

Questions?

Call: 1-800-239-7889

Email: maine.prams@maine.gov

Visit: www.maine.gov/dhhs/prams

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Phase 9.2 05/2025

Maine PRAMS

Pregnancy Risk Assessment Monitoring System
A Survey of the Health of Parents and Babies



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

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

BEFORE PREGNANCY

The first questions are about you.

1. What is your date of birth?

/

/

Month

Day

Year

2. How would you describe your sexual orientation?

- ☐ Heterosexual or "straight"
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Prefer to self-describe ———→ Please tell us:

3. Before you got pregnant, did you...?
For each one, check No or Yes.

No Yes

- a. Have serious difficulty hearing, or are you deaf?

☐

☐
- b. Have serious difficulty seeing, even when wearing glasses, or are you blind? ..

☐

☐
- c. Have serious difficulty walking or climbing stairs?.....

☐

☐
- d. Have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?

☐

☐
- e. Have difficulty with dressing or bathing yourself?

☐

☐
- f. Have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition?

☐

☐

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

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. Anxiety

☐

☐
- e. Asthma

☐

☐

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 at all
- ☐ 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 of the following healthcare visits?

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

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

Please tell us:

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

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

- | Talk to me about... | No | Yes |
|-----------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. My weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regularly checking my blood pressure.... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My desire to have or not have children | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Birth control methods | <input type="checkbox"/> | <input type="checkbox"/> |
| e. How I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sexually transmitted infections such as chlamydia, gonorrhea, syphilis, or HIV | <input type="checkbox"/> | <input type="checkbox"/> |

Ask me...

- | | | |
|-------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| g. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I felt depressed or anxious | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about your *health insurance*.

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

Check ALL that apply

- ☐ Private health insurance (paid for by me, someone else, or through a job)
- ☐ Medicaid or MaineCare
- ☐ TRICARE or other military healthcare
- ☐ Other health insurance —→ Please tell us:
- ☐ I didn't have any health insurance during the *month before* I got pregnant

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

Check ALL that apply

- ☐ Private health insurance (paid for by me, someone else, or through a job)
- ☐ Medicaid or MaineCare
- ☐ TRICARE or other military healthcare
- ☐ Other health insurance —→ Please tell us:
- ☐ I didn't have any health insurance *during my pregnancy*

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

Check ALL that apply

- ☐ Private health insurance (paid for by me, someone else, or through a job)
- ☐ Medicaid or MaineCare
- ☐ TRICARE or other military healthcare
- ☐ Other health insurance —→ Please tell us:
- ☐ I don't have any health insurance *now*

11. Thinking back to *just before* you got pregnant with your new baby, how did you feel about becoming pregnant?

Check ONE answer

- ☐ I wanted to be pregnant later
☐ I wanted to be pregnant sooner
☐ I wanted to be pregnant then
☐ I didn't want to be pregnant then or at any time in the future
☐ I wasn't sure what I wanted

DURING PREGNANCY

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

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

- ☐ No
☐ Yes

Go to Question 15

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

- ☐ No
☐ Yes

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

No Yes

Talk to me about...

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

Ask me...

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

15. During the 12 months before your new baby was born, did a healthcare provider offer you the following shots or vaccinations? For each one, check **No or **Yes**.**

No Yes

- a. Flu shot ☐ ☐
b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough]) ☐ ☐
c. COVID-19 shot ☐ ☐
d. RSV shot (given during pregnancy to protect the baby from respiratory syncytial virus) ☐ ☐

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

For each shot, check ALL that apply:

B for **3 months before** pregnancy

D for **During** pregnancy

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

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

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

- ☐ No
☐ Yes

18. During your most recent pregnancy, did a healthcare provider tell you that you had any of the following health conditions?

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

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

If you **had** high blood pressure **before or during** your pregnancy, go to Question 19. If you **didn't**, go to Question 20.

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

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

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

- ☐ No —————→ **Go to Question 22**
☐ Yes

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

- | | No | Yes |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. A healthcare provider (such as a doctor, nurse, or midwife) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Websites or social media (such as Facebook, Instagram, or X/Twitter) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any source of information that used the slogan “ Hear Her ” (such as websites, social media, or paper handouts)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

☐ No → **Go to Question 26**

☐ Yes

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

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

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

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

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

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

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

☐ No → **Go to Question 30**

☐ Yes

Go to Question 27

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

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

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

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

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

- ☐ No
- ☐ Yes

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

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

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

No Yes

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

If you did not have any alcoholic drinks during your pregnancy, go to Page 6, Question 32.

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

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

No Yes

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

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

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

No Yes

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

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

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

No Yes

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

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

No Yes

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

AFTER PREGNANCY

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

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

No Yes

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

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

- ☐ Less than 3 days
- ☐ 3 to 5 days
- ☐ 6 to 14 days
- ☐ More than 14 days
- ☐ My baby was not born in a hospital
- ☐ My baby is still in the hospital → **Go to Question 39**

37. Is your baby alive now?

- ☐ No → *We are very sorry for your loss.*
- ☐ Yes → **Go to Page 8, Question 46**

38. Is your baby living with you now?

- ☐ No → **Go to Page 8, Question 46**
- ☐ Yes

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

Check ONE answer

- ☐ I didn't breastfeed my baby → **Go to Question 41**
- ☐ I breastfed my baby for less than 1 week
- ☐ I breastfed my baby for: _____ week(s) OR _____ month(s)
- ☐ I'm still breastfeeding or feeding pumped milk to my new baby → **Go to Question 41**

Go to Question 40

40. What were your reasons for stopping breastfeeding?

Check ALL that apply

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

If your baby is still in the hospital, go to Page 8, Question 46.

41. In the *past 2 weeks*, how did you place your new baby to sleep at night and during naps?

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

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

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never → **Go to Page 8, Question 44**

Go to Page 8, Question 43

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

- ☐ No
☐ Yes

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

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

Please tell us:

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

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

Please tell us:

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

- ☐ No
☐ Yes → **Go to Question 48**
☐ I'm pregnant now → **Go to Question 49**

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

Check ALL that apply

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

If you're not doing anything to keep from getting pregnant now, go to Question 49.

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

Check ALL that apply

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

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

- ☐ No _____ → **Go to Question 51**
- ☐ Yes

Go to Question 50

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

No Yes

Talk to me about...

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

Ask me...

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

A healthcare provider...

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

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

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

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

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

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

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

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

- ☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never

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

- | | No | Yes |
|------------------------------------------|--------------------------|--------------------------|
| a. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Since my new baby was born | <input type="checkbox"/> | <input type="checkbox"/> |

56. Since your new baby was born, have you felt that you've needed mental health services such as counseling, medications, or support groups to help with feelings of anxiety, depression, grief, or other issues?

- ☐ No —————→ **Go to Question 58**
☐ Yes

57. Were you able to get the mental health services that you needed?

- ☐ No
☐ Yes

OTHER EXPERIENCES

The next questions are on a variety of topics.

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

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

59. During the 12 months before your new baby was born, did lack of transportation keep you from any of the following?
 For each one, check No or Yes.

- | | No | Yes |
|---------------------------------------------------------------|--------------------------|--------------------------|
| a. Going to medical appointments | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Going to non-medical appointments, meetings, or work | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Doing errands | <input type="checkbox"/> | <input type="checkbox"/> |

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

- ☐ No —————→ **Go to Question 65**
☐ Yes

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

Check ALL that apply

- ☐ Yes, I took *paid* leave from my job
☐ Yes, I took *unpaid* leave from my job
☐ Yes, I took leave and used Temporary/Short-Term Disability Insurance
☐ No, I didn't take any leave —————→ **Go to Question 63**

Go to Question 62

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

Write ONE answer

☐ Less than 1 week

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

63. Did any of the following things affect your decision about taking leave from work after your new baby was born?

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

No Yes

- a. I couldn't 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 doesn't have paid leave..... ☐ ☐
- e. My job doesn't offer a flexible work schedule..... ☐ ☐
- f. I hadn't built up enough leave time to take any or more time off ☐ ☐

64. Have you returned to the job you had during your most recent pregnancy?

Check ONE answer

- ☐ No, and I don't plan to return
- ☐ No, but I will be returning
- ☐ Yes

65. Did you use doula support during any of the following time periods? A doula is a trained pregnancy and labor companion who gives comfort, emotional support, and information during birth. A doula does not provide medical care. For each time period, check **No** or **Yes**.

No Yes

- a. During my most recent pregnancy ☐ ☐
- b. During the birth of my new baby..... ☐ ☐
- c. Since my new baby was born ☐ ☐

66. During any of the following time periods, did you use marijuana or cannabis in any form? Please do not include hemp or CBD-only products. For each time period, check **No** or **Yes**.

No Yes

- a. During the 3 months before I got pregnant ☐ ☐
- b. During my most recent pregnancy ☐ ☐
- c. Since my new baby was born..... ☐ ☐

If you did not use marijuana in any form during your pregnancy, go to Page 12, Question 68.

67. Why did you use marijuana products during pregnancy? For each one, check **No** or **Yes**.

No Yes

- a. To relieve nausea or vomiting..... ☐ ☐
- b. To relieve stress or anxiety..... ☐ ☐
- c. To relieve symptoms of a chronic condition ☐ ☐
- d. To help me sleep..... ☐ ☐
- e. To relieve pain..... ☐ ☐
- f. For fun or to relax ☐ ☐
- g. Some other reason..... ☐ ☐

Please tell us:

68. The following questions are about the people in your life and the support they provided you while you were pregnant.

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

- | | No | Yes |
|--------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Did you have someone you could go to if you felt lonely? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did you have someone you could talk with about things that were important to you or how you were feeling? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did you have someone you could count on to listen to your problems, worries, and fears? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Did you have someone who showed you love and affection? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Did you have someone who did things with you to relax or have fun? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Did you have someone you could count on to loan you money for things like food or bills? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Did you have someone who could take care of your children if you needed help? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Did you have someone who could help with daily chores if you were sick? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Did you have someone who could take you to the clinic or doctor's office if you needed a ride? | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is not alive or is not living with you, go to Question 71.

69. 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 Question 71

Go to Question 70

70. 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:

71. While getting healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?

For each one, check **No** if you did not experience discrimination because of it or **Yes** if you did.

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

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

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

73. Have you ever been treated unfairly due to your race, ethnicity, or skin color in any of the following situations?

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

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

74. The next questions are about things that may have happened to you during your childhood, before your 18th birthday.

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

- | | No | Yes |
|-----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Did you live with someone who was depressed, mentally ill, or suicidal? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did you live with someone who had a problem with alcohol or drug use?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Were you separated from a parent or guardian because they went to jail, prison, or a detention center? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Did your parents or other adults in your home slap, hit, kick, punch, or beat each other up? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Did a parent or other adult in your home hit, beat, kick, or physically hurt you in any way? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Did a parent or other adult in your home swear at you, insult you, or put you down? | <input type="checkbox"/> | <input type="checkbox"/> |

Before your 18th birthday...

No Yes

- g. Did an adult or person at least 5 years older than you ever make you do sexual things that you didn't want to do (such as kissing, touching, or having sexual intercourse)? ☐ ☐
- h. Was there an adult in your household who tried hard to make sure your basic needs were met, such as looking after your safety and making sure you had clean clothes and enough to eat? ☐ ☐
- i. Was there an adult in your household who tried hard to make sure you felt loved, supported, valued, and like you were special to them? ☐ ☐
- j. Did you feel that you were treated badly or unfairly because of your race, ethnicity, or skin color? ☐ ☐
- k. Did you feel that you were treated badly or unfairly because of your sexual orientation or because someone may think you are a lesbian or bisexual? This could include being treated badly because of who you're sexually attracted to. ☐ ☐
- l. Did you see someone get physically attacked, beaten, stabbed, or shot in your neighborhood? ☐ ☐
- m. Were your parents or guardians divorced or separated? ☐ ☐

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

Check ONE answer

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

76. Please tell us about the home you live in now. Was the building built before 1950?

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

77. What is your living situation today?

Check ONE answer

- ☐ I have a steady place to live
☐ I have a place to live today, but I'm worried about losing it in the future
☐ I don't have a steady place to live (I'm temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

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

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

- ☐ \$0 to \$18,000
☐ \$18,001 to \$23,000
☐ \$23,001 to \$27,000
☐ \$27,001 to \$32,000
☐ \$32,001 to \$34,000
☐ \$34,001 to \$37,000
☐ \$37,001 to \$42,000
☐ \$42,001 to \$48,000
☐ \$48,001 to \$52,000
☐ \$52,001 to \$60,000
☐ \$60,001 to \$69,000
☐ \$69,001 to \$78,000
☐ \$78,001 to \$85,000
☐ \$85,001 or more

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

Number of people _____

80. What is today's date?

____ / ____ / _____
 Month Day Year

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

Thanks for answering our questions!

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

