Form Approved:

OMB No. 0923-xxxx

Exp. Date xx/xx/20xx

Participant Number: Version 1 \_

**POSTPARTUM SURVEY FOR MOTHERS: ZERO MONTHS**

INTERVIEWERS: PLEASE PRINT CLEARLY]

Date of Interview:

Interviewer Name:

Location of Interview:

Is there any change in your contact information since we last spoke to you?

 Yes  No  Don’t Know

UPDATED CONTACT INFORMATION Mailing Address

Telephone Number – Home Cell Message

Are you willing to give us the name of the person who will be providing care for your baby, so that we may contact them to do baby’s growth and development questionnaires if you are unavailable?

 Yes

 No

 Don’t know

 Refused

If you don’t mind if we contact them please provide their name and contact information below: Name

Phone number

Location of home

1. Where did you deliver your newborn?

 Chinle Comprehensive Health Care Facility

 Ft. Defiance Indian Hospital

 Gallup Indian Medical Center

 Kayenta Health Center

 Northern Navajo Medical Center (i.e., Shiprock Hospital)

 Tuba City Regional Health Care Corporation

2. What is baby’s birth date? / / DD MM YYYY

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3. Did you **ever** breastfeed your baby?

 Yes **If yes**, **3a.** Infant age when first breastfed: days old

 No [ **If No, skip** to **7.**]

 Refused

4. Since your baby’s birth, have you ever fed your baby **exclusively (ONLY) with** breast milk?

 Yes **If yes, 4a.** For how long? months days

 No

 Refused

5. Are you **currently** breastfeeding your baby?

 Yes **If yes**, **5a.** Number of times **breastfeed** baby per day

 No, [ **skip** to **7.**]

 Refused

6. Do you currently feed your baby **exclusively (ONLY) with** breast milk?

Yes

 No

 Refused

**PREPARATION OF INFANT FOOD/FORMULA**

7. Do you use **baby formula** to feed your baby?

 Yes **If yes**, specify below:

**7a. Brand** of baby formula

**7b.** Number of times per day

 No

 Refused

8. Do you use water **to mix or prepare** baby formula?

 Yes **If yes**, specify type of water below:

**8a. Type of water** used to prepare baby formula

 Unfiltered tap water

 Filtered tap water

 Bottled water

 Other → **8b.** Specify

 No

 Refused

**CESSATION OF BREASTFEEDING**

9. Have you completely stopped breastfeeding?

 Yes **If Yes**,**9a.** How old was your baby when you completely stopped breastfeeding?

 months weeks

 No

 Refused

10. Are you currently receiving WIC assistance?

 Yes

 No

 Don’t know

 Refused

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**PREGNANCY AND DELIVERY HISTORY**

At any time during this recent pregnancy did the doctor or other healthcare provider tell you that you have any of the following conditions?

11.Diabetes

 Yes

 No

 Don’t know

 Refused

12. High Blood Pressure?

 Yes

 No

 Don’t know

 Refused

13. Protein in your urine?

 Yes

 No

 Don’t know

 Refused

14. Preeclampsia or toxemia?

 Yes

 No

 Don’t know

 Refused

15. Early or premature labor?

 Yes

 No

 Don’t know

 Refused

16. Anemia or low blood count?

 Yes

 No

 Don’t know

 Refused

17. Severe nausea or vomiting (hyperemesis)?

 Yes

 No

 Don’t know

 Refused

18. Bladder or kidney infection?

 Yes

 No

 Don’t know

 Refused

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19. Rh disease or isoimmunization?

 Yes

 No

 Don’t know

 Refused

20. Infection with bacteria called Group B strep?

 Yes

 No

 Don’t know

 Refused

21. Infection with a Herpes virus?

 Yes

 No

 Don’t know

 Refused

22. Infection of the vagina with bacteria (bacterial vaginosis)?

 Yes

 No

 Don’t know

 Refused

23. Any other serious condition?

|  |  |  |
| --- | --- | --- |
|  | Yes – specify |   |
|  | No |  |
|  | Don’t know |  |
|  | Refused |  |

**MEDICATION AND SUBSTANCE USE**

24. Any change in medications, vitamins, or over the counter medications since your first survey?

 Yes – if yes go to question **25**

 No – if no go to question **27**

 Don’t know

 Refused

25. Are you currently taking **doctor-prescribed medications and/or vitamins** on a daily basis?

 Yes →What [prescribed] medications do you take?

25a.

25b.

25c.

25d.

 No

25e.

26. Are you currently taking **over-the-counter (non-prescription) medications and/or vitamins** on a daily basis?

 Yes →What [over the counter medications] do you take?

26a.

26b.

26c.

26d.

 No

26e.

27. Are you currently taking **herbal supplements** on a daily basis?

 Yes →What herbal supplements do you take?

27a.

27b.

27c.

27d.

 No

27e.

28. Are you currently using any **traditional or home remedies**?

 Yes →What remedies do you take?

28a.

28b.

28c.

28d.

 No

28e.

29. Have you **ever tried or used** any other recreational drugs, including illicit or street drugs or drugs that you did not have a doctor’s prescription for?

 Yes → **29a.** How many times?

 Once or twice

10 or more times

 Don’t know

 Refused

 No

30. Are you **currently** smoking marijuana?

 Yes

 No

 Refused

31. Are you **currently using** other recreational or street drugs, including drugs that you smoke or inject?

Yes →What drugs are they?

31a.

31b.

31c.

31d.

 No

31e.

32. Have you **ever tried or used** any other recreational drugs, including illicit or street drugs or drugs that you did not have a doctor’s prescription for?

 Yes →3 2a. How many times?

 Once or twice

 10 or more times

 Don’t know

 Refused

 No

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**ALCOHOL USE**

33. How often did you have a drink containing alcohol in the past year?

 Never

 Monthly or less

 Two to four times a month

 Two to three times a week

 Four or more times a week

34. How many drinks containing alcohol did you have on atypical day when you were drinking in the past year?

 0 drinks

 1 or 2

 3 or 4

 5 or 6

 7 to 9

35. How often did you have six or more drinks on one occasion in the past year?

 Never

 Less than monthly

 Monthly

 Weekly

 Daily or almost daily

**TOBACCO USE**

36. Do you smoke tobacco only for ceremonial use?

 Yes → [skip to 45]

 No

37. In your lifetime, have you smoked as many as 100 cigarettes?

 Yes

 No→ [skip to 45]

38. Was there ever a time that you smoked at least 1 cigarette a day for a month or longer?

 Yes

 No→ [skip to 45]

39. Do you now smoke cigarettes (not including those for ceremonial use only)?

 Yes

 No

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40. For about how many years total would you say that you smoked at least 1 cigarette per day?

| | |.................................................  Don’t Know

YEARS

41. During the time you smoked at least 1 cigarette a day, about how many cigarettes a day on average?

| | \_|

cigarettes/day .........................................  Don’t Know

42. When was your last cigarette?

 Today

 In the past week

 More than a week ago

 More than a month ago

 Before pregnancy

 Don’t know

 Refused

43. Did you ever quit smoking for 6 months or longer?

 Yes → If Yes: 57a. Did you quit because of your pregnancy?

 Yes

 No

No

44. If you stopped smoking cigarettes and then started smoking again, for how many years did you quit?

|  |  |  |
| --- | --- | --- |
| |\_ | | | | | | |  Don’t Know |
| months quit | years quit |  |

45. Does anyone else in your household smoke on a daily basis?

 Yes

 No

 Don’t know

 Refused

**POSTNATAL DEPRESSION SCALE QUESTIONS**

As you have recently had a baby, we would like to know how you are feeling. Please let us know which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

**In the past 7 days:**

46. I have been able to laugh and see the funny side of things

 As much as I always could

 Not quite so much now

 Definitely not so much now

 Not at all

47. I have looked forward with enjoyment to things

 As much as I ever did

 Rather less than I used to

 Definitely less than I used to

 Hardly at all

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48 .I have blamed myself unnecessarily when things went wrong

 Yes, most of the time

 Yes, some of the time

 Not very often

 No, never

49. I have been anxious or worried for no good reason

 No, not at all

 Hardly ever

 Yes, sometimes

 Yes, very often

50. I have felt scared or panicky for no very good reason

 Yes, quite a lot

 Yes, sometimes

 No, not much

 No, not at all

51. Things have been getting on top of me

 Yes, most of the time I haven’t been able to cope at all

 Yes, sometimes I haven’t been coping as well as usual

 No, most of the time I have coped quite well

 No, have been coping as well as ever

52. I have been so unhappy that I have had difficulty sleeping

 Yes, most of the time

 Yes, sometimes

 Not very often

 No, not at all

53. I have felt sad or miserable

 Yes, most of the time

 Yes, quite often

 Not very often

 No, not at all

54. I have been so unhappy that I have been crying

 Yes, most of the time

 Yes, quite often

 Only occasionally

 No, never

55. The thought of harming myself has occurred to me

 Yes, quite often

 Sometimes

 Hardly ever

 Never

**HOUSING CHARACTERISTICS**

50. Has the location of your home changed since your first survey?

 Yes

 No [Skip to question

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*[The participant may give his or her house number and street/road name, rural address, nearest highway or natural feature, or distance from Chapter House.]*

51. Is the house you are living in now…?

 Owned or being bought by you or someone in your household

 Rented by you or someone in your household, or

 Some other arrangement

 Don’t know

 Refused

52. Can you tell us, which of these categories do you think best describes when your home or building was built?

 2001 TO present

 1981 TO 2000

 1961 TO 1980

 1941 TO 1960

 1940 or before

 Don’t know

 Refused

53. How long have you lived in this home?

| | |  Weeks

NUMBER .....  Months

..........  Years

..........  Don’t know

..........  Refused

54. What type of home do you live in?

 Hogan

 Modular or site-built house

 Mobile home

 Multi-family dwelling or Apartment building

 Seasonal camp or lodging

 Hotel /motel or other temporary housing

 Other Specify

 Don’t know

 Refused

55. What is the construction of your home? (Check all that apply)

 Mobile home

 Wood frame

 Stone

 Adobe

 Crawlspace or basement

 Dirt floor

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56. Does your home contain any wood, sheet metal, metal pipes, rocks, sand, tarps, utility poles, railroad ties, or other materials from an abandoned uranium mine or mill?

 Yes

 No

56a.If yes which materials were used  Wood

 Sheet metal

 Metal pipes

 Rocks

 Sand

 Tarps

 Utility poles

 Railroad ties

 Other:

 Don’t know

 Refused

57. Does your home contain any wood, sheet metal, metal pipes, rocks, sand, utility poles, railroad ties, or other materials from oil and gas operations?

 Yes

 No

57a.If yes which materials were used  Wood

 Sheet metal

 Metal pipes

 Rocks

 Sand

 Utility poles

 Railroad ties

 Other:

 Don’t know

 Refused

58. Including yourself, how many people live in your home?

| | | NUMBER

59. Excluding bathrooms, how many total rooms are in your home?

| | | NUMBER

60. Which of these types of heat /fuel sources do you use to heat your home?

 Electric

 Gas-Natural

 Gas-Propane or LP

 Oil

 Wood

 Kerosene or diesel fuel

 Coal

 Solar energy

 No heating source

 Other specify

 Don’t know

 Refused

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60a.If you burn wood or coal in your home, what is the approximate age of your stove.

 1-5 yrs

 5-10 yrs

 10-15 yrs

 >15 yrs

60b.If you burn wood or coal in your home, how often do you personally tend the fire?

 Once per day

 1-5 x per day or more

 Once per week

 1-3 times per week

 Occasionally

61. How do you cool your home? SELECT ALL THAT APPLY.

 Fan

 Window or wall air conditioners

 Central air conditioning

 Evaporative cooler (swamp cooler)

 No cooling or air conditioning used

 Other specify

 Don’t know

 Refused

62. In the past 12 months, have you seen any water damage inside your home?

 Yes

 No

 Don’t know

 Refused

63. In the past 12 months, have you seen any mold or mildew on walls or other surfaces inside your home?

 Yes

 No

 Don’t know

 Refused

64. Since you became pregnant, have any additions been built onto your home to make it bigger, or have any renovations or other construction been done in your home? Include all projects such as painting, wallpapering, carpeting or re-finishing floors.

 Yes

 No

 Don’t know

 Refused

65. Do you have any pets that spend any time inside your home?

 Yes

 No

 Don’t know

 Refused

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66. What kind of pets are these? SELECT ALL THAT APPLY.

 Dog

 Cat

66a. Do you change the cat box?  Yes  No

 Lambs or baby goats

 Small mammal (rabbit, gerbil, hamster, guinea pig, ferret)

 Bird (including chicks)

 Fish or reptile (turtle, snake lizard)

 Other specify

 Don’t know

 Refused

67. Do you tend livestock on a regular basis in a corral or around your home now?

 Yes

 No

**WATER USAGE**

Please answer the following questions if you have moved and/or are hauling water from a new location not mentioned previously. If there is no change since the first survey this survey is complete.

68. Is your home connected to a community water system?  Yes  No  Don’t Know

68a. If yes, what is the name of the water system?

68b. If yes, is this your main source of drinking water?  Yes  No  Don’t Know

69. Do you haul water?  Yes  No  Refused

69a. If you haul water, what type of container do you use to haul water?

 Plastic

 Metal

 Glass

 Wood

 Other Specify

 Don’t know

69b. If you haul water, where do you haul water from? *[Check all that apply]*

 Lake/pond

 Stream/river

 Spring

 Rain Water

 Irrigation Water

 Cistern or tank at windmill

 Windmill

 Private well

 Grocery or convenience store/ trading post

 Navajo Tribal Utility Authority (NTUA) or other public water supply

 Other Specify

 Don’t know

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69c. If yes, in what types of containers do you store this hauled water?

 Plastic

 Metal

 Glass

 Wood

 Concrete

 Other Specify

 Don’t know

69d.If you haul water, do you filter the water you haul?

 Yes

If yes, what filters do you use?

 Charcoal filter

 Ceramic filter

 Distillation

 Boil

 Disinfect

 No, don’t do anything to the water

 Don’t know

69e. How many places do you currently haul water from? | | |

............................................................................. NUMBER

70. Using the map, can you identify the location of any water sources from which you or someone in your household has hauled water for drinking or other household use?

Please note all uses of this water for each source identified.

Name/Number of Uses of the water (drinking, cooking, livestock Number of years

Water Source watering, irrigation, bathing, other household uses)

 | | |

 | | |

 | | |

 | | |

71. What water source in your home do you use most of the time for **drinking**?

 Hauled water

 Tap or piped in water

 Filtered tap/piped in water

 Bottled water

 Other specify

 Don’t know

 Refused

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72. What water source in your home is used most of the time for **cooking**?

 Hauled water

 Tap or piped in water

 Filtered tap/piped in water

 Bottled water

 Other specify

 Don’t know

 Refused

**THANK YOU FOR YOUR TIME AND PARTICIPATION**

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