


Maryland PRAMS Grantee Web Questionnaire

In PRAMS Integrated Data Collection System [PIDS]

Prms Web Survey Module Porta 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

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

User ID *

Passcode *

Next

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

 [Department of Health and Human Services](#)



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

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

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Welcome to Maryland'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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Maryland
MomID: 2021MD200016

Choose a language:

- English
- Spanish

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Maryland
MomID: 2021MD200016

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 Maryland Department of Health and Mental Hygiene

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

We are asking 1 in 35 women in Maryland to answer the same questions. All of your names were picked by a computer from recent birth certificates.

It takes about 25-42 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 and will be used only to answer questions related to the purpose of this study. This is so because this study has been given a Certificate of Confidentiality. This means that we may not share information that may identify you in legal suits or proceeding, even if a court orders us to do so,

unless you say it's okay.

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 Maryland.

If you have any questions about your rights in the project, please call Ms. Gay Y. Hutchen at 410-767-8448.

If you have questions about PRAMS, please contact us at 1-877-363-0480 or mdh.marylandprams@maryland.gov.

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

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Maryland
MomID: 2021MD200016

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

- feet, inches, pounds
- centimeters, kilograms

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Maryland
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The first questions are about you.

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Maryland
MomID: 2021MD200016

0%

1. How tall are you without shoes?

Feet

Inches

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

Pounds

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1%

3. What is *your* date of birth?

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1%

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

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1%

4. Before you got pregnant with your new baby, did you ever have any other babies who were born alive?

- No
- Yes

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Maryland
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3%

5. Before you had your new baby, did you ever have a baby by cesarean delivery or c-section (when a doctor cuts through the mother's belly to bring out the baby)?

- No
- Yes

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4%

6. Before you got pregnant, would you say that, in general, your health was?

- Excellent
- Very good
- Good
- Fair
- Poor

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Maryland
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5%

7. 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"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Anemia (poor blood, low iron)	<input type="radio"/>	<input type="radio"/>
Thyroid problems	<input type="radio"/>	<input type="radio"/>
PCOS (polycystic ovarian syndrome)	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>

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4%

8. 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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7%

9. 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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4%

10. 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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MomID: 2021MD200016

2%

10. 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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Maryland
MomID: 2021MD200016

4%

10. 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 checked="" 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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MomID: 2021MD200016

4%

11. 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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Maryland
MomID: 2021MD200016

10%

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

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MomID: 2021MD200016

10%

12. 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 Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input type="radio"/> |

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MomID: 2021MD200016

10%

12. 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 Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input checked="" type="radio"/> |

Please tell us:

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MomID: 2021MD200016

10%

12. 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 checked="" type="radio"/> |
| Private health insurance from my parents | <input type="radio"/> | <input type="radio"/> |
| Private health insurance from the Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input checked="" type="radio"/> | <input type="radio"/> |

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MomID: 2021MD200016

10%

13. 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 Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input type="radio"/> |

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MomID: 2021MD200016

10%

13. 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 Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input checked="" type="radio"/> |

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MomID: 2021MD200016

10%

13. 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 checked="" type="radio"/> |
| Private health insurance from the Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input checked="" type="radio"/> | <input type="radio"/> |

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10%

14. 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 Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input type="radio"/> |

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10%

14. 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 Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input type="radio"/> | <input checked="" type="radio"/> |

Please tell us:

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MomID: 2021MD200016

10%

14. 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 Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov , or HealthCare.gov | <input type="radio"/> | <input type="radio"/> |
| Medicaid or HealthChoice | <input type="radio"/> | <input checked="" type="radio"/> |
| TRICARE or other military health care | <input type="radio"/> | <input type="radio"/> |
| Other health insurance | <input checked="" type="radio"/> | <input type="radio"/> |

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10%

I do not have health insurance *now*

- No
- Yes

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10%

15. 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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14%

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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14%

16. 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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15%

17. 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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100%

18. At any time during *your most recent* pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)?

- No
- Yes
- I don't know

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10%

19. 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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17%

20. 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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MomID: 2021MD200016

10%

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

- No
- Yes

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MomID: 2021MD200016

10%

22. 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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20%

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

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20%

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

- No
- Yes

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21%

24. 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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12%

25. 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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23%

26. 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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24%

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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24%

27. 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"/>

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MomID: 2021MD200016

25%

28. 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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MomID: 2021MD200016

25%

29. 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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27%

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

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27%

30. 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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28%

31. 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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20%

32. During the 3 months *before* you got pregnant, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span?

- 6 or more times
- 4 to 5 times
- 2 to 3 times
- 1 time
- I didn't have 4 drinks or more in a 2 hour time span

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30%

33. 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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MomID: 2021MD200016

31%

34. During the *last 3 months* of your pregnancy, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span?

- 6 or more times
- 4 to 5 times
- 2 to 3 times
- 1 time
- I didn't have 4 drinks or more in a 2 hour time span

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32%

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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32%

35. 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"/>

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MomID: 2021MD200016

100%

36. 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"/>

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

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37. When was your new baby born?

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38. How was your new baby delivered?

- Vaginally
- Cesarean delivery (c-section)

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35%

39. 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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25%

39. 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"/> |

Please tell us:

Maryland
MomID: 2021MD200016

35%

39. 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 checked="" type="radio"/>
I didn't want to have my baby vaginally	<input type="radio"/>	<input type="radio"/>
Other	<input checked="" type="radio"/>	<input type="radio"/>

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40. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)? Check ONE answer

- My health care provider recommended a cesarean delivery *before* I went into labor
- My health care provider recommended a cesarean delivery while I was in labor
- I asked for the cesarean delivery

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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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40%

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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40%

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 checked="" 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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48. 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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49. 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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45%

50. 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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41%

51. 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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52. 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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100%

53. 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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50%

54. 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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50%

54. 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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50%

54. 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 checked="" 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 checked="" 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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55. 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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50%

55. 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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50%

55. 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 checked="" type="radio"/>
Natural family planning (including rhythm method)	<input type="radio"/>	<input type="radio"/>
Withdrawal (pulling out)	<input type="radio"/>	<input checked="" type="radio"/>
Not having sex (abstinence)	<input type="radio"/>	<input type="radio"/>
Other	<input checked="" type="radio"/>	<input type="radio"/>

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56. *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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57. Did any of these things keep you from having a postpartum checkup? Check ALL that apply

- | | No | Yes |
|--|-----------------------|-----------------------|
| I didn't have health insurance to cover the cost of the visit | <input type="radio"/> | <input type="radio"/> |
| I felt fine and did not think I needed to have a visit | <input type="radio"/> | <input type="radio"/> |
| I couldn't get an appointment when I wanted one | <input type="radio"/> | <input type="radio"/> |
| I didn't have any transportation to get to the clinic or doctor's office | <input type="radio"/> | <input type="radio"/> |
| I had too many things going on | <input type="radio"/> | <input type="radio"/> |
| I couldn't take time off from work | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input type="radio"/> |

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57. Did any of these things keep you from having a postpartum checkup? Check ALL that apply

- | | No | Yes |
|--|-----------------------|----------------------------------|
| I didn't have health insurance to cover the cost of the visit | <input type="radio"/> | <input type="radio"/> |
| I felt fine and did not think I needed to have a visit | <input type="radio"/> | <input type="radio"/> |
| I couldn't get an appointment when I wanted one | <input type="radio"/> | <input type="radio"/> |
| I didn't have any transportation to get to the clinic or doctor's office | <input type="radio"/> | <input type="radio"/> |
| I had too many things going on | <input type="radio"/> | <input type="radio"/> |
| I couldn't take time off from work | <input type="radio"/> | <input type="radio"/> |
| Other | <input type="radio"/> | <input checked="" type="radio"/> |

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57. Did any of these things keep you from having a postpartum checkup? Check ALL that apply

- | | No | Yes |
|--|----------------------------------|----------------------------------|
| I didn't have health insurance to cover the cost of the visit | <input type="radio"/> | <input type="radio"/> |
| I felt fine and did not think I needed to have a visit | <input type="radio"/> | <input checked="" type="radio"/> |
| I couldn't get an appointment when I wanted one | <input type="radio"/> | <input type="radio"/> |
| I didn't have any transportation to get to the clinic or doctor's office | <input type="radio"/> | <input type="radio"/> |
| I had too many things going on | <input type="radio"/> | <input type="radio"/> |
| I couldn't take time off from work | <input type="radio"/> | <input type="radio"/> |
| Other | <input checked="" type="radio"/> | <input type="radio"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

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60. *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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61. *Since your new baby was born, how often have you felt panicky?*

- Always
- Often
- Sometimes
- Rarely
- Never

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62. *Since your new baby was born, how often have you felt restless?*

- Always
- Often
- Sometimes
- Rarely
- Never

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The next questions are on a variety of topics.

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

- Wanted me to be pregnant sooner
- Wanted me to be pregnant later
- Wanted me to be pregnant then
- Didn't want me to be pregnant then or at any time in the future
- I didn't have a husband or partner
- I don't know

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64. 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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65. Are you currently in school or working?

- No, I don't go to school or work
- Yes, I go to school or work outside the home
- Yes, I go to school or work from home

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66. Which *one* of the following people spends the most time taking care of your new baby when you are at school or work? Check ONE answer

- My husband or partner
- Baby's grandparent
- Other close family member or relative
- Friend or neighbor
- Babysitter, nanny, or other child care provider
- Staff at a day care center
- Other — Please tell us: Please tell us:
- The baby is with me while I am at school or work

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67. While you are away from your new baby for school or work, how often do you feel that he or she is well cared for? Check ONE answer

- Always
- Often
- Sometimes
- Rarely
- Never

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68. At any time during *your most recent* pregnancy, did you work at a job for pay?

- No
- Yes

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69. Have you returned to the job you had during *your most recent* pregnancy? Check ONE answer

- No, and I do not plan to return
- No, but I will be returning
- Yes

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70. Did you take leave from work *after* your new baby was born? Check ALL that apply

I took *paid* leave from my job No Yes
I took *unpaid* leave from my job No Yes

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I did not take leave

- No
- Yes

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71. How many weeks or months of leave, in total, did you take or will you take?

- Weeks
- Months
- Less than 1 week

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72. How did you feel about the amount of time you were able to take off *after* the birth of your new baby? Check ONE answer

- Too little time
- Just the right amount of time
- Too much time

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MomID: 2021MD200016

6%

73. Did any of the things listed below affect your decision about taking leave from work *after* your new baby was born? For each item, check **No** if it does not apply to you or **Yes** if it does.

- | | No | Yes |
|---|-----------------------|-----------------------|
| I could not financially afford to take leave | <input type="radio"/> | <input type="radio"/> |
| I was afraid I'd lose my job if I took leave or stayed out longer | <input type="radio"/> | <input type="radio"/> |
| I had too much work to do to take leave or stay out longer | <input type="radio"/> | <input type="radio"/> |
| My job does not have paid leave | <input type="radio"/> | <input type="radio"/> |
| My job does not offer a flexible work schedule | <input type="radio"/> | <input type="radio"/> |
| I had not built up enough leave time to take any or more time off | <input type="radio"/> | <input type="radio"/> |

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85%

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

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88%

74. 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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83%

75. 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 your ability to do different activities.

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Maryland
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100%

D1. Do you have difficulty seeing, even when wearing glasses or contact lenses?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

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11%

D2. Do you have difficulty hearing, even if using a hearing aid(s)?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

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72%

D3. Do you have difficulty walking or climbing steps?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

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73%

D4. Do you have difficulty remembering or concentrating?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

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74%

D5. Do you have difficulty with self care, such as washing all over or dressing?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

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75%

D6. Using your usual language, do you have difficulty communicating, for example, understanding or being understood?

- No difficulty
- Some difficulty
- A lot of difficulty
- I cannot do this at all

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Maryland
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75%

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

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75%

O1. 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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17%

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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25%

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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MamID: 2021MD200016

100%

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 checked="" type="radio"/> |

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MomID: 2021MD200016

25%

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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MomID: 2021MD200016

25%

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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MomID: 2021MD200016

75%

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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MomID: 2021MD200016

██████████ 45%

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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25%

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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81%

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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100%

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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MomID: 2021MD200016

82%

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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82%

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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54%

Q10. 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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55%

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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98%

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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81%

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

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MomID: 2021MD200016

89%

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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Maryland
MomID: 2021MD200016

 88%

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

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Maryland
MomID: 2021MD200016

88%

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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Maryland
MomID: 2021MD200016

50%

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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Maryland
MomID: 2021MD200016

25%

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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Maryland
MomID: 2021MD200016

100%

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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100%

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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MHID: 2021MD000018

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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MomID: 2021MD200016

62%

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: 2021MD200016

43%

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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MomID: 2021MD200016

43%

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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MomID: 2021MD200016

43%

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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43%

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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88%

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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MomID: 2021MD200016

98%

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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48%

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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 60%

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 Maryland.

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 Maryland mothers and babies healthier. Goodbye.

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