

**Attachment C**  
**Baseline Instrument**

# **Outcome Evaluation of “Teenage Pregnancy Prevention: Integrating Services, Programs, and Strategies Through Community-Wide Initiatives”**

## **Household Baseline Survey**

**July 6, 2011**

### **PRIVACY**

**Thank you for your help with this important study. It will help us to understand what things are like for people your age today. Your answers will be kept private to the extent allowed by law. Your name will not be on the questionnaire. Please answer all questions as well as you can.**

**We want you to know that:**

- 1. We hope that you will answer all the questions, but you may skip any questions you do not wish to answer.**
- 2. The answers you give will never be identified as yours. Your responses will be combined with those of other people your age.**

#### **THE PAPERWORK REDUCTION ACT OF 1995**

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

## GENERAL INSTRUCTIONS

[A recording of verbal instructions will be played for each respondent following their assent.]

*While each question is read to you, you will be shown several answer choices on the screen. Select the answer that you think is best. If you need to have the question read again, click on the Hear Question Again button. Once you have selected your answer, click Next. Once you move to the next question you cannot go back to a previous question. If you need help at any time, click on the Help button.*

## SECTION 1: YOU AND YOUR BACKGROUND

### 1.1. In what month and year were you born?

MARK (X) ONE MONTH AND ONE YEAR

<u>Month</u> Born
<input type="checkbox"/> January
<input type="checkbox"/> February
<input type="checkbox"/> March
<input type="checkbox"/> April
<input type="checkbox"/> May
<input type="checkbox"/> June
<input type="checkbox"/> July
<input type="checkbox"/> August
<input type="checkbox"/> September
<input type="checkbox"/> October
<input type="checkbox"/> November
<input type="checkbox"/> December

<u>Year</u> Born
<input type="checkbox"/> 2000
<input type="checkbox"/> 1999
<input type="checkbox"/> 1998
<input type="checkbox"/> 1997
<input type="checkbox"/> 1996
<input type="checkbox"/> 1995
<input type="checkbox"/> 1994
<input type="checkbox"/> 1993
<input type="checkbox"/> 1992
<input type="checkbox"/> 1991

### 1.2. Are you male or female?

MARK (X) ONE

- Male
- Female

### 1.3. Are you Hispanic or Latino?

MARK (X) ONE

- Yes
- No

### 1.4. What is your race?

YOU MAY MARK (X) MORE THAN ONE ANSWER

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other (Specify \_\_\_\_\_)



**1.5. When you are at home or with your family, what language or languages do you usually speak? [GO TO 1.6 if only one language is spoken.]**

YOU MAY MARK (X) MORE THAN ONE ANSWER

- English
- Spanish
- Chinese language such as Mandarin or Cantonese
- Other (Print other languages \_\_\_\_\_)

**1.5.1. What is the main language you speak at home?**

MARK (X) ONE

- English
- Spanish
- Chinese language such as Mandarin or Cantonese
- Other (Print other language \_\_\_\_\_)

**1.6. Have you graduated from high school?**

MARK (X) ONE

- Yes [GO TO 1.6.2]
- No [GO TO 1.6.1]

**1.6.1. What grade are you in?**

MARK (X) ONE

- 7th
- 8th
- 9th
- 10th
- 11th
- 12th
- Not currently in school

**1.6.2. Are you attending or have you attended college? [Will be programmed with 1.6, not relevant if answered "No" to 1.6]**

MARK (X) ONE

- Yes, a 4-year college or university
- Yes, a 2-year technical school or community college
- No, but currently enrolled in a trade school (e.g., beauty or automotive school)
- Not currently in school

**1.6.3. Are you employed at a paying job?**

MARK (X) ONE

- Yes, full-time (usually more than 30 hours per week)
- Yes, part-time (usually less than 30 hours per week)
- Not currently employed at a paying job

**1.7. In the last 12 months, how often did you attend religious services or activities?**

MARK (X) ONE

- Never
- Less than once a month
- 1–3 times per month
- Once a week
- More than once a week

**1.8. How important is religion in your life?**

MARK (X) ONE

- Not at all important
- Somewhat important
- Very important

**1.9. In an average week last month, including weekends, about how many hours did you spend participating in each of the following?**

MARK (X) ONE FOR EACH QUESTION

	ZERO HOURS PER WEEK	LESS THAN 2 HOURS PER WEEK	2-5 HOURS PER WEEK	MORE THAN 5 HOURS PER WEEK
a. Sports-related clubs, teams, or organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Lessons, clubs, or performances for art, music, or drama	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Other clubs, teams, and organizations, such as academic clubs, Scouts, chess clubs, or debating teams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Services or programs at a church, temple, synagogue, mosque, or other place of worship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Working at a paid job [ <b>Can be programmed for skip on basis of employment question in 1.6.3.</b> ]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Volunteering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**1.10. How likely is it that you will do each of the following things? [Program to ask on basis of responses to 1.6 series.]**

MARK (X) ONE FOR EACH QUESTION

	NOT AT ALL LIKELY	A LITTLE BIT LIKELY	SOMEWHAT LIKELY	VERY LIKELY
a. Graduate from high school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Go to a technical or vocational school after high school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Go to college	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Graduate from a 2-year or community college program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Graduate from a 4-year college program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next questions are about where you live and who lives with you.

**1.11. Which of the following best describes where you live?**

MARK (X) ONE

- You live in one home
- You live in two or more homes
- You are homeless (living on the street, in a car or shelter, or staying with friends/relatives) [**GO TO 2.1**]



**1.11.1. Who lives with you in your home or homes? If you live in one home, fill out Column A. If you live in two or more homes, fill out Columns B and C.**

<b>You Live in <u>One</u> Home</b>	<b>You Live in <u>Two or More</u> Homes</b>	
<i>Column A</i> <i>Mark (X) all the people who live with you in your home</i>	<i>Column B</i> <i>Mark (X) all the people who live with you in your MAIN home</i>	<i>Column C</i> <i>Mark (X) all the people who live with you in your OTHER home(s)</i>
<input type="checkbox"/> Your biological mother	<input type="checkbox"/> Your biological mother	<input type="checkbox"/> Your biological mother
<input type="checkbox"/> Your biological father	<input type="checkbox"/> Your biological father	<input type="checkbox"/> Your biological father
<input type="checkbox"/> A stepmother or adoptive mother	<input type="checkbox"/> A stepmother or adoptive mother	<input type="checkbox"/> A stepmother or adoptive mother
<input type="checkbox"/> A foster mother	<input type="checkbox"/> A foster mother	<input type="checkbox"/> A foster mother
<input type="checkbox"/> A stepfather or adoptive father	<input type="checkbox"/> A stepfather or adoptive father	<input type="checkbox"/> A stepfather or adoptive father
<input type="checkbox"/> A foster father	<input type="checkbox"/> A foster father	<input type="checkbox"/> A foster father
<input type="checkbox"/> Your parent's partner, boyfriend, or girlfriend	<input type="checkbox"/> Your parent's partner, boyfriend, or girlfriend	<input type="checkbox"/> Your parent's partner, boyfriend, or girlfriend
<input type="checkbox"/> Any grandmothers	<input type="checkbox"/> Any grandmothers	<input type="checkbox"/> Any grandmothers
<input type="checkbox"/> Any grandfathers	<input type="checkbox"/> Any grandfathers	<input type="checkbox"/> Any grandfathers
<input type="checkbox"/> Any older brothers or sisters	<input type="checkbox"/> Any older brothers or sisters	<input type="checkbox"/> Any older brothers or sisters
<input type="checkbox"/> Any younger brothers or sisters	<input type="checkbox"/> Any younger brothers or sisters	<input type="checkbox"/> Any younger brothers or sisters
<input type="checkbox"/> Any aunts, uncles, or other relatives	<input type="checkbox"/> Any aunts, uncles, or other relatives	<input type="checkbox"/> Any aunts, uncles, or other relatives
<input type="checkbox"/> Your children	<input type="checkbox"/> Your children	<input type="checkbox"/> Your children
<input type="checkbox"/> Your husband or wife	<input type="checkbox"/> Your husband or wife	<input type="checkbox"/> Your husband or wife
<input type="checkbox"/> Your boyfriend or girlfriend	<input type="checkbox"/> Your boyfriend or girlfriend	<input type="checkbox"/> Your boyfriend or girlfriend
<input type="checkbox"/> Any other people you are not related to	<input type="checkbox"/> Any other people you are not related to	<input type="checkbox"/> Any other people you are not related to
<input type="checkbox"/> You live by yourself	<input type="checkbox"/> You live by yourself	<input type="checkbox"/> You live by yourself

## SECTION 2: YOUR EXPOSURE TO PREVENTION MESSAGES AND INFORMATION

**2.1. In the last 12 months, have you had any classes, special programs, or instruction:**

MARK (X) ONE FOR EACH QUESTION

	YES	NO
a. About relationships, dating, marriage, or family life?	<input type="checkbox"/>	<input type="checkbox"/>
b. About abstinence from sex?	<input type="checkbox"/>	<input type="checkbox"/>
c. About methods of birth control?	<input type="checkbox"/>	<input type="checkbox"/>
d. About where to get birth control?	<input type="checkbox"/>	<input type="checkbox"/>
e. About sexually transmitted diseases, also known as STDs?	<input type="checkbox"/>	<input type="checkbox"/>
f. About how to talk to your partner about whether to have sex or whether to use birth control?	<input type="checkbox"/>	<input type="checkbox"/>
g. About alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
h. About physical development and reproduction?	<input type="checkbox"/>	<input type="checkbox"/>
i. About refusal skills, such as how to say no to sex, or how to resist peer pressure?	<input type="checkbox"/>	<input type="checkbox"/>

**2.1.1. [If yes to any item in 2.1:]**

**For the items above that you marked yes, did you learn about that type of information in a class or program that occurred over multiple days?**

MARK (X) ONE

- Yes  
 No

**2.1.2. [If yes to 2.1.1:]**

**What was the name of the program or programs?**

MARK (X) ONE

- Name of program/programs: \_\_\_\_\_  
 The program(s) didn't have a name

- I don't remember the name of the program(s)

**2.2. In the last 12 months, have you:**

[For each of the following, response options will be tailored to the content and mode of campaign undertaken by the grantee in the target community.]

CHECK ALL THAT APPLY

- Seen any television commercials [that provide pregnancy prevention information or advertise pregnancy prevention services]?
- Heard any radio commercials [that provide pregnancy prevention information or advertise pregnancy prevention services]?
- Seen any billboards [that provide pregnancy prevention information or advertise pregnancy prevention services]?
- Seen any flyers or posters [that provide pregnancy prevention information or advertise pregnancy prevention service]?
- Seen any brochures [that advertise pregnancy prevention services – referral guides]?
- [Been provided information about pregnancy prevention services or information] through an online social network (such as Facebook or Twitter)
- [Been provided information about pregnancy prevention or services] through a website?
- [Been provided information about pregnancy prevention or pregnancy prevention services] by text message?
- Been to any events (e.g., health fair, sporting event, etc.) where [information on pregnancy prevention or pregnancy prevention services] was provided?

**2.3. In the last 12 months, have you discussed pregnancy prevention with:**

CHECK ALL THAT APPLY

- Your mother or father?
- A doctor or nurse?
- A teacher or school counselor?
- Another adult
- A friend
- I have not talked about these issues with anyone

**2.4. If you were concerned about preventing pregnancy, is there a place in your community that could provide you with information or other assistance (such birth control or a prescription for birth control)?**

MARK (X) ONE

- Yes
- No [GO TO 2.5]

**2.4.1. Given what you know about this place, how likely would it be that you would go there to access information or other assistance?**

MARK (X) ONE

- 1 = Not at all likely
- 2 = A little likely
- 3 = Moderately likely
- 4 = Mostly likely
- 5 = Extremely likely

**2.4.2. How much would the following issues affect your decision to get information or other assistance about pregnancy prevention?**

MARK (X) ONE IN EACH COLUMN

Cost or Money	Confidentiality or Privacy	Transportation
<input type="checkbox"/> 1 = Not at all	<input type="checkbox"/> 1 = Not at all	<input type="checkbox"/> 1 = Not at all
<input type="checkbox"/> 2 = A little	<input type="checkbox"/> 2 = A little	<input type="checkbox"/> 2 = A little
<input type="checkbox"/> 3 = Moderately	<input type="checkbox"/> 3 = Moderately	<input type="checkbox"/> 3 = Moderately
<input type="checkbox"/> 4 = Mostly	<input type="checkbox"/> 4 = Mostly	<input type="checkbox"/> 4 = Mostly
<input type="checkbox"/> 5 = Extremely	<input type="checkbox"/> 5 = Extremely	<input type="checkbox"/> 5 = Extremely

**2.5. Have you ever received any of these services from a medical provider or clinic?**

CHECK ALL THAT APPLY

- Counseling or information about birth control
- Counseling or information about an Intrauterine Device (IUD)
- Counseling or information about Implanon® (a hormone-release device placed under the skin on your arm)
- Counseling or information about emergency contraception, also known as “Plan B” or “Preven” or the “morning-after pill”
- Counseling or information about sexually transmitted diseases (STDs)
- I have never received any of these services [GO TO 3.1]

**[If yes to any of the above:]**

**2.5.1. Where did you receive your services?**

CHECK ALL THAT APPLY

- Family planning clinic (a clinic that focuses on reproductive health and provides birth control and STD testing)
- School or school-based clinic

- Gynecologist's office
- Other doctor's office such as your primary care physician or family doctor
- Hospital emergency room, urgent care center, or walk-in facility
- Some other place (Specify: \_\_\_\_\_)

**2.5.2. Where did you hear about the service?**

CHECK ALL THAT APPLY

- Your mother or father?
- A doctor or nurse?
- A teacher or school counselor?
- Another adult?
- A friend?
- A TV advertisement
- A radio advertisement
- A poster or flyer
- A brochure
- A billboard
- A website
- A text message
- An online social network site such as Facebook or Twitter
- Other (Specify: \_\_\_\_\_)

**2.6. In the last 12 months, have you received any of these services from a medical provider or clinic?**

CHECK ALL THAT APPLY

- Counseling or information about birth control
- Counseling or information about an Intrauterine Device (IUD)
- Counseling or information about Implanon® (a hormone-release device placed under the skin on your arm)
- Counseling or information about emergency contraception, also known as "Plan B" or "Preven" or the "morning-after pill"
- Counseling or information about sexually transmitted diseases (STDs)
- I have not received any of these services in the last 12 months **[GO TO 3.1]**

**[If yes to any of the above:]**

**2.6.1. Where did you receive your services?**

CHECK ALL THAT APPLY

- Family planning clinic (a clinic that focuses on reproductive health and provides birth control and STD testing)

- School or school-based clinic
- Gynecologist's office
- Other doctor's office such as your primary care physician or family doctor
- Hospital emergency room, urgent care center, or walk-in facility
- Some other place (Specify: \_\_\_\_\_)

**2.6.2. Where did you hear about the service?**

CHECK ALL THAT APPLY

- Your mother or father?
- A doctor or nurse?
- A teacher or school counselor?
- Another adult?
- A friend?
- A TV advertisement
- A radio advertisement
- A poster or flyer
- A brochure
- A billboard
- A website
- A text message
- An online social network site such as Facebook or Twitter
- Other (Specify: \_\_\_\_\_)

### SECTION 3: FAMILY

The following questions are about your family and those who you think of as your family.

**3.1. On how many days last week did all the family members who live in your household sit down together for a meal? [Program to skip if inappropriate on basis of response to 1.11.1.]**

MARK (X) ONE

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
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**3.2. On how many days last week did you do something with at least one adult in your family such as play a game, watch a movie, go to a sporting event, or work on something you enjoy doing together?**

MARK (X) ONE

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
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### MOTHER

**3.3. Now we have some questions about your mother, or the person you think of as a mother. Is this person:**

MARK (X) ONE

Your biological mother, that is, the woman who gave birth to you?

- Your stepmother or adoptive mother?
- Your foster mother?
- Your grandmother?
- Your aunt?
- Some other adult?
- Don't have a mother or person I think of as a mother [GO TO 3.11]

The following questions are about the person you marked as your mother or the person you think of as your mother.

**3.4. Did she graduate from high school?**

MARK (X) ONE

- Yes
- No
- Don't know

**3.5. Did she graduate from a 4-year college?**

MARK (X) ONE

- Yes
- No
- Don't know

**3.6. Is she working now?**

MARK (X) ONE

- She is not working at a paid job
- Yes, she is working part-time or less than 30 hours a week
- Yes, she is working full-time or at more than one job for 30 hours a week or more
- Yes, she works, but I don't know how many hours
- Don't know if she is working

**3.7. How close do you feel to your mother or the person you think of as a mother?**



MARK (X) ONE

- Not at all close
- A little close
- Somewhat close
- Very close

**3.8. In general, how much do you think she cares about you?**

MARK (X) ONE

- Does not care at all
- Cares a little bit
- Cares somewhat
- Cares very much

**3.9. Whether you have done this or not, how would she feel about you having sex at this time in your life?**

MARK (X) ONE

<b>STRONGLY APPROVE</b> <input type="checkbox"/>	<b>APPROVE</b> <input type="checkbox"/>	<b>NEITHER APPROVE NOR DISAPPROVE</b> <input type="checkbox"/>	<b>DISAPPROVE</b> <input type="checkbox"/>	<b>STRONGLY DISAPPROVE</b> <input type="checkbox"/>
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**3.10. Whether you have done this or not, how would she feel about you having a baby at this time in your life?**

MARK (X) ONE

<b>STRONGLY APPROVE</b> <input type="checkbox"/>	<b>APPROVE</b> <input type="checkbox"/>	<b>NEITHER APPROVE NOR DISAPPROVE</b> <input type="checkbox"/>	<b>DISAPPROVE</b> <input type="checkbox"/>	<b>STRONGLY DISAPPROVE</b> <input type="checkbox"/>
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**FATHER**

**3.11. Next we have some questions about your father, or the person you think of as a father. Is this person:**

MARK (X) ONE

- Your biological father, that is, the man who is genetically related to you?
- Your stepfather or adoptive father?
- Your foster father?
- Your grandfather?
- Your uncle?
- Some other adult?

- Don't have a father or person I think of as a father [GO TO 3.21]

The following questions are about the person you marked as your father or the person you think of as your father.

**3.12. Did he graduate from high school?**

MARK (X) ONE

- Yes  
 No  
 Don't know

**3.13. Did he graduate from a 4-year college?**

MARK (X) ONE

- Yes  
 No  
 Don't know

**3.14. Is he working now?**

MARK (X) ONE

- He is not working at a paid job  
 Yes, he is working part-time or less than 30 hours a week  
 Yes, he is working full-time or at more than one job for 30 hours a week or more  
 Yes, he works, but I don't know how many hours  
 Don't know if he is working

**3.15. How close do you feel to your father or the person you think of as your father?**

MARK (X) ONE

- Not at all close  
 A little close  
 Somewhat close  
 Very close

**3.16. In general, how much do you think he cares about you?**

MARK (X) ONE

- Does not care at all
- Cares a little bit
- Cares somewhat
- Cares very much

**3.17. Whether you have done this or not, how would he feel about you having sex at this time in your life?**

MARK (X) ONE

<b>STRONGLY APPROVE</b> <input type="checkbox"/>	<b>APPROVE</b> <input type="checkbox"/>	<b>NEITHER APPROVE NOR DISAPPROVE</b> <input type="checkbox"/>	<b>DISAPPROVE</b> <input type="checkbox"/>	<b>STRONGLY DISAPPROVE</b> <input type="checkbox"/>
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**3.18. Whether you have done this or not, how would he feel about you having a baby at this time in your life?**

MARK (X) ONE

<b>STRONGLY APPROVE</b> <input type="checkbox"/>	<b>APPROVE</b> <input type="checkbox"/>	<b>NEITHER APPROVE NOR DISAPPROVE</b> <input type="checkbox"/>	<b>DISAPPROVE</b> <input type="checkbox"/>	<b>STRONGLY DISAPPROVE</b> <input type="checkbox"/>
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**3.19. My mother and father are:**

MARK (X) ONE

- Married to each other now
- Were married to each other, but are now separated from each other
- Were married to each other, but are now divorced
- Have never been married to each other
- One of my parents has passed away

**3.20. Do your mother and father live together?**

MARK (X) ONE

- Yes
- No
- Don't know

**PARENTS**

The next questions ask what your parents know about your activities. By parents, we mean the parents or guardians you live with most of the time.

**3.21. Thinking about the last month, how often did your parents know where you were after school?**

MARK (X) ONE

- Always
- Usually
- Sometimes
- Rarely
- Never

**3.22. Thinking about the last month, how often did your parents know who you were going to be with before you went out?**

MARK (X) ONE

- Always
- Usually
- Sometimes
- Rarely
- Never
- Did not go out

**3.23. Thinking about the last month, how often did your parents know where you were when you went out at night?**

MARK (X) ONE

- Always
- Usually
- Sometimes
- Rarely
- Never
- Did not go out at night

**3.24. If you were going to be home late, would your parents expect you to call?**

MARK (X) ONE

- Yes
- No

**3.25. In the last 12 months, how many times have you talked with at least one of your parents or guardians about:**

MARK (X) ONE FOR EACH QUESTION

	NEVER	1-2 TIMES	3-9 TIMES	10 OR MORE TIMES
a. How things are going with school work or with your grades?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A personal problem you were having?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How to have good romantic relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Strategies for safe dating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. How to resist pressures to have sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Avoiding drugs and alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Avoiding pregnancy or birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Avoiding sexually transmitted diseases, also called STDs, HIV, or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next two questions are about your biological parents.

**3.26.1. About how old was your biological mother when she had her first child?**

MARK (X) ONE

<input type="checkbox"/> Under 15 years	<input type="checkbox"/> 15–17 years	<input type="checkbox"/> 18–19 years	<input type="checkbox"/> 20–21 years	<input type="checkbox"/> 22 years or older
<input type="checkbox"/> Don't know				

3.26.2. About how old was your biological father when his first child was born?

MARK (X) ONE

<input type="checkbox"/> Under 15 years	<input type="checkbox"/> 15–17 years	<input type="checkbox"/> 18–19 years	<input type="checkbox"/> 20–21 years	<input type="checkbox"/> 22 years or older
<input type="checkbox"/> Don't know				

## SECTION 4: VIEWS AND PERCEPTIONS

These questions are your views and perceptions around sexual behaviors. Please be as honest as possible, and remember that everything you tell us will be kept private.

The next series of questions is about your views on sexual intercourse. In this survey, when we ask about sexual intercourse, we mean vaginal sex—when a male inserts his penis into a female’s vagina.

### 4.1. How strongly do you agree or disagree that:

MARK (X) ONE FOR EACH QUESTION

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
a. Having sexual intercourse is a good thing for you to do at your age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. At your age right now, having sexual intercourse would create problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. At your age right now, <u>not</u> having sexual intercourse is important for you to be safe and healthy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. At your age right now, it is okay for you to have sexual intercourse if you use birth control, like a condom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. It is against your values to have sexual intercourse before marriage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 4.2.1 FOR GIRLS ONLY: If you got pregnant now, how would you feel?

MARK (X) ONE

VERY UPSET <input type="checkbox"/>	A LITTLE UPSET <input type="checkbox"/>	NEITHER UPSET NOR PLEASED <input type="checkbox"/>	A LITTLE PLEASED <input type="checkbox"/>	VERY PLEASED <input type="checkbox"/>
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### 4.2.2 FOR BOYS ONLY: If you got a female pregnant now, how would you feel?

MARK (X) ONE

VERY UPSET <input type="checkbox"/>	A LITTLE UPSET <input type="checkbox"/>	NEITHER UPSET NOR PLEASED <input type="checkbox"/>	A LITTLE PLEASED <input type="checkbox"/>	VERY PLEASED <input type="checkbox"/>
--	--	--	--	--

**4.3. Imagine you are alone with someone you like very much. How likely is it that you could:**

MARK (X) ONE FOR EACH QUESTION

	NOT AT ALL LIKELY	A LITTLE BIT LIKELY	SOMEWHAT LIKELY	VERY LIKELY
a. Stop them if they wanted to touch your chest and you did not want them to do that? <b>[Should be programmed for girls only.]</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Stop them if they wanted to touch your private parts below the waist, meaning the parts of the body covered by underwear, and you did not want them to do that?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Avoid having sexual intercourse if you didn't want to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4.4. The next series of questions is about condom use. How strongly do you agree or disagree that:**

MARK (X) ONE FOR EACH QUESTION

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
a. Condoms should always be used if a person your age has sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Condoms are a hassle to use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Condoms are pretty easy to get?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Condoms are important to make sexual intercourse safer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Using condoms means you don't trust your sexual partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Using condoms is morally wrong?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Condoms decrease sexual pleasure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Condoms and other birth control methods should be used together (at the same time)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



The next series of questions is about condoms, birth control pills, pregnancy, and sexually transmitted diseases, also called STDs.

**4.5. If a condom is used correctly, how much can it decrease the risk of pregnancy?**

MARK (X) ONE

- Not at all
- A little
- A lot
- Don't know [GO TO 4.6]

**4.5.1. How confident are you that your answer is correct?**

MARK (X) ONE

- Not at all confident
- A little confident
- Somewhat confident
- Very confident

**4.6. If a condom is used correctly, how much can it decrease the risk of getting HIV, the virus that causes AIDS?**

MARK (X) ONE

- Not at all
- A little
- A lot
- Don't know

**4.7. If a condom is used correctly, how much can it decrease the risk of getting Chlamydia and gonorrhea?**

MARK (X) ONE

- Not at all
- A little
- A lot
- Don't know

**4.7.1. The next series of questions is about other forms of birth control, not including condoms. How strongly do you agree or disagree that:**

MARK (X) ONE FOR EACH QUESTION

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
a. Birth control should always be used if a person your age has sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Birth control is a hassle to use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Birth control is pretty easy to get?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Birth control is important to make sexual intercourse safer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Birth control has too many negative side effects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Using birth control is morally wrong?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4.8. If birth control pills are used correctly, how much can they decrease the risk of pregnancy?**

MARK (X) ONE

- Not at all
- A little
- A lot
- Don't know [GO TO 4.9]

**4.8.1. How confident are you that your answer is correct?**

MARK (X) ONE

- Not at all confident
- A little confident
- Somewhat confident
- Very confident

**4.9. If birth control pills are used correctly, how much can they decrease the risk of getting HIV, the virus that causes AIDS?**

MARK (X) ONE

- Not at all
- A little
- A lot
- Don't know

**4.10. If birth control pills are used correctly, how much can they decrease the risk of getting chlamydia and gonorrhea?**

MARK (X) ONE

- Not at all
- A little
- A lot
- Don't know

**4.11. Can you get a sexually transmitted disease, or STD, from having oral sex?**

MARK (X) ONE

- Yes
- No
- Don't know [GO TO 4.12]

**4.11.1. How confident are you that your answer is correct?**

MARK (X) ONE

- Not at all confident
- A little confident
- Somewhat confident
- Very confident

**4.12. In the last 3 months, how many times have you gone out on a date?**

- Zero or none [GO TO 4.14]

|\_|\_| Number of times (your best guess is fine)

**4.13. Thinking about these dates in the last 3 months, how many different people did you go out on a date with?**

|\_|\_| Number of people (your best guess is fine)

**4.14. Do you intend to have oral sex in the next year?**

MARK (X) ONE

- Yes, definitely
- Yes, probably
- No, probably not
- No, definitely not

**4.15. Do you intend to have sexual intercourse in the next year?**

MARK (X) ONE

- Yes, definitely
- Yes, probably
- No, probably not
- No, definitely not [GO TO 4.18]

**4.16. If you have sexual intercourse in the next year, do you intend to use a condom?**

MARK (X) ONE

- Yes, definitely
- Yes, probably
- No, probably not
- No, definitely not

**The next question is about your intention to use effective methods of birth control. By effective methods, we mean the following:**

**Condoms**  
**Birth control pills**  
**The shot (Depo Provera)**  
**The patch**  
**The ring (NuvaRing)**  
**IUD (Mirena or Paragard)**  
**Implants (Implanon)**  
**Diaphragm/cervical cap**

**4.17. If you have sexual intercourse in the next year, do you intend to use any of these methods of birth control?**

MARK (X) ONE

- Yes, definitely
- Yes, probably
- No, probably not
- No, definitely not

**4.18. Think about whether you will have sexual intercourse without being married. Which statement is most true for you?**

MARK (X) ONE

- You **will not** have sexual intercourse unless you are married
- You **probably will** not have sexual intercourse unless you are married
- You **probably will** have sexual intercourse without being married
- You **will** have sexual intercourse without being married

## SECTION 5: TOBACCO, ALCOHOL, AND DRUG USE

The next questions are about tobacco, alcohol, and drugs. Please be as honest as possible, and remember that everything you tell us will be kept private.

**5.1. Have you ever smoked a cigarette?**

MARK (X) ONE

- Yes
- No [GO TO 5.4]

**5.2. The very first time you smoked a cigarette, how old were you?**

|\_|\_| Number of years old (your best guess is fine)

**5.3. During the last 30 days, on how many days did you smoke one or more cigarettes?**

MARK (X) ONE

- More than 25 days
- 5–25 days
- 1–4 days
- 0 days

**5.4. Have you ever had an alcoholic drink, such as beer, wine, or other liquor, NOT counting any times you just had a sip?**

MARK (X) ONE

- Yes
- No [GO TO 5.8]

**5.5. The very first time you had an alcoholic drink, how old were you?**

|\_|\_| Number of years old (your best guess is fine)

**5.6. During the last 30 days, not including any times you just had a sip, on how many days did you have one or more alcoholic beverages?**

MARK (X) ONE

- More than 25 days
- 5–25 days
- 1–4 days
- 0 days

**5.7. [For boys only] During the last 30 days, on how many days did you have five or more drinks in 2 hours?**

MARK (X) ONE

- More than 25 days
- 5–25 days
- 1–4 days
- 0 days

**5.7.1 [For girls only] During the last 30 days, on how many days did you have four or more drinks in 2 hours?**

MARK (X) ONE

- More than 25 days
- 5–25 days
- 1–4 days
- 0 days

**5.8. Have you ever used marijuana, also called weed or pot?**

MARK (X) ONE

- Yes
- No [GO TO 5.10]

**5.9. During the last 30 days, on how many days did you use marijuana?**

MARK (X) ONE

- More than 25 days
- 5–25 days
- 1–4 days
- 0 days

**5.10. Have you ever used any other type of illegal drug, for example methamphetamine, speed, PCP, ecstasy, or any form of cocaine, such as crack?**

MARK (X) ONE

- Yes
- No

**5.10.1 During the last 30 days, on how many days did you use an illegal drug other than marijuana?**

MARK (X) ONE

- More than 25 days
- 5–25 days
- 1–4 days
- 0 days

**5.11. Have you ever used any prescription pills or other prescription drugs that were not prescribed for you?**

MARK (X) ONE

- Yes
- No

**5.12. Have you ever used an inhalant, such as sniffed glue, breathed the contents of spray cans, or inhaled any paints or solvents to get high?**

MARK (X) ONE

- Yes
- No



## SECTION 6: FRIENDS AND RELATIONSHIPS

### 6.1 How much do you feel that your friends care about you?

MARK (X) ONE

- Do not care at all
- Care a little bit
- Care somewhat
- Care very much

### 6.2 How many of your friends who are your age think the following things? (Your best guess is fine.)

MARK (X) ONE FOR EACH QUESTION

	NONE	SOME	HALF	MOST	ALL	DON'T KNOW
a. Having sexual intercourse is a good thing for them to do at their age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. It would be okay for them to have sexual intercourse as long as they used birth control, like a condom.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. It would be okay for them to have sexual intercourse if they were dating the same person for a long time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. They should wait until they are older to have sexual intercourse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. They should wait until marriage to have sexual intercourse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 6.3 How many of your friends who are your age have done the following things?

MARK (X) ONE FOR EACH QUESTION

	NONE	SOME	HALF	MOST	ALL	DON'T KNOW
a. Had sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Had oral sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Had anal sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6.4. Here are some reasons people your age might choose NOT to have sexual intercourse. How important is each of these reasons to you? B2**

MARK (X) ONE FOR EACH QUESTION

	VERY IMPORTANT	SOMEWHAT IMPORTANT	NOT TOO IMPORTANT	NOT AT ALL IMPORTANT
a. (GIRLS ONLY) I do not want to get pregnant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. (BOYS ONLY) I do not want to get a girl pregnant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I don't want to get a sexually transmitted disease, that is, an STD.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I don't want to disappoint my parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Having sex would interfere with my progress in school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I am too young to have sex.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. My boyfriend or girlfriend doesn't want to have sex.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I want to wait until I'm married.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. It is against my personal values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I haven't met the right person yet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. It would interfere with my future goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. I haven't had the chance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. I don't want to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6.5. In general, how much pressure, if any, do you feel from your friends (not your boyfriend or girlfriend) to have sexual intercourse?**

MARK (X) ONE

- A lot of pressure
- Some pressure
- A little pressure
- No pressure at all

**6.5.1 In general, how much pressure, if any, do you feel from your boyfriend or girlfriend to have sexual intercourse?**

MARK (X) ONE

- A lot of pressure
- Some pressure
- A little pressure
- No pressure at all

**6.6. Have you ever been in a situation where someone touched you in a sexual way that you did not want, or someone forced you to touch him or her in a sexual way that you did not want to?**

MARK (X) ONE

- Yes
- No

**6.7. Have you ever been fearful that someone you were dating or having sex with might physically hurt you?**

MARK (X) ONE

- Yes
- No
- I have never dated anyone

**6.8. People are different in their sexual attraction to other people. Which of the following best describes your feelings?**

MARK (X) ONE

- I am only attracted to males
- I am attracted to both males and females
- I am only attracted to females
- I am not attracted to either males or females
- I am not sure

## SECTION 7: DEVELOPMENT, BEHAVIORS, AND EXPERIENCES

The next questions are about your physical growth and maturation.

### 7.0.1. FOR GIRLS ONLY:

a. Have you ever had your period, that is, your menstrual period?

MARK (X) ONE

- Yes  
 No [GO TO 7.1]

b. How old were you when you had your first period, that is, your first menstrual period?

|\_|\_| Number of years old (your best guess is fine)

### 7.0.2. FOR BOYS ONLY:

a. People reach puberty at different ages. Signs of puberty for males include physical changes such as developing pubic or facial hair, or the voice cracking or lowering. Which of the following best describes these changes for you?

MARK (X) ONE

- These changes have not yet started [GO TO 7.1]  
 These changes have barely started  
 These changes are definitely under way  
 These changes seem complete

b. How old were you when these changes started?

|\_|\_| Number of years old (your best guess is fine)

The next section is about your sexual behaviors and experiences. Please be as honest as possible. Everything you say will be kept private.

7.1. Have you ever had sexual intercourse, oral sex, or anal sex?

MARK (X) ONE

- No [STOP]  
 Yes [CONTINUE]

7.2. The first questions are about sexual intercourse. Remember that by sexual intercourse, we mean when a male puts his penis into a female's vagina. Have you ever had sexual intercourse?

MARK (X) ONE

- Yes  
 No [GO TO 7.7, and will also skip out of other questions specific to sexual intercourse]

**7.3. The very first time you had sexual intercourse, what month and year was it?**

MARK (X) ONE MONTH AND ONE YEAR

<u>Month</u> of First Sexual intercourse	
<input type="checkbox"/>	January
<input type="checkbox"/>	February
<input type="checkbox"/>	March
<input type="checkbox"/>	April
<input type="checkbox"/>	May
<input type="checkbox"/>	June
<input type="checkbox"/>	July
<input type="checkbox"/>	August
<input type="checkbox"/>	September
<input type="checkbox"/>	October
<input type="checkbox"/>	November
<input type="checkbox"/>	December

<u>Year</u> of First Sexual intercourse	
<input type="checkbox"/>	2011
<input type="checkbox"/>	2010
<input type="checkbox"/>	2009
<input type="checkbox"/>	2008
<input type="checkbox"/>	2007
<input type="checkbox"/>	2006
<input type="checkbox"/>	2005
<input type="checkbox"/>	2004
<input type="checkbox"/>	2003
<input type="checkbox"/>	2002
<input type="checkbox"/>	2001
<input type="checkbox"/>	Before 2001

**7.4. The very first time you had sexual intercourse, how old were you?**

|\_\_|\_\_| Number of years old (your best guess is fine)

**7.5. The very first time you had sexual intercourse, how old was your partner?**

MARK (X) ONE

- Three or more years younger than you
- A year or two younger than you
- The same age as you
- A year or two older than you
- Three or more years older than you

**7.6. The very first time you had sexual intercourse, would you say that it was voluntary or not voluntary?**

MARK (X) ONE

- Voluntary
- Not voluntary

The next section is about medical services that you may have received.

**7.7. Have you ever received any of these services from a medical provider or clinic?**

CHECK ALL THAT APPLY

- A method of birth control or a prescription for a method
- A checkup or medical test related to using a birth control method
- Emergency contraception, also known as “Plan B” or “Preven” or the “morning after pill,” or a prescription for it?
- A pregnancy test?
- Testing or treatment for a sexually transmitted diseases (STDs)
- I have never received any of these services **[GO TO 7.13]**

**[If yes to any of the above:]**

**7.8. Where did you receive your services?**

CHECK ALL THAT APPLY

- Family planning clinic (a clinic that focuses on reproductive health and provides birth control and STD testing)
- School or school-based clinic
- Gynecologist’s office
- Other doctor’s office such as your primary care physician or family doctor
- Hospital emergency room, urgent care center, or walk-in facility
- Some other place (Specify: \_\_\_\_\_)

**7.9. Where did you hear about the service?**

CHECK ALL THAT APPLY

- Your mother or father?
- A doctor or nurse?
- A teacher or school counselor?
- Another adult?
- A friend?
- A TV advertisement
- A radio advertisement
- A poster or flyer
- A brochure
- A billboard
- A website
- A text message

- An online social network site such as Facebook or Twitter
- Other (Specify: \_\_\_\_\_)

**7.10. In the last 12 months, have you received any of these services from a medical provider or clinic?**

CHECK ALL THAT APPLY

- A method of birth control or a prescription for a method
- A checkup or medical test related to using a birth control method
- Emergency contraception, also known as “Plan B” or “Preven” or the “morning after pill,” or a prescription for it?
- A pregnancy test?
- I have not received any of these services in the last 12 months **[GO TO 7.13]**

**[If yes to any of the above:]**

**7.11. Where did you receive your services?**

CHECK ALL THAT APPLY

- Family planning clinic (a clinic that focuses on reproductive health and provides birth control and STD testing)
- School or school-based clinic
- Gynecologist's office
- Other doctor's office such as your primary care physician or family doctor
- Hospital emergency room, urgent care center, or walk-in facility
- Some other place (Specify: \_\_\_\_\_)

**7.12. Where did you hear about the service?**

CHECK ALL THAT APPLY

- Your mother or father?
- A doctor or nurse?
- A teacher or school counselor?
- Another adult?
- A friend?
- A TV advertisement
- A radio advertisement
- A poster or flyer
- A brochure
- A billboard
- A website
- A text message
- An online social network site such as Facebook or Twitter

Other (Specify: \_\_\_\_\_)

The next series of questions is about your sexual behaviors and experiences, and use of birth control.

**7.13. Birth control methods are something used to reduce the risk of pregnancy, and some can reduce the risk of sexually transmitted diseases, also called STDs. The first time you had sexual intercourse, did you or your partner use any type of birth control, including condoms?**

MARK (X) ONE

Yes

No [GO TO 7.15]

**7.14. The first time you had sexual intercourse, did you or your partner use:**

CHECK ALL THAT APPLY

Condoms?

Diaphragm/cervical cap?

Birth control pills or the patch?

NuvaRing® or the ring?

Depo-Provera or other injectable birth control?

Intrauterine device (IUD)?

Implanon® (a hormone-release device placed under the skin on your arm)?

Another method? (Please specify what method \_\_\_\_\_)

**7.15. Have you had sexual intercourse more than one time?**

MARK (X) ONE

Yes

No [GO TO 7.17]

**7.16. How many different people have you ever had sexual intercourse with, even if only one time?**

|\_\_|\_\_| Number of people (your best guess is fine)

**7.17. Now please think about the last 12 months. In the last 12 months have you had sexual intercourse? [We'll use a calendar prompt for all of this section for 12- and 3-month recall.]**

MARK (X) ONE

Yes

No [GO TO 7.31]



7.18. **How many different people have you had sexual intercourse with in the last 12 months, even if only one time?**

|\_\_|\_\_| Number of people (your best guess is fine)

7.19. **How many times have you had sexual intercourse in the last 12 months?**

|\_\_|\_\_| Number of times (your best guess is fine)

7.20. **When you have had sexual intercourse in the last 12 months, how often have you used a condom?**

MARK (X) ONE

- Every time
- Most of the time
- About half of the time
- Some of the time
- None of the time

The next question is about your use of effective methods of birth control. By effective methods, we mean the following:

Condoms  
Birth control pills  
The shot (Depo Provera)  
The patch  
The ring (NuvaRing)  
IUD (Mirena or Paragard)  
Implants (Implanon)  
Diaphragm/cervical cap

7.21. **When you have had sexual intercourse in the last 12 months, how often have you used any of these methods of birth control?**

MARK (X) ONE

- Every time
- Most of the time
- About half of the time
- Some of the time
- None of the time

**7.22. In the last 12 months, which of the following methods of birth control have you or your partner used?**

CHECK ALL THAT APPLY

- Condoms
- Diaphragm/cervical cap
- Birth control pills or the patch
- NuvaRing® or the ring
- Depo-Provera or other injectable birth control
- Intrauterine device (IUD)
- Implanon® (a hormone-release device placed under the skin on your arm)
- Another method (\_\_\_\_\_)

[7.23 will be programmed to only appear for those with “condoms” and another method selected in 7.22.]

**7.23. When you had sexual intercourse in the last 12 months, how often did you use a condom at the same time you used (fill in the other effective method(s) they used based on response to 7.22)?**

MARK (X) ONE

- Every time
- Most of the time
- About half of the time
- Some of the time
- None of the time

**7.24. In the last 12 months, did you use emergency contraception, also known as “Plan B” or “Preven” or the “morning after pill”?**

MARK (X) ONE

- Yes
- No

**7.25. Now please think about the last 3 months. In the last 3 months have you had sexual intercourse? [We’ll use a calendar prompt for all of this section for 12- and 3-month recall.]**

MARK (X) ONE

- Yes
- No [GO TO 7.31]

7.26. **How many different people have you had sexual intercourse with in the last 3 months, even if only one time?**

|\_|\_|\_| Number of people (your best guess is fine)

7.27. **In the last 3 months, how many times have you had sexual intercourse?**

|\_|\_|\_| Number of times (your best guess is fine)

7.28. **In the last 3 months, how many times have you had sexual intercourse with a condom?**

|\_|\_|\_| Number of times (your best guess is fine)

The next questions are about your use of effective methods of birth control. By effective methods, we mean the following:

- Condoms
- Birth control pills
- The shot (Depo Provera)
- The patch
- The ring (NuvaRing)
- IUD (Mirena or Paragard)
- Implants (Implanon)
- Diaphragm/cervical cap

7.29. **In the last 3 months, how many times have you had sexual intercourse using any of these methods of birth control?**

|\_|\_|\_| Number of times (your best guess is fine)

7.30. **In the last 3 months, which of the following methods of birth control have you or your partner used?**

CHECK ALL THAT APPLY

- Condoms
- Diaphragm/cervical cap
- Birth control pills or the patch
- NuvaRing® or the ring
- Depo-Provera or other injectable birth control
- Intrauterine device (IUD)
- Implanon® (a hormone-release device placed under the skin on your arm)
- Another method (\_\_\_\_\_)

7.31. **Now, please think about the last time you had sexual intercourse. Did you use birth control?**

MARK (X) ONE

- Yes

No [GO TO 7.33]

**7.32. Please describe the type of birth control used the last time you had sexual intercourse.**

CHECK ALL THAT APPLY

- Condoms
- Diaphragm/cervical cap
- Birth control pills or the patch
- NuvaRing® or the ring
- Depo-Provera or other injectable birth control
- Intrauterine device (IUD)
- Implanon® (a hormone-release device placed under the skin on your arm)
- Another method ( \_\_\_\_\_ )

**7.33. Again, think about the last time you had sexual intercourse. Were you drunk or high?**

MARK (X) ONE

- Yes
- No

**7.34. Oral sex is when someone puts his or her mouth on another person's penis or vagina, or lets someone else put his or her mouth on their penis or vagina. Have you ever had oral sex?**

MARK (X) ONE

- Yes
- No [GO TO 7.39]

**7.35. The very first time you had oral sex, what month and year was it?**

MARK (X) ONE MONTH AND ONE YEAR

Month of First Oral Sex		Year of First Oral Sex	
<input type="checkbox"/>	January	<input type="checkbox"/>	2011
<input type="checkbox"/>	February	<input type="checkbox"/>	2010
<input type="checkbox"/>	March	<input type="checkbox"/>	2009
<input type="checkbox"/>	April	<input type="checkbox"/>	2008
<input type="checkbox"/>	May	<input type="checkbox"/>	2007
<input type="checkbox"/>	June	<input type="checkbox"/>	2006
<input type="checkbox"/>	July	<input type="checkbox"/>	2005
<input type="checkbox"/>	August	<input type="checkbox"/>	2004
<input type="checkbox"/>	September	<input type="checkbox"/>	2003
<input type="checkbox"/>	October	<input type="checkbox"/>	2002
<input type="checkbox"/>	November	<input type="checkbox"/>	2001
<input type="checkbox"/>	December	<input type="checkbox"/>	Before 2001

**7.36. How many different people have you ever had oral sex with, even if only one time?**

|\_\_|\_\_| Number of people (your best guess is fine)

**7.37. Now, please think about the last 3 months. In the last 3 months, how many times have you had oral sex?**

None [GO TO 7.39]

|\_\_|\_\_| Number of times (your best guess is fine)

**7.38. In the last 3 months, how many times did you have oral sex while using a condom?**

None

|\_\_|\_\_| Number of times (your best guess is fine)

**7.39. Anal sex is when a male puts his penis in someone else's anus, or their butt, or someone lets a male put his penis in their anus or butt. Have you ever had anal sex?**

MARK (X) ONE

Yes

No [GO TO 7.43]

**7.40. How many different people have you ever had anal sex with, even if only one time?**

MARK (X) ONE

|\_\_|\_\_| Number of people (your best guess is fine)

**7.41. Now, please think about the last 3 months. In the last 3 months, how many times have you had anal sex? B1**

None [GO TO 7.43]

|\_\_|\_\_| Number of times (your best guess is fine)

**7.42. In the last 3 months, how many times did you have anal sex while using a condom?**

None

|\_\_|\_\_| Number of times (your best guess is fine)

**7.43. Have you ever had oral sex or anal sex with a person the same sex as you?**

MARK (X) ONE

Yes

No

**FOR GIRLS ONLY:**

**7.44. To the best of your knowledge, have you ever been pregnant, even if no child was born?**

MARK (X) ONE

Yes

No [GO TO 7.52]

**7.45. To the best of your knowledge, how many times have you been pregnant? (If you are or think you are pregnant now, include that in your count.)**

|\_\_|\_\_| Number of times (your best guess is fine)

**7.46. Have you ever had a baby?**

MARK (X) ONE

- Yes
- No

**FOR GIRLS ONLY:**

**7.47. To the best of your knowledge, are you pregnant now?**

MARK (X) ONE

- Yes [GO TO 7.52]
- No [GO TO 7.52]
- Don't know

**7.48. Do you think you are probably pregnant or not?**

MARK (X) ONE

- Probably yes
- Probably no

**FOR BOYS ONLY:**

**7.49. To the best of your knowledge, have you ever gotten someone pregnant, even if no child was born?**

MARK (X) ONE

- Yes
- No [GO TO 7.52]

**7.50. To the best of your knowledge, how many times have you gotten someone pregnant?**

|\_\_|\_\_| Number of times (your best guess is fine)

**7.51. Has anyone you got pregnant had the baby?**

MARK (X) ONE

- Yes
- No
- Don't Know

**7.52. In the last 12 months, have you spoken with a doctor or nurse about having sex, birth control, or sexually transmitted diseases, also known as STDs?**

MARK (X) ONE

- Yes

No

**7.53. In the last 12 months, have you been tested by a doctor or nurse for a sexually transmitted disease (STD), such as gonorrhea, chlamydia, syphilis, or HIV?**

MARK (X) ONE

Yes

No

**7.54. In the last 12 months, have you been told by a doctor or nurse that you had a sexually transmitted disease (STD)?**

MARK (X) ONE

Yes

No

**7.55. The next series of questions is about the types of sexually transmitted diseases (STDs) you have had. In the last 12 months, did you have:**

MARK (X) ONE FOR EACH QUESTION

	YES	NO	DON'T KNOW
a. Chlamydia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Genital herpes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Syphilis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Human papilloma virus, also known as HPV or genital warts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Another sexually transmitted disease (STD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you for completing this survey.**