

STUDY ID: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Form Approved  
OMB No. 0920-XXXX  
Exp. Date xx/xx/20xx

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

D D M M M Y Y Y Y

Staff Administered: \_\_\_\_\_

## **PREGNANT WOMAN Enrollment Questionnaire**

City: \_\_\_\_\_

Clinic: \_\_\_\_\_

### **First, I will start with some questions about you.**

1. What is your birthdate?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
D D M M M Y Y Y Y

<sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

2. What is the highest level of education that you have completed?

<sub>1</sub> Less than primary   <sub>2</sub> Primary   <sub>3</sub> Secondary   <sub>4</sub> Technical   <sub>5</sub> University or more   <sub>6</sub> None  
<sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

3. What is your household's socioeconomic stratum?

<sub>1</sub> 1   <sub>2</sub> 2   <sub>3</sub> 3   <sub>4</sub> 4   <sub>5</sub> 5   <sub>6</sub> 6   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

4. What type of health insurance do you have?

<sub>1</sub> Contributory   <sub>2</sub> Subsidized   <sub>3</sub> Not insured   <sub>4</sub> Specialized   <sub>5</sub> Exception  
<sub>6</sub> Indeterminate / independent   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

5. What is the name of your health insurance provider?

Name: \_\_\_\_\_ <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

6. How many adults and children live in your household, including yourself?

\_\_\_\_\_ adults (18+ years)   \_\_\_\_\_ children (<18 years)   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

7. What is your marital status?

<sub>1</sub> Married   <sub>2</sub> Free Union   <sub>3</sub> Single, divorced, or widowed   <sub>4</sub> Other, specify: \_\_\_\_\_

<sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**8.** Do you live in the same household as your husband or male partner?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>66</sub> I don't have a husband or a male partner   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**The next questions are about mosquito bites.**

**9.** In the past 7 days, how many mosquito bites did you get?

<sub>0</sub> None   <sub>1</sub> Less than 20   <sub>2</sub> 20 or more, or too many to count   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**10.** In the past 7 days, how often have you done the following things? Response options include never, some of the time, or always.

	Never <sub>0</sub>	Some of the time <sub>1</sub>	Always <sub>2</sub>	<i>Don't know</i> <sub>77</sub>	<i>Refused</i> <sub>88</sub>
Worn long pants that covered your legs					
Worn shirts or jackets with long sleeves that covered your arms					
Kept your feet and ankles completely covered					
Used mosquito repellent					

**11.** In the past 7 days, when you were inside your home, how often was the air conditioner running?

<sub>3</sub> Never   <sub>2</sub> Some of the time   <sub>1</sub> Always   <sub>0</sub> I don't have air conditioning  
<sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**12.** Does your home have intact screens on all windows and doors that prevent mosquitos from entering?

<sub>2</sub> Yes, on all windows and doors   <sub>1</sub> Some   <sub>0</sub> None   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**The next questions are about what you might have heard about Zika virus.**

**13.** Do you think it's possible for a person to get Zika virus in your community?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**14.** Do you think that everybody with Zika virus has symptoms?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**15.** Do you know anyone who has had Zika virus?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─→ Have you had Zika virus?

<sub>1</sub> Yes    <sub>0</sub> No    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

**16.** How worried have you been about getting Zika virus during this pregnancy?

<sub>3</sub> Very worried    <sub>2</sub> Somewhat worried    <sub>1</sub> Not at all worried  
<sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

**17.** Momentarily, I will give you a number of statements about Zika virus; we ask that you respond if you consider it to be “very likely”, “somewhat likely”, or “impossible” that Zika can be transmitted by any of these means.

	Very likely <sub>2</sub>	Somewhat likely <sub>1</sub>	Impossible <sub>0</sub>	<i>Don't know</i> <sub>77</sub>	<i>Refused</i> <sub>88</sub>
Being bitten by an infected mosquito					
Having vaginal sex with a man who has Zika without using a condom					
Kissing someone on the mouth who has Zika					
Shaking hands with someone who has Zika					
Being coughed or sneezed on by someone who has Zika					
Receiving a blood transfusion with Zika in it					
Being in utero if a mother has Zika during pregnancy					

**18.** Momentarily, I will give you a number of statements about the possible side effects on a baby if their mother was infected with Zika during her pregnancy; we ask that you respond if you consider it to be “very likely”, “somewhat likely”, or “impossible” that a baby could be born with the following conditions:

	Very likely <sub>2</sub>	Somewhat likely <sub>1</sub>	Impossible <sub>0</sub>	<i>Don't know</i> <sub>77</sub>	<i>Refused</i> <sub>88</sub>
Microcephaly (a small sized head)					
Other birth defects					
Intrauterine growth restriction (small baby)					
Miscarriages/stillbirths					

**The next few questions are about Zika symptoms that you or your family might have had.**

**19.** In the past 3 months, have you had symptoms of Zika virus? Symptoms of Zika virus means being sick with 2 or more of fever, rash, red eyes, and joint pain that are not explained by other causes.

<sub>1</sub> Yes    <sub>0</sub> No    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

└─> When did these symptoms first start?

_	/	_	_	/	_	_	_	_
D	D	M	M	M	Y	Y	Y	Y

<sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

**20.** At any time, has a doctor or healthcare provider ever told you that you might have Zika virus?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─┬─> When?

  D  D  /  M  M  M  /  Y  Y  Y  Y

<sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

❖ **If according to question #6, this participant lives alone in her house, go to question #23.**

**21.** In the past 3 months, did anyone in your household other than you have symptoms of Zika? Symptoms of Zika means being sick with 2 or more of fever, rash red eyes, or joint pain that are not explained by any other cause.

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─┬─> Was it...

Your husband or partner?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>66</sub> Not applicable <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Your child?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>66</sub> Not applicable <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Another person in the household?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>66</sub> Not applicable <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>  <i>If yes:, Who was it?</i> _____

**22.** Has a doctor or healthcare provider ever told anyone in your household, aside from yourself, that they might have Zika virus?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─┬─> Was it...

Your husband or partner?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>66</sub> Not applicable <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Your child?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>66</sub> Not applicable <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Another person in the household?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>66</sub> Not applicable <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>  <i>If yes:, Who was it?</i> _____

**Next I'll ask you some questions about your home, community, and environment.**

**23.** Where do you usually get your drinking water? (Select all that apply.)

Public or private water utility	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Well	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Cistern or tank	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Bottled water	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Lake, river, or other natural source	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Another water source, specify:	

**24.** In the past 3 months, have you worked at a job? Include jobs in which you don't have a formal employer, such as selling goods or providing services.

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

↳ Have any of your jobs in the past 3 months involved:

X-rays	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Contact with body fluids such as urine, saliva, or blood	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Applying pesticides, insecticides, or rat poison	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Battery manufacturing or battery recycling	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Electronic waste recycling	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Gold mining or gold processing	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Other metal mining (for example: uranium, nickel, cobalt)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
A job in which you or your coworkers use lead	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
A job in which you your coworkers use mercury	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>

❖ **If according to question #6, this participant lives alone in her house, go to question #26.**

**25.** In the past 3 months, has anyone in your household other than yourself worked in the following jobs?

Battery manufacturing or battery recycling	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Electronic waste recycling	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Gold mining or gold processing	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Other metal mining (for example: uranium, nickel, cobalt)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
A job in which they or their coworkers use lead	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
A job in which they or their coworkers use mercury	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**26.** In the past 3 months, have you or your household members used any pesticides, insecticides, or rat poison in or around your home?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**Now I'll ask you about medical conditions you might have had.**

**27. Have you ever had...?**

**27a. Yellow fever**

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─> When?

Less than 3 months ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Between 3-6 months ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
7-12 months ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
13 months-5 years ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
More than 5 years ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**27b. Dengue**

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─> When?

Less than 3 months ago	<input type="checkbox"/> <sub>1</sub> Yes ──> <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>	Was it hemorrhagic? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Between 3-6 months ago	<input type="checkbox"/> <sub>1</sub> Yes ──> <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>	Was it hemorrhagic? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
7-12 months ago	<input type="checkbox"/> <sub>1</sub> Yes ──> <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>	Was it hemorrhagic? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
13 months-5 years ago	<input type="checkbox"/> <sub>1</sub> Yes ──> <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>	Was it hemorrhagic? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
More than 5 years ago	<input type="checkbox"/> <sub>1</sub> Yes ──> <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>	Was it hemorrhagic? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**27c. Chikungunya**

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─┬─> When?

Less than 3 months ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Between 3-6 months ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
7-12 months ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
13 months-5 years ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
More than 5 years ago	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**28. Have you ever been vaccinated for yellow fever?**

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**The next questions are about smoking, drug use, alcohol, and vitamin use.**

**29. In the past 3 months, have you ...?**

Smoked cigarettes	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Smoked marijuana	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Used drugs such as crack, cocaine, or heroin	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**30. In the past 3 months, how many alcoholic drinks (such as beer, wine, or others) have you had in an average week?**

- <sub>6</sub> I drank, but I don't know how much  
<sub>5</sub> 14 drinks or more a week  
<sub>4</sub> 7-13 drinks a week  
<sub>3</sub> 4-6 drinks a week  
<sub>2</sub> 1-3 drinks a week  
<sub>1</sub> Less than 1 drink a week  
<sub>0</sub> None  
<sub>77</sub> *Don't know*  
<sub>88</sub> *Refused*

**31. In the past 3 months, have you taken folic acid?**

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

└─┬─> **31a.** When did you start taking it?

- <sub>1</sub> Before I found out I was pregnant  
<sub>0</sub> After I found out I was pregnant  
<sub>77</sub> *Don't know*  
<sub>88</sub> *Refused*

**31b. Are you currently taking folic acid?**

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

**The next questions are about your pregnancies.**

**32.** What was your weight when you got pregnant?

\_\_\_\_\_ kg    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

**33.** What is your height?

\_\_\_\_\_ cm    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

**34.** How many total pregnancies have you had (not including this pregnancy)? (All previous pregnancies, including miscarriages):

\_\_\_\_\_ number of pregnancies    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

❖ **If participant responds “zero”, go to question #39.**

**35.** Did any of these pregnancies have more than one fetus, such as twins or triplets?

<sub>1</sub> Yes    <sub>0</sub> No    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

↳ How many pregnancies had more than one fetus?

\_\_\_\_\_ number of pregnancies    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

**36.** In how many of your previous pregnancies (not including this pregnancy) did you have...?

Live birth	_____ number of live births <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Miscarriage (loss before 20 <sup>th</sup> week)	_____ number of miscarriages (loss before 20 <sup>th</sup> week) <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Stillbirth (loss at or after the 20 <sup>th</sup> week)	_____ number of stillbirths (loss at or after the 20 <sup>th</sup> week) <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Abortion	_____ number of abortions <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Ectopic or molar pregnancy	_____ number of ectopic or molar pregnancies <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**37.** During your previous [pregnancy/pregnancies], in how many pregnancies (not including this pregnancy)...?

Did your doctor tell you that you had pre-eclampsia (high blood pressure in pregnancy)	_____ number of pregnancies with with pre-eclampsia <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Did your doctor tell you that you had gestational diabetes (diabetes diagnosed in pregnancy)	_____ number of pregnancies with gestational diabetes <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>




Did you have a premature birth (delivery before 37 weeks)	_____ number of premature births <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Did you have a baby who was born weighing less than 2500g, or 2.5 kg	_____ number of babies with low birth weight <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Did you have a Cesarean section	_____ number of Cesarean sections <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Did you breastfeed your baby	_____ number of babies breastfed <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>

38. When did your last pregnancy end?

<sub>77</sub> *Don't know*   <sub>88</sub> *Refused*  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 D D M M M Y Y Y Y

39. For your current pregnancy, when was your last menstrual period?


<sub>77</sub> *Don't know*   <sub>88</sub> *Refused*  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 D D M M M Y Y Y Y


 How sure are you about the date of your last menstrual period?

<sub>0</sub> Not sure   <sub>1</sub> Sure   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*

40. Did you use any fertility treatments to help you get pregnant?

<sub>1</sub> Yes   <sub>0</sub> No   <sub>77</sub> *Don't know*   <sub>88</sub> *Refused*


 Did you use...?

Medicine for ovarian stimulation, such as clomiphene citrate or Femara	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Intrauterine insemination	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
In vitro fertilization (IVF)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Intracytoplasmic sperm injection	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>

41. Thinking back to right before you became pregnant, which of these statements best describes how you felt about being pregnant?

- <sub>4</sub> I wanted to be pregnant sooner
- <sub>3</sub> I wanted to be pregnant later
- <sub>2</sub> I wanted to be pregnant then
- <sub>1</sub> I didn't want to be pregnant then or at any time in the future
- <sub>77</sub> I don't know
- <sub>88</sub> *Refused*

**These next few questions are about your recent sexual experiences. You do not have to answer any questions if they make you uncomfortable.**

**42.** In the past 3 months, how many men have you had sex with?

- <sub>0</sub> None → **This is the end of the questionnaire.**  
<sub>1</sub> 1  
<sub>2</sub> 2  
<sub>3</sub> 3 or more  
<sub>77</sub> *Don't know* → **This is the end of the questionnaire.**  
<sub>88</sub> *Refused* → **This is the end of the questionnaire.**

**43.** In the past 3 months, how often have you had vaginal sex with a man? Choose the best answer.

- <sub>1</sub> Once a day or more (About 7 times or more per week)  
<sub>2</sub> 2-6 times a week  
<sub>3</sub> Once a week (About 4 times per month)  
<sub>4</sub> 2-3 a month  
<sub>5</sub> Once a month  
<sub>6</sub> Less than once a month  
<sub>0</sub> Never → **Go to question #46**  
<sub>77</sub> *Don't know* → **Go to question #46**  
<sub>88</sub> *Refused* → **Go to the question #46**

**44.** When you had vaginal sex in the past 3 months, how often has your male partner used a condom?

- <sub>2</sub> Always    <sub>1</sub> Sometimes    <sub>0</sub> Never    <sub>77</sub> *Don't know*    <sub>88</sub> *Refused*

**45.** In the past 3 months, have you...?

Received oral sex from someone	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Performed oral sex on someone	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Had anal sex	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**46.** Since you found out that you were pregnant, have you and your male partner changed how often you use condoms during sex?

- <sub>1</sub> Yes, we use them more often  
<sub>2</sub> Yes, we use them less often  
<sub>3</sub> No, we haven't changed how often we use condoms  
<sub>4</sub> No, we don't use condoms  
<sub>0</sub> I haven't had regular sex with a male partner  
<sub>77</sub> *Don't know*  
<sub>88</sub> *Refused*

**Thank you for answering the questionnaire. Do you have any questions?**