in a hospital, go to Question 62.

61. 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"/> |

62. How old was your new baby the first time he or she ate food (such as baby cereal, baby food, or any other food)?

____ Weeks **OR** ____ Months

- My baby was less than 1 week old
- My baby has not eaten any foods

If your baby is still in the hospital, go to Question 68.

63. 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

64. 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 66**

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

- No
- Yes

66. 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"/> |

67. 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"/> |

68. 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 Page 12, Question 70**

69. 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 71.

70. 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:

71. 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 73**
- Yes

Go to Question 72

72. 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"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

74. 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

75. Since your new baby was born, have any of the following people pushed, hit, slapped, kicked, choked, or physically hurt you in any other way? For each person, check **No** if they have not hurt you during this time or **Yes** if they have.

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

OTHER EXPERIENCES

The next questions are on a variety of topics.

76. How did you feel when you found out you were pregnant with your new baby?

- Very unhappy to be pregnant
- Unhappy to be pregnant
- Not sure
- Happy to be pregnant
- Very happy to be pregnant

77. 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 | <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"/> |

78. 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. Marijuana or hash..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Amphetamines (uppers, speed, crystal meth, crank, ice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cocaine (crack, rock, coke, blow, snow) ... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Tranquilizers (downers, ludes)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing) | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is not alive or is not living with you, go to Page 14, Question 83.

79. Since your new baby was born, have you used WIC services for yourself or your new baby?

- No
 - Yes, only I am using WIC services
 - Yes, both my new baby and I use WIC services
 - Yes, only my new baby uses WIC services
- Go to Page 14, Question 81**

80. Why wasn't your new baby enrolled in WIC?

Check ALL that apply

- I didn't think my new baby would be eligible
- I was told that my baby didn't qualify for WIC
- I'm not sure what WIC is
- WIC hours did not fit my schedule
- The WIC office was too far away
- I don't need the services that WIC offers
- Other _____ → Please tell us:

81. Have you ever heard or read about what can happen if a baby is shaken from any of the following sources?

Check ALL that apply

- Magazine
- Radio or television
- Doctor, nurse, or other health care worker
- Book
- Family or friends
- The Period of Purple Crying video
- Other _____ → Please tell us:

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

- Drinking water
- Dust from paint
- Food
- Toys
- I don't know or I am unsure

83. Do you have any insurance that pays for some or all of your dental care? Please include dental insurance, prepaid plans such as HMOs, or government plans such as MaineCare or Medicaid.

- No
- Yes

For the next two questions please tell us about the home you live in now.

84. Was the building built before 1950?

- No
- Yes
- I don't know or I am unsure

85. Do you own or rent the home?

- Own
- Rent
- Other arrangement

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

86. 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

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

_____ People

88. What is today's date?

____ / ____ / 20____
 Month Day Year

The next questions are about marijuana.

D1. At any time during the 3 months *before* you got pregnant OR *during* your most recent pregnancy, did you use marijuana or hash in any form?

- No → **Go to Question D6**
 Yes

D2. During the 3 months *before* you got pregnant, about how often did you use marijuana products in an average month?

- Daily
 2-6 days a week
 1 day a week
 2-3 days a month
 1 day a month or less
 I did not use marijuana then

D3. During *your most recent* pregnancy, about how often did you use marijuana products in an average month?

- Daily
 2-6 days a week
 1 day a week
 2-3 days a month
 1 day a month or less
 I did not use marijuana then → **Go to Question D6**

D4. During *your most recent* pregnancy, how did you use marijuana?

Check ALL that apply

- Smoked it
 Ate it
 Drank it
 Vaporized it
 Dabbed it
 Other → Please tell us:

D5. Why did you use marijuana products during pregnancy? For each item, check **No** if it is not a reason for you or **Yes** if it was.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. To relieve nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| b. To relieve vomiting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. To relieve stress or anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. To relieve symptoms of a chronic condition..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. To relieve pain | <input type="checkbox"/> | <input type="checkbox"/> |
| f. For fun or to relax | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Some other reason..... | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:

If you did not get prenatal care, go to Page 16, Question D8.

D6. During any of your prenatal care visits, did a doctor, nurse, or other health care worker do any of the following things? Please include if they asked you on a written form or in a conversation. For each item, check **No** if they did not do this or **Yes** if they did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Ask me if I was using marijuana | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Recommend that I use marijuana for any reason | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Advise me not to use marijuana | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Advise me not to breastfeed my baby if I was using marijuana..... | <input type="checkbox"/> | <input type="checkbox"/> |

D7. During any of your prenatal care visits, did a doctor, nurse, or other health care worker refer you to treatment because of drug use (prescribed or non-prescribed drugs)?

- No
 Yes
 I did not use any drugs (or only used over-the-counter pain relievers) during my pregnancy

D8. Since your new baby was born, have you used marijuana or hash in any form?

- No
- Yes

D9. How long do you think it is necessary for a woman to wait after using marijuana to breastfeed her baby?

Check ONE answer

- I don't think she needs to wait at all
- I think it is best to wait until she is no longer high
- I think it is best to wait at least 2-3 hours after she is no longer high
- I don't think it is safe for breastfeeding women to use marijuana at all

The last questions are about prescription drugs.

D10. During your most recent pregnancy, did you take prescription antidepressants or selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, or Lexapro?

- No
- Yes

D11. During your most recent pregnancy, did you use prescription pain relievers such as hydrocodone (Vicodin[®]), oxycodone (Percocet[®]), or codeine?

- No → **Go to the end**
- Yes

D12. How would you describe the way you got the prescription pain relievers that you used during your most recent pregnancy?

Check ALL that apply

- I had a current prescription
- I had pain relievers left over from an old prescription
- I got the pain relievers without a prescription

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 Maine.

Thanks for answering our questions!

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

