

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

BEFORE PREGNANCY

The first questions are about you.

1. What is your date of birth?

<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/> /	<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/> /	<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/>
Month	Day	Year

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Have serious difficulty hearing, or are you deaf? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have serious difficulty seeing, even when wearing glasses, or are you blind? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have serious difficulty walking or climbing stairs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have difficulty with dressing or bathing yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes (not gestational diabetes or diabetes that starts during pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Anemia (poor blood, low iron) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| i. PCOS (polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> |

4. 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

5. 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 7.

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

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

Ask me...

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

The next questions are about your *health insurance*.

7. 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)
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid (MO HealthNet, Healthy Blue, Home State Health, or United Health Care Community Plan)
- 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

8. 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)
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid (MO HealthNet, Healthy Blue, Home State Health, or United Health Care Community Plan)
- TRICARE or other military healthcare
- Other health insurance → Please tell us:

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

9. 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)
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid (MO HealthNet, Healthy Blue, Home State Health, or United Health Care Community Plan)
- TRICARE or other military healthcare
- Other health insurance → Please tell us:

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

10. 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

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

No

Yes → **Go to Page 4, Question 14**

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

No

Yes → **Go to Page 4, Question 14**

13. What were your reasons for not doing anything to keep from getting pregnant?

Check ALL that apply

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

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.)

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

- No
 Yes

Go to Question 16

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

- No
 Yes

Go to Question 17

16. Did any of these things keep you from getting prenatal care when you wanted it?

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

- | | | No | Yes |
|---|--------------------------|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan wouldn't start care as early as I wanted..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid, MO HealthNet, Healthy Blue, Home State Health, or United Health Care Community Plan card..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't have anyone to take care of my children..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I didn't know that I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I didn't want anyone else to know I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I didn't want prenatal care..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. The doctor's office was too far away..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not get prenatal care, go to Question 18.

17. 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..... | | <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. What to do if I feel depressed or anxious during my pregnancy or after my baby is born..... | | <input type="checkbox"/> | <input type="checkbox"/> |

Ask me...

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

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

No Yes

- | | | | |
|--|--|--------------------------|--------------------------|
| a. Flu shot..... | | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough])..... | | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot..... | | <input type="checkbox"/> | <input type="checkbox"/> |

19. 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"/> |

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

- No
 Yes

21. 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 one, check **No** or **Yes**.

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

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

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

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

23. 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 24. If you didn't, go to Question 25.

24. 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"/> |

25. 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 27**
 Yes

26. 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 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.

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

- No —————→ **Go to Question 31**
 Yes

28. 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

29. 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

30. 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

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

- No —————→ **Go to Question 35**
 Yes

32. 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

33. 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

34. 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.

35. 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 (1 st trimester)? <i>This includes the time before knowing you were pregnant</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2 nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 rd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not have any alcoholic drinks during your pregnancy, go to Question 37.

36. 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 (1 st trimester)? <i>This includes the time before knowing you were pregnant</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2 nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 rd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |

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

37. 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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was evicted or forced to move | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have a regular place to sleep..... | <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 spouse, partner, or I lost a job..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My spouse, partner, or I had a cut in work hours or pay..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I had problems paying the rent, mortgage, or other bills..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My spouse or partner went to jail/prison.. | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I went to jail/prison | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Someone close to me had a problem with drinking or drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Someone close to me was very sick or died..... | <input type="checkbox"/> | <input type="checkbox"/> |

38. 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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Another family member | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone else | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

40. Did your current, or ex, spouse or partner do any of the following things during your most recent pregnancy?

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Threatened me or made me feel unsafe in some way..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Made me afraid for my safety or my family's safety because of their anger or threats..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tried to control my daily activities, for example, controlling who I could talk to or where I could go..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Forced me to take part in touching or any sexual activity when I didn't want to..... | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

41. 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 44**

42. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 10, Question 52**

43. Is your baby living with you now?

- No → **Go to Page 10, Question 52**
- Yes

44. 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 46**
- 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 47**

Go to Question 45

45. 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 you ever breastfed your baby, go to Question 47.

46. 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 other things going on
- 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 your baby is still in the hospital, go to Page 10, Question 52.

47. 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"/> |

48. 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 Question 50

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

- No
- Yes

50. 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:

51. 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:

52. 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 54
- I'm pregnant now → Go to Question 55

Go to Question 53

53. 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 55.

54. 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:

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

- No
- Yes

→ **Go to Question 57**

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

Check ALL that apply

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

If you did not have a postpartum checkup, go to Question 58.

57. 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.....

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
 Often
 Sometimes
 Rarely
 Never

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

- Always
 Often
 Sometimes
 Rarely
 Never

62. 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"/> |

OTHER EXPERIENCES

The next questions are on a variety of topics.

63. 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

64. 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"/> |

65. During your most recent pregnancy, did you take or use any of the following medications or drugs for any reason? Your answers are strictly confidential.

For each one, check No or Yes.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Medication for depression..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Medication for anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Adderall®, Ritalin®, or another stimulant.. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Benzodiazepines (Valium®, Ativan®, Xanax®) or Tranquilizers (downers or ludes)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Methadone, Subutex®, Suboxone®, or buprenorphine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Naloxone..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Marijuana or cannabis in any form (not including hemp or CBD-only products)... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. CBD products..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Synthetic marijuana (K2 or Spice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Kratom..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Fentanyl or heroin (smack, junk, Black Tar or Chiva) | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Amphetamines (uppers, speed, crystal meth, crank, ice or <i>agua</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Cocaine (crack, rock, coke, blow, snow or <i>nieve</i>)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, or bath salts) | <input type="checkbox"/> | <input type="checkbox"/> |

66. Did a healthcare provider talk with you about the warning signs of both pregnancy and postpartum complications during any of the following time periods?

For each time period, check **No** or **Yes**.

No Yes

- a. During the 12 months before my most recent pregnancy
- b. During my most recent pregnancy
- c. During my labor and delivery hospital stay.....
- d. Since my new baby was born

67. The following questions are about the people in your life and the support they provide you now. For each one, check **No or **Yes**.**

No Yes

- a. Do you have someone you can go to if you're feeling lonely?.....
- b. Do you have someone you can talk with about things that are important to you or how you're feeling?.....
- c. Do you have someone you can count on to listen to your problems, worries, and fears?
- d. Do you have someone who shows you love and affection?.....
- e. Do you have someone who does things with you to relax or have fun?
- f. Do you have someone you can count on to loan you money for things like food or bills?.....
- g. Do you have someone who can take care of your children if you need help?...
- h. Do you have someone who can help with daily chores if you're sick?
- i. Do you have someone who can take you to the clinic or doctor's office if you need a ride?.....

68. 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
- b. My disability status
- c. My immigration status.....
- d. My age
- e. My weight.....
- f. My income.....
- g. My sex or gender
- h. My sexual orientation.....
- i. My religion
- j. My language or accent
- k. My type or lack of health insurance.....
- l. My use of substances (alcohol, tobacco, or other drugs).....
- m. My involvement with the justice system (jail or prison)
- n. Another reason.....

Please tell us:

69. 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

70. 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"/> |

71. Below is a list of things that some people do to prepare for a disaster.

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I have an emergency meeting place for family members (other than my home) ... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My family and I have practiced what to do in case of a disaster | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I have a plan for how my family and I would keep in touch if we were separated..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I have an evacuation plan if I need to leave my home and community | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I have an evacuation plan for my children in case of a disaster (permission for day care or school to release my child to another adult) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I have copies of important documents like birth certificates and insurance policies in a safe place outside my home | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I have emergency supplies in my home for my family such as enough extra water, food, and medicine to last for at least three days..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I have emergency supplies that I keep in my car, at work, or at home to take with me if I have to leave quickly..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

- \$0 to \$18,000
- \$18,001 to \$23,000
- \$23,001 to \$27,000
- \$27,001 to \$32,000
- \$32,001 to \$37,000
- \$37,001 to \$42,000
- \$42,001 to \$48,000
- \$48,001 to \$60,000
- \$60,001 to \$85,000
- \$85,001 to \$100,000
- \$100,001 to \$125,000
- \$125,001 to \$150,000
- \$150,001 or more

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

Number of people

74. 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 Missouri healthier.

