


Wyoming PRAMS Grantee Web Questionnaire In PRAMS Integrated Data Collection System [PIDS]

Prms Web Survey Module Portal x +

prams-test.cdc.gov

 Department of Health and Human Services
Centers for Disease Control and Prevention

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Welcome to Pregnancy Risk Assessment Monitoring System (PRAMS) Survey

1 ————— 2 ————— 3


Please enter the User ID and Passcode that were provided in your letter.

User ID *

Passcode *


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Centers for Disease Control and Prevention
1600 Clifton Rd, Atlanta, GA 30333, U.S.A

 [Department of Health and Human Services](#)



Welcome to Wyoming's Pregnancy Risk Assessment Monitoring System (PRAMS) Survey



Form Approved
OMB No. 0920-1273
Exp. Date 11/30/2022

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Welcome to Wyoming's Pregnancy Risk Assessment Monitoring System (PRAMS) Survey



Please confirm your year of birth.

Mother's Year Of Bir... ▾

Email Address (optional)

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MomID: 2021WY081099

Choose a language:

- English
- Spanish

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MatrID: 2021WY081099

Important Information About PRAMS

Please Read Before Starting the Survey

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a research project sponsored by the Centers for Disease Control and Prevention and the Wyoming Department of Health

The purpose of the study is to find out why some babies are born healthy and others are not.

We are asking 1 out of every 7 women in Wyoming to answer the same questions. All of your names were picked by a computer from recent birth certificates.

It takes about 25 to 42 minutes to answer all questions. Some questions may be sensitive, such as questions about smoking or drinking during pregnancy.

You are free to do the survey or not. If you don't want to participate at all, or if you don't want to answer a particular question, that's okay. There is no penalty or loss of benefits for not participating or answering all questions.

Your survey may be combined with information the health department has from other sources.

If you choose to do the survey, your answers will be kept private to the extent allowed by law and will be used only for research. If you are currently in jail, your participation in the study will have no effect on parole.

Your name will not be on any reports from PRAMS.

Your answers will be grouped with those from other women. What we learn from PRAMS will be used to plan programs to help mothers and babies in Wyoming.

If you have any questions about your rights in the project, please call Amy Spieker at 307-777-5825.

If you have questions about PRAMS, please call 307-777-5825.

If you want to complete the survey by telephone, please call 1-855-822-1778. The call is free.

I have read the information above and agree to continue with the survey.

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Choose how you would like to answer questions about height and weight:

- feet, inches, pounds
- centimeters, kilograms

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The first questions are about you.

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1. How tall are you without shoes?

Feet

Inches

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2. *Just before you got pregnant with your new baby, how much did you weigh?*

Pounds

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3. What is *your* date of birth?

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The next questions are about the time before you got pregnant with your new baby.

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1%

4. During the 3 months before you got pregnant with your new baby, did you have any of the following health conditions? For each one, check No if you did not have the condition or Yes if you did.

	No	Yes
Type 1 or Type 2 diabetes (<u>not</u> gestational diabetes or diabetes that starts during pregnancy)	<input type="radio"/>	<input type="radio"/>
High blood pressure or hypertension	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>

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5. During the *month before* you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

- I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the *month before* I got pregnant
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week

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6. In the 12 months before you got pregnant with your new baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?

- No
- Yes

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7. What type of health care visit did you have in the 12 months before you got pregnant with your new baby? Check ALL that apply

- | | No | Yes |
|---|-----------------------|-----------------------|
| Regular checkup at my family doctor's office | <input type="radio"/> | <input type="radio"/> |
| Regular checkup at my OB/GYN's office | <input type="radio"/> | <input type="radio"/> |
| Visit for an illness or chronic condition | <input type="radio"/> | <input type="radio"/> |
| Visit for an injury | <input type="radio"/> | <input type="radio"/> |
| Visit for family planning or birth control | <input type="radio"/> | <input type="radio"/> |
| Visit for depression or anxiety | <input type="radio"/> | <input type="radio"/> |
| Visit to have my teeth cleaned by a dentist or dental hygienist | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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7. What type of health care visit did you have in the 12 months before you got pregnant with your new baby? Check ALL that apply

- | | No | Yes |
|---|-----------------------|----------------------------------|
| Regular checkup at my family doctor's office | <input type="radio"/> | <input type="radio"/> |
| Regular checkup at my OB/GYN's office | <input type="radio"/> | <input type="radio"/> |
| Visit for an illness or chronic condition | <input type="radio"/> | <input type="radio"/> |
| Visit for an injury | <input type="radio"/> | <input type="radio"/> |
| Visit for family planning or birth control | <input type="radio"/> | <input type="radio"/> |
| Visit for depression or anxiety | <input type="radio"/> | <input type="radio"/> |
| Visit to have my teeth cleaned by a dentist or dental hygienist | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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5%

7. What type of health care visit did you have in the 12 months before you got pregnant with your new baby? Check ALL that apply

- | | No | Yes |
|---|----------------------------------|----------------------------------|
| Regular checkup at my family doctor's office | <input type="radio"/> | <input type="radio"/> |
| Regular checkup at my OB/GYN's office | <input type="radio"/> | <input checked="" type="radio"/> |
| Visit for an illness or chronic condition | <input type="radio"/> | <input type="radio"/> |
| Visit for an injury | <input type="radio"/> | <input type="radio"/> |
| Visit for family planning or birth control | <input type="radio"/> | <input type="radio"/> |
| Visit for depression or anxiety | <input type="radio"/> | <input type="radio"/> |
| Visit to have my teeth cleaned by a dentist or dental hygienist | <input type="radio"/> | <input type="radio"/> |
| Other | <input checked="" type="radio"/> | <input type="radio"/> |

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8. During any of your health care visits in the *12 months before* you got pregnant, did a doctor, nurse, or other health care worker do any of the following things? For each item, check **No** if they did not or **Yes** if they did.

	No	Yes
Tell me to take a vitamin with folic acid	<input type="radio"/>	<input type="radio"/>
Talk to me about maintaining a healthy weight	<input type="radio"/>	<input type="radio"/>
Talk to me about controlling any medical conditions such as diabetes or high blood pressure	<input type="radio"/>	<input type="radio"/>
Talk to me about my desire to have or not have children	<input type="radio"/>	<input type="radio"/>
Talk to me about using birth control to prevent pregnancy	<input type="radio"/>	<input type="radio"/>
Talk to me about how I could improve my health before a pregnancy	<input type="radio"/>	<input type="radio"/>
Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis	<input type="radio"/>	<input type="radio"/>
Ask me if I was smoking cigarettes	<input type="radio"/>	<input type="radio"/>
Ask me if someone was hurting me emotionally or physically	<input type="radio"/>	<input type="radio"/>
Ask me if I was feeling down or depressed	<input type="radio"/>	<input type="radio"/>
Ask me about the kind of work I do	<input type="radio"/>	<input type="radio"/>
Test me for HIV (the virus that causes AIDS)	<input type="radio"/>	<input type="radio"/>

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The next questions are about your *health insurance coverage* before, during and after your pregnancy with your *new baby*.

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9. During the *month before* you got pregnant with your new baby, what kind of health insurance did you have? Check ALL that apply

	No	Yes
Private health insurance from my job or the job of my husband or partner	<input type="radio"/>	<input type="radio"/>
Private health insurance from my parents	<input type="radio"/>	<input type="radio"/>
Private health insurance from the Health Insurance Marketplace or HealthCare.gov	<input type="radio"/>	<input type="radio"/>
Medicaid or Equality Care	<input type="radio"/>	<input type="radio"/>
Kid Care (CHIP)	<input type="radio"/>	<input type="radio"/>
TRICARE or other military health care	<input type="radio"/>	<input type="radio"/>
Indian Health Service (IHS)	<input type="radio"/>	<input type="radio"/>
Other health insurance	<input type="radio"/>	<input type="radio"/>

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9. During the *month before* you got pregnant with your new baby, what kind of health insurance did you have? Check ALL that apply

- | | No | Yes |
|--|-----------------------|----------------------------------|
| Private health insurance from my job or the job of my husband or partner | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from my parents | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or Equality Care | <input type="radio"/> | <input type="radio"/> |
| Kid Care (CHIP) | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Indian Health Service (IHS) | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input checked="" type="radio"/> |

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9. During the *month before* you got pregnant with your new baby, what kind of health insurance did you have? Check ALL that apply

	No	Yes
Private health insurance from my job or the job of my husband or partner	<input type="radio"/>	<input type="radio"/>
Private health insurance from my parents	<input type="radio"/>	<input type="radio"/>
Private health insurance from the Health Insurance Marketplace or HealthCare.gov	<input type="radio"/>	<input type="radio"/>
Medicaid or Equality Care	<input type="radio"/>	<input type="radio"/>
Kid Care (CHIP)	<input type="radio"/>	<input checked="" type="radio"/>
TRICARE or other military health care	<input type="radio"/>	<input type="radio"/>
Indian Health Service (IHS)	<input type="radio"/>	<input type="radio"/>
Other health insurance	<input type="radio"/>	<input checked="" type="radio"/>

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I did not have any health insurance during the *month before* I got pregnant

- No
- Yes

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Did you go for prenatal care?

- No
- Yes

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10. During your *most recent pregnancy*, what kind of health insurance did you have for your *prenatal care*? Check ALL that apply

	No	Yes
I did not go for prenatal care	<input type="radio"/>	<input type="radio"/>
Private health insurance from my job or the job of my husband or partner	<input type="radio"/>	<input type="radio"/>
Private health insurance from my parents	<input type="radio"/>	<input type="radio"/>
Private health insurance from the Health Insurance Marketplace or HealthCare.gov	<input type="radio"/>	<input type="radio"/>
Medicaid or Equality Care	<input type="radio"/>	<input type="radio"/>
Kid Care (CHIP)	<input type="radio"/>	<input type="radio"/>
TRICARE or other military health care	<input type="radio"/>	<input type="radio"/>
Indian Health Service (IHS)	<input type="radio"/>	<input type="radio"/>
Other health insurance	<input type="radio"/>	<input type="radio"/>

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10. During your **most recent pregnancy**, what kind of health insurance did you have for your **prenatal care**? Check ALL that apply

- | | No | Yes |
|--|-----------------------|----------------------------------|
| I did not go for prenatal care | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from my job or the job of my husband or partner | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from my parents | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or Equality Care | <input type="radio"/> | <input type="radio"/> |
| Kid Care (CHIP) | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Indian Health Service (IHS) | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input checked="" type="radio"/> |

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10. During your *most recent pregnancy*, what kind of health insurance did you have for your *prenatal care*? Check ALL that apply

- | | No | Yes |
|--|----------------------------------|----------------------------------|
| I did not go for prenatal care | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from my job or the job of my husband or partner | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from my parents | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input checked="" type="radio"/> |
| Medicaid or Equality Care | <input type="radio"/> | <input type="radio"/> |
| Kid Care (CHIP) | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Indian Health Service (IHS) | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input checked="" type="radio"/> | <input type="radio"/> |

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11. What kind of health insurance do you have now? Check ALL that apply

	No	Yes
Private health insurance from my job or the job of my husband or partner	<input type="radio"/>	<input type="radio"/>
Private health insurance from my parents	<input type="radio"/>	<input type="radio"/>
Private health insurance from the Health Insurance Marketplace or HealthCare.gov	<input type="radio"/>	<input type="radio"/>
Medicaid or Equality Care	<input type="radio"/>	<input type="radio"/>
Kid Care (CHIP)	<input type="radio"/>	<input type="radio"/>
TRICARE or other military health care	<input type="radio"/>	<input type="radio"/>
Indian Health Service (IHS)	<input type="radio"/>	<input type="radio"/>
Other health insurance	<input type="radio"/>	<input type="radio"/>

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11. What kind of health insurance do you have now? Check ALL that apply

- | | No | Yes |
|--|-----------------------|----------------------------------|
| Private health insurance from my job or the job of my husband or partner | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from my parents | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or Equality Care | <input type="radio"/> | <input type="radio"/> |
| Kid Care (CHIP) | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Indian Health Service (IHS) | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input checked="" type="radio"/> |

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11. What kind of health insurance do you have *now*? Check ALL that apply

- | | No | Yes |
|--|----------------------------------|----------------------------------|
| Private health insurance from my job or the job of my husband or partner | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from my parents | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or Equality Care | <input type="radio"/> | <input type="radio"/> |
| Kid Care (CHIP) | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input checked="" type="radio"/> |
| Indian Health Service (IHS) | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input checked="" type="radio"/> | <input type="radio"/> |

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I do not have health insurance *now*

- No
- Yes

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

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

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11%

The next questions are about the prenatal care you received during your most recent pregnancy. Prenatal care includes visits to a doctor, nurse, or other health care worker before your baby was born to get checkups and advice about pregnancy. It may help to look at the calendar when you answer these questions.

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13. How many weeks or months pregnant were you when you had your first visit for prenatal care?

- Weeks
- Months
- I didn't go for prenatal care

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12%

14. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the things listed below? For each item, check No if they did not ask you about it or Yes if they did.

- | | No | Yes |
|---|-----------------------|-----------------------|
| If I knew how much weight I should gain during pregnancy | <input type="radio"/> | <input type="radio"/> |
| If I was taking any prescription medication | <input type="radio"/> | <input type="radio"/> |
| If I was smoking cigarettes | <input type="radio"/> | <input type="radio"/> |
| If I was drinking alcohol | <input type="radio"/> | <input type="radio"/> |
| If someone was hurting me emotionally or physically | <input type="radio"/> | <input type="radio"/> |
| If I was feeling down or depressed | <input type="radio"/> | <input type="radio"/> |
| If I was using drugs such as marijuana, cocaine, crack, or meth | <input type="radio"/> | <input type="radio"/> |
| If I wanted to be tested for HIV (the virus that causes AIDS) | <input type="radio"/> | <input type="radio"/> |
| If I planned to breastfeed my new baby | <input type="radio"/> | <input type="radio"/> |
| If I planned to use birth control after my baby was born | <input type="radio"/> | <input type="radio"/> |

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15. During the 12 months *before the delivery* of your new baby, did a doctor, nurse, or other health care worker *offer* you a flu shot or *tell* you to get one?

- No
- Yes

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16. During the 12 months *before the delivery* of your new baby, did you get a flu shot? Check ONE answer

- No
- Yes, before my pregnancy
- Yes, during my pregnancy

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15%

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

- No
- Yes

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18%

18. During *your most recent pregnancy*, did a home visitor come to your home to help you prepare for your new baby? A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps pregnant women.

- No
- Yes

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17%

19. During your most recent pregnancy, what did you think about breastfeeding your new baby? Check ONE answer

- I knew I wanted to breastfeed
- I thought I might breastfeed
- I knew I would *not* breastfeed
- I didn't know what to do about breastfeeding

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15%

20. During *your most recent pregnancy*, did you have any of the following health conditions? For each one, check **No** if you did not have the condition or **Yes** if you did.

	No	Yes
Gestational diabetes (diabetes that started during <i>this pregnancy</i>)	<input type="radio"/>	<input type="radio"/>
High blood pressure (that started during <i>this pregnancy</i>), pre-eclampsia or eclampsia	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>

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The next questions are about smoking cigarettes before, during, and after pregnancy.

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

- No
- Yes

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20%

22. In the 3 months *before* you got pregnant, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I didn't smoke then

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21%

23. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I didn't smoke then

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22%

24. How many cigarettes do you smoke on an average day *now*? A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I don't smoke now

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22%

24. How many cigarettes do you smoke on an average day *now*? A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I don't smoke now

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23%

The next questions are about using other tobacco products around the time of pregnancy.

E-cigarettes (electronic cigarettes) and other electronic nicotine products (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.

Hookahs are water pipes used to smoke tobacco. These are not e-hookahs or hookah pens.

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23%

25. Have you used any of the following products in the past 2 years? For each item, check No if you did not use it or Yes if you did.

- | | No | Yes |
|--|-----------------------|-----------------------|
| E-cigarettes or other electronic nicotine products | <input type="radio"/> | <input type="radio"/> |
| Hookah | <input type="radio"/> | <input type="radio"/> |
| Chewing tobacco, snuff, snus, or dip | <input type="radio"/> | <input type="radio"/> |

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24%

26. During the 3 months *before* you got pregnant, on average, how often did you use e-cigarettes or other electronic nicotine products?

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

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25%

27. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes or other electronic nicotine products?

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

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The next questions are about drinking alcohol around the time of pregnancy.

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28. Have you had any alcoholic drinks in the past 2 years? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

- No
- Yes

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29. During the 3 months *before* you got pregnant, how many alcoholic drinks did you have in an average week?

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

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28%

30. During the *last 3 months* of your pregnancy, how many alcoholic drinks did you have in an average week?

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

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

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31. This question is about things that may have happened during the 12 months before your new baby was born. For each item, check No if it did not happen to you or Yes if it did. (It may help to look at the calendar when you answer these questions.)

	No	Yes
A close family member was very sick and had to go into the hospital	<input type="radio"/>	<input type="radio"/>
I got separated or divorced from my husband or partner	<input type="radio"/>	<input type="radio"/>
I moved to a new address	<input type="radio"/>	<input type="radio"/>
I was homeless or had to sleep outside, in a car, or in a shelter	<input type="radio"/>	<input type="radio"/>
My husband or partner lost their job	<input type="radio"/>	<input type="radio"/>
I lost my job even though I wanted to go on working	<input type="radio"/>	<input type="radio"/>
My husband, partner, or I had a cut in work hours or pay	<input type="radio"/>	<input type="radio"/>
I was apart from my husband or partner due to military deployment or extended work-related travel	<input type="radio"/>	<input type="radio"/>
I argued with my husband or partner more than usual	<input type="radio"/>	<input type="radio"/>
My husband or partner said they didn't want me to be pregnant	<input type="radio"/>	<input type="radio"/>
I had problems paying the rent, mortgage, or other bills	<input type="radio"/>	<input type="radio"/>
My husband, partner, or I went to jail	<input type="radio"/>	<input type="radio"/>
Someone very close to me had a problem with drinking or drugs	<input type="radio"/>	<input type="radio"/>
Someone very close to me died	<input type="radio"/>	<input type="radio"/>

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32. During the 12 months before your new baby was born, did you ever eat less than you felt you should because there wasn't enough money to buy food?

- No
- Yes

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33. During the 12 months before your new baby was born, did you feel emotionally upset (for example, angry, sad, or frustrated) as a result of how you were treated based on your race?

- No
- Yes

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34. In the **12 months before you got pregnant** with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

	No	Yes
My husband or partner	<input type="radio"/>	<input type="radio"/>
My ex-husband or ex-partner	<input type="radio"/>	<input type="radio"/>
Another family member	<input type="radio"/>	<input type="radio"/>
Someone else	<input type="radio"/>	<input type="radio"/>

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35. During *your most recent pregnancy*, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check No if they did not hurt you during this time or Yes if they did.

	No	Yes
My husband or partner	<input type="radio"/>	<input type="radio"/>
My ex-husband or ex-partner	<input type="radio"/>	<input type="radio"/>
Another family member	<input type="radio"/>	<input type="radio"/>
Someone else	<input type="radio"/>	<input type="radio"/>

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

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36. When was your new baby born?

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37. Did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)?

- No
- Yes
- I don't know

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38. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)? Check ALL that apply

	No	Yes
My water broke and there was a fear of infection	<input type="radio"/>	<input type="radio"/>
I was past my due date	<input type="radio"/>	<input type="radio"/>
My health care provider worried about the size of the baby	<input type="radio"/>	<input type="radio"/>
My baby was not doing well and needed to be born	<input type="radio"/>	<input type="radio"/>
I had a complication in my pregnancy (such as low amniotic fluid or preeclampsia)	<input type="radio"/>	<input type="radio"/>
I wanted to schedule my delivery	<input type="radio"/>	<input type="radio"/>
I wanted to give birth with a specific health care provider	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

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38. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)? Check ALL that apply

- | | No | Yes |
|---|-----------------------|----------------------------------|
| My water broke and there was a fear of infection | <input type="radio"/> | <input type="radio"/> |
| I was past my due date | <input type="radio"/> | <input type="radio"/> |
| My health care provider worried about the size of the baby | <input type="radio"/> | <input type="radio"/> |
| My baby was not doing well and needed to be born | <input type="radio"/> | <input type="radio"/> |
| I had a complication in my pregnancy (such as low amniotic fluid or preeclampsia) | <input type="radio"/> | <input type="radio"/> |
| I wanted to schedule my delivery | <input type="radio"/> | <input type="radio"/> |
| I wanted to give birth with a specific health care provider | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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38. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)? Check ALL that apply

	No	Yes
My water broke and there was a fear of infection	<input type="radio"/>	<input type="radio"/>
I was past my due date	<input type="radio"/>	<input type="radio"/>
My health care provider worried about the size of the baby	<input type="radio"/>	<input type="radio"/>
My baby was not doing well and needed to be born	<input type="radio"/>	<input type="radio"/>
I had a complication in my pregnancy (such as low amniotic fluid or preeclampsia)	<input type="radio"/>	<input checked="" type="radio"/>
I wanted to schedule my delivery	<input type="radio"/>	<input type="radio"/>
I wanted to give birth with a specific health care provider	<input type="radio"/>	<input type="radio"/>
Other	<input checked="" type="radio"/>	<input type="radio"/>

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39. How was your new baby delivered?

- Vaginally
- Cesarean delivery (c-section)

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40. What was the reason that your new baby was born by cesarean delivery (c-section)? Check ALL that apply

	No	Yes
I had a previous cesarean delivery (c-section)	<input type="radio"/>	<input type="radio"/>
My baby was in the wrong position (such as breech)	<input type="radio"/>	<input type="radio"/>
I was past my due date	<input type="radio"/>	<input type="radio"/>
My health care provider worried that my baby was too big	<input type="radio"/>	<input type="radio"/>
I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)	<input type="radio"/>	<input type="radio"/>
I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)	<input type="radio"/>	<input type="radio"/>
My health care provider tried to induce my labor, but it didn't work	<input type="radio"/>	<input type="radio"/>
Labor was taking too long	<input type="radio"/>	<input type="radio"/>
The fetal monitor showed that my baby was having problems before or during labor (fetal distress)	<input type="radio"/>	<input type="radio"/>
I wanted to schedule my delivery	<input type="radio"/>	<input type="radio"/>
I didn't want to have my baby vaginally	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

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40. What was the reason that your new baby was born by cesarean delivery (c-section)? Check ALL that apply

- | | No | Yes |
|--|-----------------------|----------------------------------|
| I had a previous cesarean delivery (c-section) | <input type="radio"/> | <input type="radio"/> |
| My baby was in the wrong position (such as breech) | <input type="radio"/> | <input type="radio"/> |
| I was past my due date | <input type="radio"/> | <input type="radio"/> |
| My health care provider worried that my baby was too big | <input type="radio"/> | <input type="radio"/> |
| I had a medical condition that made labor dangerous for me (such as heart condition, physical disability) | <input type="radio"/> | <input type="radio"/> |
| I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor) | <input type="radio"/> | <input type="radio"/> |
| My health care provider tried to induce my labor, but it didn't work | <input type="radio"/> | <input type="radio"/> |
| Labor was taking too long | <input type="radio"/> | <input type="radio"/> |
| The fetal monitor showed that my baby was having problems before or during labor (fetal distress) | <input type="radio"/> | <input type="radio"/> |
| I wanted to schedule my delivery | <input type="radio"/> | <input type="radio"/> |
| I didn't want to have my baby vaginally | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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3%

40. What was the reason that your new baby was born by cesarean delivery (c-section)? Check ALL that apply

	No	Yes
I had a previous cesarean delivery (c-section)	<input type="radio"/>	<input type="radio"/>
My baby was in the wrong position (such as breech)	<input type="radio"/>	<input type="radio"/>
I was past my due date	<input type="radio"/>	<input type="radio"/>
My health care provider worried that my baby was too big	<input type="radio"/>	<input type="radio"/>
I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)	<input type="radio"/>	<input type="radio"/>
I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)	<input type="radio"/>	<input type="radio"/>
My health care provider tried to induce my labor, but it didn't work	<input type="radio"/>	<input type="radio"/>
Labor was taking too long	<input type="radio"/>	<input checked="" type="radio"/>
The fetal monitor showed that my baby was having problems before or during labor (fetal distress)	<input type="radio"/>	<input type="radio"/>
I wanted to schedule my delivery	<input type="radio"/>	<input type="radio"/>
I didn't want to have my baby vaginally	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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41. After your baby was delivered, how long did he or she stay in the hospital?

- Less than 24 hours (less than 1 day)
- 24 to 48 hours (1 to 2 days)
- 3 to 5 days
- 6 to 14 days
- More than 14 days
- My baby was not born in a hospital
- My baby is still in the hospital

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42. Is your baby alive now?

- No - We are very sorry for your loss.
- Yes

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43. Is your baby living with you now?

- No
- Yes

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44. Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources? For each one, check **No** if you did not receive information from this source or **Yes** if you did.

- | | No | Yes |
|---|-----------------------|-----------------------|
| My doctor | <input type="radio"/> | <input type="radio"/> |
| A nurse, midwife, or doula | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding or lactation specialist | <input type="radio"/> | <input type="radio"/> |
| My baby's doctor or health care provider | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding support group | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding hotline or toll-free number | <input type="radio"/> | <input type="radio"/> |
| Family or friends | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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44. Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources? For each one, check **No** if you did not receive information from this source or **Yes** if you did.

- | | No | Yes |
|---|-----------------------|----------------------------------|
| My doctor | <input type="radio"/> | <input type="radio"/> |
| A nurse, midwife, or doula | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding or lactation specialist | <input type="radio"/> | <input type="radio"/> |
| My baby's doctor or health care provider | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding support group | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding hotline or toll-free number | <input type="radio"/> | <input type="radio"/> |
| Family or friends | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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44. Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources? For each one, check **No** if you did not receive information from this source or **Yes** if you did.

- | | No | Yes |
|---|----------------------------------|----------------------------------|
| My doctor | <input type="radio"/> | <input type="radio"/> |
| A nurse, midwife, or doula | <input type="radio"/> | <input checked="" type="radio"/> |
| A breastfeeding or lactation specialist | <input type="radio"/> | <input type="radio"/> |
| My baby's doctor or health care provider | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding support group | <input type="radio"/> | <input type="radio"/> |
| A breastfeeding hotline or toll-free number | <input type="radio"/> | <input type="radio"/> |
| Family or friends | <input type="radio"/> | <input type="radio"/> |
| Other | <input checked="" type="radio"/> | <input type="radio"/> |

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45. Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time?

- No
- Yes

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46. Are you currently breastfeeding or feeding pumped milk to your new baby?

- No
- Yes

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

- Less than 1 week
- Weeks
- Months

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45%

48. What were your reasons for stopping breastfeeding? Check ALL that apply

- | | No | Yes |
|---|-----------------------|-----------------------|
| My baby had difficulty latching or nursing | <input type="radio"/> | <input type="radio"/> |
| Breast milk alone did not satisfy my baby | <input type="radio"/> | <input type="radio"/> |
| I thought my baby was not gaining enough weight | <input type="radio"/> | <input type="radio"/> |
| My nipples were sore, cracked, or bleeding or it was too painful | <input type="radio"/> | <input type="radio"/> |
| I thought I was not producing enough milk, or my milk dried up | <input type="radio"/> | <input type="radio"/> |
| I had too many other household duties | <input type="radio"/> | <input type="radio"/> |
| I felt it was the right time to stop breastfeeding | <input type="radio"/> | <input type="radio"/> |
| I got sick or I had to stop for medical reasons | <input type="radio"/> | <input type="radio"/> |
| I went back to work | <input type="radio"/> | <input type="radio"/> |
| I went back to school | <input type="radio"/> | <input type="radio"/> |
| My partner did not support breastfeeding | <input type="radio"/> | <input type="radio"/> |
| My baby was jaundiced (yellowing of the skin or whites of the eyes) | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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48. What were your reasons for stopping breastfeeding? Check ALL that apply

- | | No | Yes |
|---|-----------------------|----------------------------------|
| My baby had difficulty latching or nursing | <input type="radio"/> | <input type="radio"/> |
| Breast milk alone did not satisfy my baby | <input type="radio"/> | <input type="radio"/> |
| I thought my baby was not gaining enough weight | <input type="radio"/> | <input type="radio"/> |
| My nipples were sore, cracked, or bleeding or it was too painful | <input type="radio"/> | <input type="radio"/> |
| I thought I was not producing enough milk, or my milk dried up | <input type="radio"/> | <input type="radio"/> |
| I had too many other household duties | <input type="radio"/> | <input type="radio"/> |
| I felt it was the right time to stop breastfeeding | <input type="radio"/> | <input type="radio"/> |
| I got sick or I had to stop for medical reasons | <input type="radio"/> | <input type="radio"/> |
| I went back to work | <input type="radio"/> | <input type="radio"/> |
| I went back to school | <input type="radio"/> | <input type="radio"/> |
| My partner did not support breastfeeding | <input type="radio"/> | <input type="radio"/> |
| My baby was jaundiced (yellowing of the skin or whites of the eyes) | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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45%

48. What were your reasons for stopping breastfeeding? Check ALL that apply

- | | No | Yes |
|---|----------------------------------|----------------------------------|
| My baby had difficulty latching or nursing | <input type="radio"/> | <input type="radio"/> |
| Breast milk alone did not satisfy my baby | <input type="radio"/> | <input type="radio"/> |
| I thought my baby was not gaining enough weight | <input type="radio"/> | <input type="radio"/> |
| My nipples were sore, cracked, or bleeding or it was too painful | <input type="radio"/> | <input type="radio"/> |
| I thought I was not producing enough milk, or my milk dried up | <input type="radio"/> | <input type="radio"/> |
| I had too many other household duties | <input type="radio"/> | <input type="radio"/> |
| I felt it was the right time to stop breastfeeding | <input type="radio"/> | <input checked="" type="radio"/> |
| I got sick or I had to stop for medical reasons | <input type="radio"/> | <input type="radio"/> |
| I went back to work | <input type="radio"/> | <input type="radio"/> |
| I went back to school | <input type="radio"/> | <input type="radio"/> |
| My partner did not support breastfeeding | <input type="radio"/> | <input type="radio"/> |
| My baby was jaundiced (yellowing of the skin or whites of the eyes) | <input type="radio"/> | <input type="radio"/> |
| Other | <input checked="" type="radio"/> | <input type="radio"/> |

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49. This question asks about things that may have happened at the hospital where your new baby was born. For each item, check No if it did not happen or Yes if it did.

	No	Yes
Hospital staff gave me information about breastfeeding	<input type="radio"/>	<input type="radio"/>
My baby stayed in the same room with me at the hospital	<input type="radio"/>	<input type="radio"/>
I breastfed my baby in the hospital	<input type="radio"/>	<input type="radio"/>
Hospital staff helped me learn how to breastfeed	<input type="radio"/>	<input type="radio"/>
I breastfed in the first hour after my baby was born	<input type="radio"/>	<input type="radio"/>
My baby was placed in skin-to-skin contact within the first hour of life	<input type="radio"/>	<input type="radio"/>
My baby was fed only breast milk at the hospital	<input type="radio"/>	<input type="radio"/>
Hospital staff told me to breastfeed whenever my baby wanted	<input type="radio"/>	<input type="radio"/>
The hospital gave me a breast pump to use	<input type="radio"/>	<input type="radio"/>
The hospital gave me a gift pack with formula	<input type="radio"/>	<input type="radio"/>
The hospital gave me a telephone number to call for help with breastfeeding	<input type="radio"/>	<input type="radio"/>
Hospital staff gave my baby a pacifier	<input type="radio"/>	<input type="radio"/>

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50. In which *one* position do you *most often* lay your baby down to sleep now? Check ONE answer

- On his or her side
- On his or her back
- On his or her stomach

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51. In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed?

- Always
- Often
- Sometimes
- Rarely
- Never

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52. When your new baby sleeps alone, is his or her crib or bed in the same room where you sleep?

- No
- Yes

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53. Listed below are some more things about how babies sleep. How did your new baby *usually* sleep in the past 2 weeks? For each item, check **No** if your baby did not *usually* sleep like this or **Yes** if he or she did.

- | | No | Yes |
|--|-----------------------|-----------------------|
| In a crib, bassinet, or pack and play | <input type="radio"/> | <input type="radio"/> |
| On a twin or larger mattress or bed | <input type="radio"/> | <input type="radio"/> |
| On a couch, sofa, or armchair | <input type="radio"/> | <input type="radio"/> |
| In an infant car seat or swing | <input type="radio"/> | <input type="radio"/> |
| In a sleeping sack or wearable blanket | <input type="radio"/> | <input type="radio"/> |
| With a blanket | <input type="radio"/> | <input type="radio"/> |
| With toys, cushions, or pillows, including nursing pillows | <input type="radio"/> | <input type="radio"/> |
| With crib bumper pads (mesh or non-mesh) | <input type="radio"/> | <input type="radio"/> |

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54. Did a doctor, nurse, or other health care worker tell you any of the following things? For each thing, check No if they did not tell you or Yes if they did.

- | | No | Yes |
|--|-----------------------|-----------------------|
| Place my baby on his or her back to sleep | <input type="radio"/> | <input type="radio"/> |
| Place my baby to sleep in a crib, bassinet, or pack and play | <input type="radio"/> | <input type="radio"/> |
| Place my baby's crib or bed in my room | <input type="radio"/> | <input type="radio"/> |
| What things should and should not go in bed with my baby | <input type="radio"/> | <input type="radio"/> |

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55. *Since your new baby was born*, has a home visitor come to your home to help you learn how to take care of yourself or your new baby? A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps mothers of newborns.

- No
- Yes

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56. Are you or your husband or partner doing anything *now* to keep from getting pregnant? Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- No
- Yes

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57. What are your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant *now*? Check ALL that apply

- | | No | Yes |
|--|-----------------------|-----------------------|
| I want to get pregnant | <input type="radio"/> | <input type="radio"/> |
| I am pregnant now | <input type="radio"/> | <input type="radio"/> |
| I had my tubes tied or blocked | <input type="radio"/> | <input type="radio"/> |
| I don't want to use birth control | <input type="radio"/> | <input type="radio"/> |
| I am worried about side effects from birth control | <input type="radio"/> | <input type="radio"/> |
| I am not having sex | <input type="radio"/> | <input type="radio"/> |
| My husband or partner doesn't want to use anything | <input type="radio"/> | <input type="radio"/> |
| I have problems paying for birth control | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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57. What are your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant *now*? Check ALL that apply

- | | No | Yes |
|--|-----------------------|----------------------------------|
| I want to get pregnant | <input type="radio"/> | <input type="radio"/> |
| I am pregnant now | <input type="radio"/> | <input type="radio"/> |
| I had my tubes tied or blocked | <input type="radio"/> | <input type="radio"/> |
| I don't want to use birth control | <input type="radio"/> | <input type="radio"/> |
| I am worried about side effects from birth control | <input type="radio"/> | <input type="radio"/> |
| I am not having sex | <input type="radio"/> | <input type="radio"/> |
| My husband or partner doesn't want to use anything | <input type="radio"/> | <input type="radio"/> |
| I have problems paying for birth control | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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57. What are your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant *now*? Check ALL that apply

- | | No | Yes |
|--|----------------------------------|----------------------------------|
| I want to get pregnant | <input type="radio"/> | <input type="radio"/> |
| I am pregnant now | <input type="radio"/> | <input type="radio"/> |
| I had my tubes tied or blocked | <input type="radio"/> | <input checked="" type="radio"/> |
| I don't want to use birth control | <input type="radio"/> | <input type="radio"/> |
| I am worried about side effects from birth control | <input type="radio"/> | <input type="radio"/> |
| I am not having sex | <input type="radio"/> | <input type="radio"/> |
| My husband or partner doesn't want to use anything | <input type="radio"/> | <input type="radio"/> |
| I have problems paying for birth control | <input type="radio"/> | <input type="radio"/> |
| Other | <input checked="" type="radio"/> | <input type="radio"/> |

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58. What kind of birth control are you or your husband or partner using *now* to keep from getting pregnant? Check ALL that apply

- | | No | Yes |
|---|-----------------------|-----------------------|
| Tubes tied or blocked (female sterilization or Essure [®]) | <input type="radio"/> | <input type="radio"/> |
| Vasectomy (male sterilization) | <input type="radio"/> | <input type="radio"/> |
| Birth control pills | <input type="radio"/> | <input type="radio"/> |
| Condoms | <input type="radio"/> | <input type="radio"/> |
| Shots or injections (Depo-Provera [®]) | <input type="radio"/> | <input type="radio"/> |
| Contraceptive patch (OrthoEvra [®]) or vaginal ring (NuvaRing [®]) | <input type="radio"/> | <input type="radio"/> |
| IUD (including Mirena [®] , ParaGard [®] , Liletta [®] , or Skyla [®]) | <input type="radio"/> | <input type="radio"/> |
| Contraceptive implant in the arm (Nexplanon [®] or Implanon [®]) | <input type="radio"/> | <input type="radio"/> |
| Natural family planning (including rhythm method) | <input type="radio"/> | <input type="radio"/> |
| Withdrawal (pulling out) | <input type="radio"/> | <input type="radio"/> |
| Not having sex (abstinence) | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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45%

58. What kind of birth control are you or your husband or partner using *now* to keep from getting pregnant? Check ALL that apply

- | | No | Yes |
|---|-----------------------|----------------------------------|
| Tubes tied or blocked (female sterilization or Essure [®]) | <input type="radio"/> | <input type="radio"/> |
| Vasectomy (male sterilization) | <input type="radio"/> | <input type="radio"/> |
| Birth control pills | <input type="radio"/> | <input type="radio"/> |
| Condoms | <input type="radio"/> | <input type="radio"/> |
| Shots or injections (Depo-Provera [®]) | <input type="radio"/> | <input type="radio"/> |
| Contraceptive patch (OrthoEvra [®]) or vaginal ring (NuvaRing [®]) | <input type="radio"/> | <input type="radio"/> |
| IUD (including Mirena [®] , ParaGard [®] , Liletta [®] , or Skyla [®]) | <input type="radio"/> | <input type="radio"/> |
| Contraceptive implant in the arm (Nexplanon [®] or Implanon [®]) | <input type="radio"/> | <input type="radio"/> |
| Natural family planning (including rhythm method) | <input type="radio"/> | <input type="radio"/> |
| Withdrawal (pulling out) | <input type="radio"/> | <input type="radio"/> |
| Not having sex (abstinence) | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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54%

58. What kind of birth control are you or your husband or partner using *now* to keep from getting pregnant? Check ALL that apply

	No	Yes
Tubes tied or blocked (female sterilization or Essure [®])	<input type="radio"/>	<input type="radio"/>
Vasectomy (male sterilization)	<input type="radio"/>	<input type="radio"/>
Birth control pills	<input type="radio"/>	<input checked="" type="radio"/>
Condoms	<input type="radio"/>	<input type="radio"/>
Shots or injections (Depo-Provera [®])	<input type="radio"/>	<input type="radio"/>
Contraceptive patch (OrthoEvra [®]) or vaginal ring (NuvaRing [®])	<input type="radio"/>	<input type="radio"/>
IUD (including Mirena [®] , ParaGard [®] , Liletta [®] , or Skyla [®])	<input type="radio"/>	<input type="radio"/>
Contraceptive implant in the arm (Nexplanon [®] or Implanon [®])	<input type="radio"/>	<input type="radio"/>
Natural family planning (including rhythm method)	<input type="radio"/>	<input type="radio"/>
Withdrawal (pulling out)	<input type="radio"/>	<input type="radio"/>
Not having sex (abstinence)	<input type="radio"/>	<input type="radio"/>
Other	<input checked="" type="radio"/>	<input type="radio"/>

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59. *Since your new baby was born*, have you had a postpartum checkup for yourself? A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.

- No
- Yes

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5%

60. During your postpartum checkup, did a doctor, nurse, or other health care worker do any of the following things? For each item, check No if they did not do it or Yes if they did.

	No	Yes
Tell me to take a vitamin with folic acid	<input type="radio"/>	<input type="radio"/>
Talk to me about healthy eating, exercise, and losing weight gained during pregnancy	<input type="radio"/>	<input type="radio"/>
Talk to me about how long to wait before getting pregnant again	<input type="radio"/>	<input type="radio"/>
Talk to me about birth control methods I can use after giving birth	<input type="radio"/>	<input type="radio"/>
Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms	<input type="radio"/>	<input type="radio"/>
Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®)	<input type="radio"/>	<input type="radio"/>
Ask me if I was smoking cigarettes	<input type="radio"/>	<input type="radio"/>
Ask me if someone was hurting me emotionally or physically	<input type="radio"/>	<input type="radio"/>
Ask me if I was feeling down or depressed	<input type="radio"/>	<input type="radio"/>
Test me for diabetes	<input type="radio"/>	<input type="radio"/>

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55%

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

- Always
- Often
- Sometimes
- Rarely
- Never

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50%

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

- Always
- Often
- Sometimes
- Rarely
- Never

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100%

The next questions are on a variety of topics.

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63%

63. During any of the following time periods, did your husband or partner threaten you, limit your activities against your will, or make you feel unsafe in any other way? For each time period, check No if it did not happen then or Yes if it did.

	No	Yes
During the 12 months before I got pregnant	<input type="radio"/>	<input type="radio"/>
During my most recent pregnancy	<input type="radio"/>	<input type="radio"/>
Since my new baby was born	<input type="radio"/>	<input type="radio"/>

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01%

64. During the *month before you got pregnant*, did you take or use any of the following drugs for any reason? Your answers are strictly confidential. For each item, check **No** if you did not use it or **Yes** if you did.

	No	Yes
Over-the-counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve®	<input type="radio"/>	<input type="radio"/>
Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine	<input type="radio"/>	<input type="radio"/>
Adderall®, Ritalin®, or another stimulant	<input type="radio"/>	<input type="radio"/>
Marijuana or hash	<input type="radio"/>	<input type="radio"/>
Synthetic marijuana (K2, Spice)	<input type="radio"/>	<input type="radio"/>
Methadone, naloxone, subutex, or Suboxone®	<input type="radio"/>	<input type="radio"/>
Heroin (smack, junk, Black Tar, Chiva)	<input type="radio"/>	<input type="radio"/>
Amphetamines (uppers, speed, crystal meth, crank, ice, <i>agua</i>)	<input type="radio"/>	<input type="radio"/>
Cocaine (crack, rock, coke, blow, snow, <i>nieve</i>)	<input type="radio"/>	<input type="radio"/>
Tranquilizers (downers, ludes)	<input type="radio"/>	<input type="radio"/>
Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)	<input type="radio"/>	<input type="radio"/>
Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing)	<input type="radio"/>	<input type="radio"/>

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MemID: 2021WY081099

100%

65. Who lives in the same house with you now? Check ALL that apply

- | | No | Yes |
|-------------------------------------|-----------------------|-----------------------|
| My husband or partner | <input type="radio"/> | <input type="radio"/> |
| Children aged less than 12 months | <input type="radio"/> | <input type="radio"/> |
| Children aged 1 year to 5 years | <input type="radio"/> | <input type="radio"/> |
| Children aged 6 years and over | <input type="radio"/> | <input type="radio"/> |
| My mother | <input type="radio"/> | <input type="radio"/> |
| My father | <input type="radio"/> | <input type="radio"/> |
| My husband's or partner's parent(s) | <input type="radio"/> | <input type="radio"/> |
| Friend or roommate | <input type="radio"/> | <input type="radio"/> |
| Other family member or relative | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

Window Snip

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65. Who lives in the same house with you *now*? Check ALL that apply

	No	Yes
My husband or partner	<input type="radio"/>	<input type="radio"/>
Children aged less than 12 months	<input type="radio"/>	<input checked="" type="radio"/>
Children aged 1 year to 5 years	<input type="radio"/>	<input type="radio"/>
Children aged 6 years and over	<input type="radio"/>	<input type="radio"/>
My mother	<input type="radio"/>	<input type="radio"/>
My father	<input type="radio"/>	<input type="radio"/>
My husband's or partner's parent(s)	<input type="radio"/>	<input type="radio"/>
Friend or roommate	<input type="radio"/>	<input type="radio"/>
Other family member or relative	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

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52%

How many children aged less than 12 months?

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MuniD: 2021WY061096

100%

65. Who lives in the same house with you now? Check ALL that apply

	No	Yes
My husband or partner	<input type="radio"/>	<input type="radio"/>
Children aged less than 12 months	<input checked="" type="radio"/>	<input type="radio"/>
Children aged 1 year to 5 years	<input type="radio"/>	<input checked="" type="radio"/>
Children aged 6 years and over	<input type="radio"/>	<input type="radio"/>
My mother	<input type="radio"/>	<input type="radio"/>
My father	<input type="radio"/>	<input type="radio"/>
My husband's or partner's parent(s)	<input type="radio"/>	<input type="radio"/>
Friend or roommate	<input type="radio"/>	<input type="radio"/>
Other family member or relative	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

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62%

How many children aged 1 year to 5 years?

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65. Who lives in the same house with you now? Check ALL that apply

- | | No | Yes |
|-------------------------------------|----------------------------------|----------------------------------|
| My husband or partner | <input type="radio"/> | <input type="radio"/> |
| Children aged less than 12 months | <input checked="" type="radio"/> | <input type="radio"/> |
| Children aged 1 year to 5 years | <input checked="" type="radio"/> | <input type="radio"/> |
| Children aged 6 years and over | <input type="radio"/> | <input checked="" type="radio"/> |
| My mother | <input type="radio"/> | <input type="radio"/> |
| My father | <input type="radio"/> | <input type="radio"/> |
| My husband's or partner's parent(s) | <input type="radio"/> | <input type="radio"/> |
| Friend or roommate | <input type="radio"/> | <input type="radio"/> |
| Other family member or relative | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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62%

How many children 6 years old and over?

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42%

65. Who lives in the same house with you now? Check ALL that apply

- | | No | Yes |
|-------------------------------------|----------------------------------|----------------------------------|
| My husband or partner | <input type="radio"/> | <input type="radio"/> |
| Children aged less than 12 months | <input checked="" type="radio"/> | <input type="radio"/> |
| Children aged 1 year to 5 years | <input checked="" type="radio"/> | <input type="radio"/> |
| Children aged 6 years and over | <input checked="" type="radio"/> | <input type="radio"/> |
| My mother | <input type="radio"/> | <input type="radio"/> |
| My father | <input type="radio"/> | <input type="radio"/> |
| My husband's or partner's parent(s) | <input type="radio"/> | <input type="radio"/> |
| Friend or roommate | <input type="radio"/> | <input type="radio"/> |
| Other family member or relative | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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100%

I live alone

- No
- Yes

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100%

66. Are you a member of an American Indian tribe?

- No
- Yes

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94%

67. What is your tribal enrollment or your tribal affiliation?

- Eastern Shoshone
- Northern Arapahoe
- Sioux
- Crow
- Northern Cheyenne
- Shoshone Bannock
- Other Please tell us:

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

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20%

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

- \$0 to \$16,000
- \$16,001 to \$20,000
- \$20,001 to \$24,000
- \$24,001 to \$28,000
- \$28,001 to \$32,000
- \$32,001 to \$40,000
- \$40,001 to \$48,000
- \$48,001 to \$57,000
- \$57,001 to \$60,000
- \$60,001 to \$73,000
- \$73,001 to \$85,000
- \$85,001 or more

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69%

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

Number of people:

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100%

The next questions are about the use of pain relievers *during* pregnancy.

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68%

Q1. During your most recent pregnancy, did you use any of the following over-the-counter pain relievers? Over-the-counter pain relievers are those *usually* available without a prescription. For each one, check **No if you did not use it *during* your pregnancy or **Yes** if you did.**

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. Acetaminophen (like regular Tylenol®, Tylenol Extra Strength®, or Tylenol PM®) | <input type="radio"/> | <input type="radio"/> |
| b. Ibuprofen (like Motrin® or Advil®), including high dose pills that may be prescribed | <input type="radio"/> | <input type="radio"/> |
| c. Aspirin (like Bayer® or Ecotrin®) | <input type="radio"/> | <input type="radio"/> |
| d. Naproxen (like Aleve® or Midol®) | <input type="radio"/> | <input type="radio"/> |

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67%

Q2. During your most recent pregnancy, did you use any of the following prescription pain relievers? For each one, check **No if you did not use it *during* your pregnancy or **Yes** if you did. Do *not* include pain relievers you used *only* during labor and delivery.**

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. Hydrocodone (like Vicodin®, Norco®, or Lortab®) | <input type="radio"/> | <input type="radio"/> |
| b. Codeine (like Tylenol® #3 or #4, not regular Tylenol®) | <input type="radio"/> | <input type="radio"/> |
| c. Oxycodone (like Percocet®, Percodan®, OxyContin®, or Roxicodone®) | <input type="radio"/> | <input type="radio"/> |
| d. Tramadol (like Ultram® or Ultracet®) | <input type="radio"/> | <input type="radio"/> |
| e. Hydromorphone or meperidine (like Demerol®, Exalgo®, or Dilaudid®) | <input type="radio"/> | <input type="radio"/> |
| f. Oxymorphone (like Opana®) | <input type="radio"/> | <input type="radio"/> |
| g. Morphine (like MS Contin®, Avinza®, or Kadian®) | <input type="radio"/> | <input type="radio"/> |
| h. Fentanyl (like Duragesic®, Fentora®, or Actiq®) | <input type="radio"/> | <input type="radio"/> |

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85%

The next questions are only about the use of *prescription* pain relievers listed in question O2.

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85%

O3. Where did you get the *prescription* pain relievers that you used *during* your most recent pregnancy? Check ALL that apply

- | | No | Yes |
|---|-----------------------|-----------------------|
| OB-GYN, midwife, or prenatal care provider | <input type="radio"/> | <input type="radio"/> |
| Family doctor or primary care provider | <input type="radio"/> | <input type="radio"/> |
| Dentist or oral health care provider | <input type="radio"/> | <input type="radio"/> |
| Doctor in the emergency room | <input type="radio"/> | <input type="radio"/> |
| I had pain relievers left over from an old prescription | <input type="radio"/> | <input type="radio"/> |
| Friend or family member gave them to me | <input type="radio"/> | <input type="radio"/> |
| I got the pain relievers <u>without a prescription</u> some other way | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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88%

Q3. Where did you get the *prescription* pain relievers that you used *during* your most recent pregnancy? Check ALL that apply

- | | No | Yes |
|---|-----------------------|----------------------------------|
| OB-GYN, midwife, or prenatal care provider | <input type="radio"/> | <input type="radio"/> |
| Family doctor or primary care provider | <input type="radio"/> | <input type="radio"/> |
| Dentist or oral health care provider | <input type="radio"/> | <input type="radio"/> |
| Doctor in the emergency room | <input type="radio"/> | <input type="radio"/> |
| I had pain relievers left over from an old prescription | <input type="radio"/> | <input type="radio"/> |
| Friend or family member gave them to me | <input type="radio"/> | <input type="radio"/> |
| I got the pain relievers <u>without a prescription</u> some other way | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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85%

O3. Where did you get the *prescription* pain relievers that you used *during* your most recent pregnancy? Check ALL that apply

- | | No | Yes |
|---|----------------------------------|----------------------------------|
| OB-GYN, midwife, or prenatal care provider | <input type="radio"/> | <input type="radio"/> |
| Family doctor or primary care provider | <input type="radio"/> | <input type="radio"/> |
| Dentist or oral health care provider | <input type="radio"/> | <input type="radio"/> |
| Doctor in the emergency room | <input type="radio"/> | <input checked="" type="radio"/> |
| I had pain relievers left over from an old prescription | <input type="radio"/> | <input type="radio"/> |
| Friend or family member gave them to me | <input type="radio"/> | <input type="radio"/> |
| I got the pain relievers <u>without a prescription</u> some other way | <input type="radio"/> | <input type="radio"/> |
| Other | <input checked="" type="radio"/> | <input type="radio"/> |

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85%

O4. What were your reasons for using *prescription* pain relievers *during* your most recent pregnancy? Check ALL that apply

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. To relieve pain from an injury, condition, or surgery I had before pregnancy | <input type="radio"/> | <input type="radio"/> |
| b. To relieve pain from an injury, condition, or surgery that happened during my pregnancy | <input type="radio"/> | <input type="radio"/> |
| c. To relax or relieve tension or stress | <input type="radio"/> | <input type="radio"/> |
| d. To help me with my feelings or emotions | <input type="radio"/> | <input type="radio"/> |
| e. To help me sleep | <input type="radio"/> | <input type="radio"/> |
| f. To feel good or get high | <input type="radio"/> | <input type="radio"/> |
| g. Because I was "hooked" or I had to have them | <input type="radio"/> | <input type="radio"/> |
| h. Other | <input type="radio"/> | <input type="radio"/> |

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68%

O4. What were your reasons for using *prescription* pain relievers *during* your most recent pregnancy? Check ALL that apply

- | | No | Yes |
|--|-----------------------|----------------------------------|
| a. To relieve pain from an injury, condition, or surgery I had before pregnancy | <input type="radio"/> | <input type="radio"/> |
| b. To relieve pain from an injury, condition, or surgery that happened during my pregnancy | <input type="radio"/> | <input type="radio"/> |
| c. To relax or relieve tension or stress | <input type="radio"/> | <input type="radio"/> |
| d. To help me with my feelings or emotions | <input type="radio"/> | <input type="radio"/> |
| e. To help me sleep | <input type="radio"/> | <input type="radio"/> |
| f. To feel good or get high | <input type="radio"/> | <input type="radio"/> |
| g. Because I was "hooked" or I had to have them | <input type="radio"/> | <input type="radio"/> |
| h. Other | <input type="radio"/> | <input checked="" type="radio"/> |

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O4. What were your reasons for using *prescription* pain relievers *during* your most recent pregnancy? Check ALL that apply

- | | No | Yes |
|---|----------------------------------|----------------------------------|
| a. To relieve pain from an injury, condition, or surgery I had <i>before</i> pregnancy | <input type="radio"/> | <input type="radio"/> |
| b. To relieve pain from an injury, condition, or surgery that happened <i>during</i> my pregnancy | <input type="radio"/> | <input type="radio"/> |
| c. To relax or relieve tension or stress | <input type="radio"/> | <input checked="" type="radio"/> |
| d. To help me with my feelings or emotions | <input type="radio"/> | <input type="radio"/> |
| e. To help me sleep | <input type="radio"/> | <input type="radio"/> |
| f. To feel good or get high | <input type="radio"/> | <input type="radio"/> |
| g. Because I was "hooked" or I had to have them | <input type="radio"/> | <input type="radio"/> |
| h. Other | <input checked="" type="radio"/> | <input type="radio"/> |

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85%

O5. In each of the following time periods *during* your pregnancy, for how many weeks or months did you use *prescription* pain relievers? Please write the total number of weeks OR months in each time period.

	Weeks	Months	Less than a week	Never
a. In the first 3 months of pregnancy	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
b. In the second 3 months of pregnancy	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
c. In the last 3 months of pregnancy	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>

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11%

O6. *During your most recent pregnancy, did you want or need to cut down or stop using prescription pain relievers?*

- No
- Yes

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72%

07. During your most recent pregnancy, did you have trouble cutting down or stopping use of the *prescription* pain relievers?

- No
- Yes

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73%

O8. *During your most recent pregnancy, did you get help from a doctor, nurse, or other health care worker to cut down or stop using prescription pain relievers?*

- No
- Yes

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74%

Q9. During your most recent pregnancy, did you receive medication-assisted treatment to help you stop using *prescription* pain relievers? This is when a doctor prescribes medicines such as methadone, buprenorphine, Suboxone®, Subutex® or naltrexone (Vivitrol®).

- No
- Yes

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75%

O10. Do you think the use of *prescription* pain relievers *during pregnancy* could be harmful to a *baby's* health? Check ONE answer

- Not harmful at all
- Not harmful, if taken as prescribed
- Harmful, even if taken as prescribed

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75%

O11. Do you think the use of *prescription* pain relievers could be harmful to a woman's *own* health? Check ONE answer

- Not harmful at all
- Not harmful, if taken as prescribed
- Harmful, even if taken as prescribed

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17%

O12. At any time *during your most recent pregnancy*, did a doctor, nurse, or other health care worker talk with you about how using prescription pain relievers during pregnancy could affect a baby?

- No
- Yes

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25%

The next question is about the use of other medications or drugs during pregnancy.

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O13. During your most recent pregnancy, did you take or use any of the following medications or drugs for any reason? For each item, check No if you did not take or use it or Yes if you did.

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. Medication for depression (like Prozac®, Zoloft®, Lexapro®, Paxil®, or Celexa®) | <input type="radio"/> | <input type="radio"/> |
| b. Medication for anxiety (like Valium®, Xanax®, Ativan®, Klonopin®, or other "benzos" (benzodiazepines)) | <input type="radio"/> | <input type="radio"/> |
| c. Methadone, Subutex®, Suboxone®, or buprenorphine | <input type="radio"/> | <input type="radio"/> |
| d. Naloxone | <input type="radio"/> | <input type="radio"/> |
| e. Cannabidiol (CBD) products | <input type="radio"/> | <input type="radio"/> |
| f. Adderall®, Ritalin®, or another stimulant | <input type="radio"/> | <input type="radio"/> |
| g. Marijuana or hash | <input type="radio"/> | <input type="radio"/> |
| h. Synthetic marijuana (K2 or Spice) | <input type="radio"/> | <input type="radio"/> |
| i. Heroin (smack; junk; Black Tar; or Chiva) | <input type="radio"/> | <input type="radio"/> |
| j. Amphetamines (uppers, speed, crystal meth, crank, ice, or <i>agua</i>) | <input type="radio"/> | <input type="radio"/> |
| k. Cocaine (crack, rock, coke, blow, snow, or <i>nieve</i>) | <input type="radio"/> | <input type="radio"/> |
| l. Tranquilizers (downers or ludes) | <input type="radio"/> | <input type="radio"/> |
| m. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, or bath salts) | <input type="radio"/> | <input type="radio"/> |
| n. Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing) | <input type="radio"/> | <input type="radio"/> |

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Wyoming
MomID: 2021WY081099

100%

These next questions are about your experiences with prenatal care, delivery, postpartum care, and infant care during the COVID-19 pandemic.

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Wyoming
MomID: 2021WY081099

100%

CV1. During the COVID-19 pandemic, which types of *prenatal care* appointments did you attend?

- In-person appointments only
- Virtual appointments (video or telephone) only
- Both, in-person and virtual appointments
- I did not have prenatal care

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Wyoming
MomID: 2021WY081099

80%

CV2. What are the reasons that you did not attend virtual appointments for prenatal care? For each one, check **No** if it was not a reason or **Yes** if it was.

- | | No | Yes |
|--|-----------------------|-----------------------|
| a. Lack of availability of virtual appointments from my provider | <input type="radio"/> | <input type="radio"/> |
| b. Lack of an available telephone to use for appointments | <input type="radio"/> | <input type="radio"/> |
| c. Lack of enough cellular data or cellular minutes | <input type="radio"/> | <input type="radio"/> |
| d. Lack of a computer or device | <input type="radio"/> | <input type="radio"/> |
| e. Lack of internet service or had unreliable internet | <input type="radio"/> | <input type="radio"/> |
| f. Lack of a private or confidential space to use | <input type="radio"/> | <input type="radio"/> |
| g. I preferred seeing my health care provider in person | <input type="radio"/> | <input type="radio"/> |
| h. Other reason | <input type="radio"/> | <input type="radio"/> |

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Wyoming
MomID: 2021WY061099

40%

CV2. What are the reasons that you did not attend virtual appointments for prenatal care? For each one, check No if it was not a reason or Yes if it was.

- | | No | Yes |
|--|-----------------------|----------------------------------|
| a. Lack of availability of virtual appointments from my provider | <input type="radio"/> | <input type="radio"/> |
| b. Lack of an available telephone to use for appointments | <input type="radio"/> | <input type="radio"/> |
| c. Lack of enough cellular data or cellular minutes | <input type="radio"/> | <input type="radio"/> |
| d. Lack of a computer or device | <input type="radio"/> | <input type="radio"/> |
| e. Lack of internet service or had unreliable internet | <input type="radio"/> | <input type="radio"/> |
| f. Lack of a private or confidential space to use | <input type="radio"/> | <input type="radio"/> |
| g. I preferred seeing my health care provider in person | <input type="radio"/> | <input type="radio"/> |
| h. Other reason | <input type="radio"/> | <input checked="" type="radio"/> |

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MomID: 2021WY081099

80%

CV2. What are the reasons that you did not attend virtual appointments for prenatal care? For each one, check No if it was not a reason or Yes if it was.

- | | No | Yes |
|--|----------------------------------|----------------------------------|
| a. Lack of availability of virtual appointments from my provider | <input type="radio"/> | <input type="radio"/> |
| b. Lack of an available telephone to use for appointments | <input type="radio"/> | <input type="radio"/> |
| c. Lack of enough cellular data or cellular minutes | <input type="radio"/> | <input type="radio"/> |
| d. Lack of a computer or device | <input type="radio"/> | <input type="radio"/> |
| e. Lack of internet service or had unreliable internet | <input type="radio"/> | <input checked="" type="radio"/> |
| f. Lack of a private or confidential space to use | <input type="radio"/> | <input type="radio"/> |
| g. I preferred seeing my health care provider in person | <input type="radio"/> | <input type="radio"/> |
| h. Other reason | <input checked="" type="radio"/> | <input type="radio"/> |

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MomID: 2021WY081099

80%

CV3. Were any of your prenatal care appointments canceled or delayed during the COVID-19 pandemic due to the following reasons? For each one, check **No** if your appointments were not canceled or delayed for that reason or **Yes** if they were.

- | | No | Yes |
|--|-----------------------|-----------------------|
| a. My appointments were canceled or delayed because my provider's office was closed or had reduced hours | <input type="radio"/> | <input type="radio"/> |
| b. I canceled or delayed because I was afraid of being exposed to COVID-19 during the appointments | <input type="radio"/> | <input type="radio"/> |
| c. I canceled or delayed because I lost my health insurance during the COVID-19 pandemic | <input type="radio"/> | <input type="radio"/> |
| d. I canceled or delayed because I had problems finding care for my children or other family members | <input type="radio"/> | <input type="radio"/> |
| e. I canceled or delayed because I was worried about taking public transportation and had no other way to get there | <input type="radio"/> | <input type="radio"/> |
| f. My appointments were canceled or delayed because I had to self-isolate due to possible COVID-19 exposure or infection | <input type="radio"/> | <input type="radio"/> |

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CV4. While you were pregnant, how often did you do the following things to avoid getting COVID-19?

For each one, check: **A** if you always did it, **S** if you sometimes did it, or **N** if you never did it.

- | | A | S | N |
|---|-----------------------|-----------------------|-----------------------|
| a. Avoided gatherings of more than 10 people | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Stayed at least 6 feet (2 meters) away from others when I left my home | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Only left my home for essential reasons | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Made trips as short as possible when I left my home | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Avoided having visitors inside my home | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Wore a mask or a cloth face covering when out in public | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Washed hands for 20 seconds with soap and water | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Used alcohol-based hand sanitizer | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Covered coughs and sneezes with a tissue or my elbow | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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CV5. While you were pregnant during the COVID-19 pandemic, did you have any of the following experiences? For each one, check **No** if you did not or **Yes** if you did.

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. I had responsibilities or a job that prevented me from staying home | <input type="radio"/> | <input type="radio"/> |
| b. Someone in my household had a job that required close contact with other people | <input type="radio"/> | <input type="radio"/> |
| c. When I went out, I found that other people around me did not practice social distancing | <input type="radio"/> | <input type="radio"/> |
| d. I had trouble getting disinfectant to clean my home | <input type="radio"/> | <input type="radio"/> |
| e. I had trouble getting hand sanitizer or hand soap for my household | <input type="radio"/> | <input type="radio"/> |
| f. I had trouble getting or making masks or cloth face coverings | <input type="radio"/> | <input type="radio"/> |
| g. It was hard for me to wear a mask or cloth face covering (trouble breathing, claustrophobia) | <input type="radio"/> | <input type="radio"/> |
| h. I was told by a health care provider that I had COVID-19 | <input type="radio"/> | <input type="radio"/> |
| i. Someone in my household was told by a health care provider that they had COVID-19 | <input type="radio"/> | <input type="radio"/> |

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MomID: 2021WY081099

54%

CV6. Who was with you in the hospital delivery room as a support person during your labor and delivery?

- | | No | Yes |
|--|-----------------------|-----------------------|
| My husband or partner | <input type="radio"/> | <input type="radio"/> |
| Another family member or friend | <input type="radio"/> | <input type="radio"/> |
| A doula | <input type="radio"/> | <input type="radio"/> |
| Some other support person (not including hospital staff) | <input type="radio"/> | <input type="radio"/> |

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54%

CV6. Who was with you in the hospital delivery room as a support person during your labor and delivery?

- | | No | Yes |
|--|-----------------------|----------------------------------|
| My husband or partner | <input type="radio"/> | <input type="radio"/> |
| Another family member or friend | <input type="radio"/> | <input type="radio"/> |
| A doula | <input type="radio"/> | <input type="radio"/> |
| Some other support person (not including hospital staff) | <input type="radio"/> | <input checked="" type="radio"/> |

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54%

CV6. Who was with you in the hospital delivery room as a support person during your labor and delivery?

- | | No | Yes |
|--|----------------------------------|----------------------------------|
| My husband or partner | <input type="radio"/> | <input type="radio"/> |
| Another family member or friend | <input type="radio"/> | <input checked="" type="radio"/> |
| A doula | <input type="radio"/> | <input type="radio"/> |
| Some other support person (not including hospital staff) | <input checked="" type="radio"/> | <input type="radio"/> |

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54%

CV6. Who was with you in the hospital delivery room as a support person during your labor and delivery?

- | | No | Yes |
|--|-----------------------|-----------------------|
| My husband or partner | <input type="radio"/> | <input type="radio"/> |
| Another family member or friend | <input type="radio"/> | <input type="radio"/> |
| A doula | <input type="radio"/> | <input type="radio"/> |
| Some other support person (not including hospital staff) | <input type="radio"/> | <input type="radio"/> |

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The hospital did not allow me to have any support people No Yes

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CV7. While in the hospital after your delivery, did any of the following things happen to you and your baby because of COVID-19? For each one, check No if it did not happen or Yes if it did.

- | | No | Yes |
|--|-----------------------|-----------------------|
| a. My baby was tested for COVID-19 in the hospital | <input type="radio"/> | <input type="radio"/> |
| b. I was separated from my baby in the hospital after delivery <u>to protect my baby from COVID-19</u> | <input type="radio"/> | <input type="radio"/> |
| c. I wore a mask when other people came into my hospital room | <input type="radio"/> | <input type="radio"/> |
| d. I wore a mask while I was alone caring for my baby in the hospital | <input type="radio"/> | <input type="radio"/> |
| e. I was given information about how to protect my baby from COVID-19 when I went home | <input type="radio"/> | <input type="radio"/> |

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98%

CV8. Did the COVID-19 pandemic affect breastfeeding for you and your baby in any of the following ways? For each one, check No if it did not apply to you or Yes if it did.

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. I was given information in the hospital about how to protect my baby from infection while breastfeeding | <input type="radio"/> | <input type="radio"/> |
| b. I wore a mask while breastfeeding in the hospital | <input type="radio"/> | <input type="radio"/> |
| c. I pumped breast milk in the hospital so someone else could feed my baby to avoid him or her getting infected | <input type="radio"/> | <input type="radio"/> |
| d. Due to COVID-19, I had trouble getting a visit from a lactation specialist while I was in the hospital | <input type="radio"/> | <input type="radio"/> |

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87%

CV9. In what ways did the COVID-19 pandemic affect your baby's routine health care? For each one, check **No** if the pandemic did not affect your baby's health care in this way or **Yes** if it did.

- | | No | Yes |
|--|-----------------------|-----------------------|
| a. My baby's well visits or checkups were canceled or delayed | <input type="radio"/> | <input type="radio"/> |
| b. My baby's well visits or checkups were changed from in-person visits to virtual appointments (video or telephone) | <input type="radio"/> | <input type="radio"/> |
| c. My baby's immunizations were postponed | <input type="radio"/> | <input type="radio"/> |

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CV10. During the COVID-19 pandemic, which types of *postpartum* appointments did you attend for *yourself*?

- In-person appointments only
- Virtual appointments (video or telephone) only
- Both, in-person and virtual appointments
- I did not have any postpartum appointments for myself

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100%

CV11. Did any of the following things happen to you *due to the COVID-19 pandemic*? For each one, check No if it did not happen or Yes if it did.

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. I lost my job or had a cut in work hours or pay | <input type="radio"/> | <input type="radio"/> |
| b. Other members of my household lost their jobs or had a cut in work hours or pay | <input type="radio"/> | <input type="radio"/> |
| c. I had problems paying the rent, mortgage, or other bills | <input type="radio"/> | <input type="radio"/> |
| d. A member of my household or I received unemployment benefits | <input type="radio"/> | <input type="radio"/> |
| e. I had to move or relocate | <input type="radio"/> | <input type="radio"/> |
| f. I became homeless | <input type="radio"/> | <input type="radio"/> |
| g. The loss of childcare or school closures made it difficult to manage all my responsibilities | <input type="radio"/> | <input type="radio"/> |
| h. I had to spend more time than usual taking care of children or other family members | <input type="radio"/> | <input type="radio"/> |
| i. I worried whether our food would run out before I got money to buy more | <input type="radio"/> | <input type="radio"/> |
| j. I felt more anxious than usual | <input type="radio"/> | <input type="radio"/> |
| k. I felt more depressed than usual | <input type="radio"/> | <input type="radio"/> |
| l. My husband or partner and I had more verbal arguments or conflicts than usual | <input type="radio"/> | <input type="radio"/> |
| m. My husband or partner was more physically, sexually, or emotionally aggressive towards me | <input type="radio"/> | <input type="radio"/> |

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100%

These next questions are about the COVID-19 vaccine.

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VC1. During *your most recent pregnancy*, did a doctor, nurse, or other health care worker do any of the following things? For each one, check No if they did not do it or Yes if they did.

- | | No | Yes |
|---|-----------------------|-----------------------|
| a. Talked with me about the COVID-19 vaccine | <input type="radio"/> | <input type="radio"/> |
| b. Recommended that I get the COVID-19 vaccine | <input type="radio"/> | <input type="radio"/> |
| c. Offered to give me the COVID-19 vaccine | <input type="radio"/> | <input type="radio"/> |
| d. Referred me to another place to get the COVID-19 vaccine | <input type="radio"/> | <input type="radio"/> |

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VC2. During your most recent pregnancy, did you get at least one shot or dose of a COVID-19 vaccine?

- No
- Yes

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MomID: 2021WY081099

02%

VC3. What were your reasons for not getting a COVID-19 vaccine during your most recent pregnancy?

- | | No | Yes |
|--|-----------------------|-----------------------|
| a. I was not in one of the groups that could get the COVID-19 vaccine | <input type="radio"/> | <input type="radio"/> |
| b. The vaccine was not available or ran out in my area | <input type="radio"/> | <input type="radio"/> |
| c. I couldn't get an appointment or was placed on a waiting list | <input type="radio"/> | <input type="radio"/> |
| d. I didn't have transportation to get to a vaccination site | <input type="radio"/> | <input type="radio"/> |
| e. The staff at the vaccination site didn't want to give me the vaccine because I was pregnant | <input type="radio"/> | <input type="radio"/> |
| f. I was concerned about possible side effects of the COVID-19 vaccine for my baby | <input type="radio"/> | <input type="radio"/> |
| g. I was concerned about possible side effects of the COVID-19 vaccine for me | <input type="radio"/> | <input type="radio"/> |
| h. I have an allergy or health condition that prevented me from getting the vaccine | <input type="radio"/> | <input type="radio"/> |
| i. My doctor or healthcare provider told me not to get the vaccine | <input type="radio"/> | <input type="radio"/> |
| j. I had gotten the COVID-19 vaccine <i>before</i> my pregnancy | <input type="radio"/> | <input type="radio"/> |
| k. I already had COVID-19 | <input type="radio"/> | <input type="radio"/> |
| l. I didn't have enough information about the vaccine to feel comfortable getting it | <input type="radio"/> | <input type="radio"/> |
| m. I was concerned that the COVID-19 vaccine was developed too fast | <input type="radio"/> | <input type="radio"/> |
| n. I didn't think the vaccine would protect me against COVID-19 | <input type="radio"/> | <input type="radio"/> |
| o. I didn't think COVID-19 was a serious illness | <input type="radio"/> | <input type="radio"/> |
| p. I didn't think I was at risk for COVID-19 infection | <input type="radio"/> | <input type="radio"/> |
| q. I preferred using masks and other precautions instead | <input type="radio"/> | <input type="radio"/> |
| r. I don't think vaccines are beneficial | <input type="radio"/> | <input type="radio"/> |
| s. Other reason | <input type="radio"/> | <input type="radio"/> |

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VC3. What were your reasons for not getting a COVID-19 vaccine during your most recent pregnancy?

- | | No | Yes |
|--|-----------------------|----------------------------------|
| a. I was not in one of the groups that could get the COVID-19 vaccine | <input type="radio"/> | <input type="radio"/> |
| b. The vaccine was not available or ran out in my area | <input type="radio"/> | <input type="radio"/> |
| c. I couldn't get an appointment or was placed on a waiting list | <input type="radio"/> | <input type="radio"/> |
| d. I didn't have transportation to get to a vaccination site | <input type="radio"/> | <input type="radio"/> |
| e. The staff at the vaccination site didn't want to give me the vaccine because I was pregnant | <input type="radio"/> | <input type="radio"/> |
| f. I was concerned about possible side effects of the COVID-19 vaccine for my baby | <input type="radio"/> | <input type="radio"/> |
| g. I was concerned about possible side effects of the COVID-19 vaccine for me | <input type="radio"/> | <input type="radio"/> |
| h. I have an allergy or health condition that prevented me from getting the vaccine | <input type="radio"/> | <input type="radio"/> |
| i. My doctor or healthcare provider told me not to get the vaccine | <input type="radio"/> | <input type="radio"/> |
| j. I had gotten the COVID-19 vaccine <i>before</i> my pregnancy | <input type="radio"/> | <input type="radio"/> |
| k. I already had COVID-19 | <input type="radio"/> | <input type="radio"/> |
| l. I didn't have enough information about the vaccine to feel comfortable getting it | <input type="radio"/> | <input type="radio"/> |
| m. I was concerned that the COVID-19 vaccine was developed too fast | <input type="radio"/> | <input type="radio"/> |
| n. I didn't think the vaccine would protect me against COVID-19 | <input type="radio"/> | <input type="radio"/> |
| o. I didn't think COVID-19 was a serious illness | <input type="radio"/> | <input type="radio"/> |
| p. I didn't think I was at risk for COVID-19 infection | <input type="radio"/> | <input type="radio"/> |
| q. I preferred using masks and other precautions instead | <input type="radio"/> | <input type="radio"/> |
| r. I don't think vaccines are beneficial | <input type="radio"/> | <input type="radio"/> |
| s. Other reason | <input type="radio"/> | <input checked="" type="radio"/> |

What was the reason? _____

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VC3. What were your reasons for not getting a COVID-19 vaccine during your most recent pregnancy?

- | | No | Yes |
|--|----------------------------------|----------------------------------|
| a. I was not in one of the groups that could get the COVID-19 vaccine | <input type="radio"/> | <input type="radio"/> |
| b. The vaccine was not available or ran out in my area | <input type="radio"/> | <input type="radio"/> |
| c. I couldn't get an appointment or was placed on a waiting list | <input type="radio"/> | <input type="radio"/> |
| d. I didn't have transportation to get to a vaccination site | <input type="radio"/> | <input type="radio"/> |
| e. The staff at the vaccination site didn't want to give me the vaccine because I was pregnant | <input type="radio"/> | <input type="radio"/> |
| f. I was concerned about possible side effects of the COVID-19 vaccine for my baby | <input type="radio"/> | <input type="radio"/> |
| g. I was concerned about possible side effects of the COVID-19 vaccine for me | <input type="radio"/> | <input type="radio"/> |
| h. I have an allergy or health condition that prevented me from getting the vaccine | <input type="radio"/> | <input type="radio"/> |
| i. My doctor or healthcare provider told me not to get the vaccine | <input type="radio"/> | <input checked="" type="radio"/> |
| j. I had gotten the COVID-19 vaccine <i>before</i> my pregnancy | <input type="radio"/> | <input type="radio"/> |
| k. I already had COVID-19 | <input type="radio"/> | <input type="radio"/> |
| l. I didn't have enough information about the vaccine to feel comfortable getting it | <input type="radio"/> | <input type="radio"/> |
| m. I was concerned that the COVID-19 vaccine was developed too fast | <input type="radio"/> | <input type="radio"/> |
| n. I didn't think the vaccine would protect me against COVID-19 | <input type="radio"/> | <input type="radio"/> |
| o. I didn't think COVID-19 was a serious illness | <input type="radio"/> | <input type="radio"/> |
| p. I didn't think I was at risk for COVID-19 infection | <input type="radio"/> | <input type="radio"/> |
| q. I preferred using masks and other precautions instead | <input type="radio"/> | <input type="radio"/> |
| r. I don't think vaccines are beneficial | <input type="radio"/> | <input type="radio"/> |
| s. Other reason | <input checked="" type="radio"/> | <input type="radio"/> |

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Window Snip

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VC4. *Since your new baby was born, have you gotten a COVID-19 vaccine?*

- No
- Yes

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20%

VC5. Which ONE of these sources do you trust the *most* for receiving information about the COVID-19 vaccine?

- My doctor, nurse, or other health care provider
- My pharmacist
- Centers for Disease Control and Prevention (CDC) website or reports
- Food and Drug Administration (FDA) website or reports
- My state or local health department
- Family or friends
- News reports such as television or radio news
- Social media sites like Facebook
- Websites about health or other topics → Please tell us which sites in the space below
- Some other source → Please tell us which source in the space below

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VC5. Which ONE of these sources do you trust the *most* for receiving information about the COVID-19 vaccine?

- My doctor, nurse, or other health care provider
- My pharmacist
- Centers for Disease Control and Prevention (CDC) website or reports
- Food and Drug Administration (FDA) website or reports
- My state or local health department
- Family or friends
- News reports such as television or radio news
- Social media sites like Facebook
- Websites about health or other topics → Please tell us which sites in the space below
- Some other source → Please tell us which source in the space below

Please tell us which websites

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20%

VC5. Which ONE of these sources do you trust the *most* for receiving information about the COVID-19 vaccine?

- My doctor, nurse, or other health care provider
- My pharmacist
- Centers for Disease Control and Prevention (CDC) website or reports
- Food and Drug Administration (FDA) website or reports
- My state or local health department
- Family or friends
- News reports such as television or radio news
- Social media sites like Facebook
- Websites about health or other topics → Please tell us which sites in the space below
- Some other source → Please tell us which source in the space below

Please tell us what other source

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100%

VC6. Which of the following describes your work or volunteer activities during your most recent pregnancy?

- | | No | Yes |
|--|-----------------------|-----------------------|
| a. I worked or volunteered providing direct medical care to patients (such as being a doctor, nurse, dentist, therapist, home health care provider, emergency responder) | <input type="radio"/> | <input type="radio"/> |
| b. I worked or volunteered in a health care setting, but <u>not</u> providing direct medical care to patients (such as being administrative staff, cleaning staff, patient transport, ward clerk) | <input type="radio"/> | <input type="radio"/> |
| c. I worked or volunteered in a position where I regularly came into contact with the public (such as education, grocery or retail stores, public transportation, restaurants or food service, law enforcement, postal or delivery services) | <input type="radio"/> | <input type="radio"/> |
| d. I worked or volunteered in a position where I did <u>not</u> regularly come in contact with the public | <input type="radio"/> | <input type="radio"/> |

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e. None of the above **No** **Yes**

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Thank you for answering these questions!

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100%

Please use this space for any additional comments you would like to make about your experiences around the time of your pregnancy or the health of mothers and babies in Wyoming.

Note: Pressing the "Enter" key will close the comment entry box and end the survey. If you want a new line in the comment, press Shift+Enter.

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Thanks for answering our questions. Your answers will help us work to make Wyoming mothers and babies healthier. Goodbye.

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