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# Pregnancy Risk Assessment Monitoring System (PRAMS)

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Phase 9 Core Mail Questionnaire - English

## Phase 9 English Mail

Please check the box next to your answer or follow the directions included with the question. You may be asked to skip some questions that do not apply to you.

### BEFORE PREGNANCY

The first questions are about *you*.

**Core 1. What is your date of birth?**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

**Insertion points for Standard questions II2, II3, PP1, PP2**

**Core 2. Before you got pregnant, did you...**

For each one, check **No** or **Yes**.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Have serious difficulty hearing, or are you deaf?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have serious difficulty seeing, even when wearing glasses, or are you blind?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have serious difficulty walking or climbing stairs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?            | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have difficulty with dressing or bathing yourself?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about the time *before* you got pregnant.

**Insertion points for Previous Pregnancy Outcomes Series: FF5-FF7, FF4**

**Insertion point for Standard question L26**

**Insertion point for Standard question L10**

**Core 3. 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                      |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes ( <b>not</b> gestational diabetes or diabetes that starts during pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety   | <input type="checkbox"/> | <input type="checkbox"/> |

**Insertion point for options from Standard question L11**

**Insertion point for Standard question G9, G8**

**Core 4. In the 12 months before you got pregnant with your new baby, did you have any of the following healthcare visits?**

For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. Regular checkup with a family doctor               | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regular checkup with an OB/GYN                     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Visit for an injury, illness, or chronic condition | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Visit to urgent care or the emergency room         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Visit for family planning or to get birth control  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Visit for depression or anxiety                    | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Visit to have my teeth cleaned                     | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other  | <input type="checkbox"/> | <input type="checkbox"/> |

↳ **Please tell us:**

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**If you didn't have any healthcare visits in the 12 months before you got pregnant, go to Question [Core 6].**

**Insertion point for Standard question J5**

**Core 5. During any of your healthcare visits in the 12 months before you got pregnant, did a healthcare provider do any of the following things?**

For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| <b>Talk to me about...</b>  |                          |                          |
| a. My weight  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regularly checking my blood pressure   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My desire to have or not have children   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Birth control  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. How I could improve my health before a pregnancy                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sexually transmitted infections such as chlamydia, gonorrhea, syphilis, or HIV   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Ask me....</b>   |                          |                          |
| g. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If someone was hurting me emotionally or physically                              | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I felt depressed or anxious   | <input type="checkbox"/> | <input type="checkbox"/> |

**Insertion points for Standard questions L27, L18**

**The next questions are about your *health insurance*.**

**Core 6. During the *month before* you got pregnant with your new baby, what kind of health insurance did you have?**

**Check ALL that apply**

- Private health insurance (paid for by me, someone else, or through a job)
- Medicaid (*site Medicaid name*)
- Site-specific option (Other government plan or program such as SCHIP/CHIP)*
- Site-specific option (Other government plan or program not listed)*

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- above such as MCH program, indigent program or family planning program)*
- Site-specific option (TRICARE or other military health care)*
  - Site-specific option (I or tribal)*
  - Other health insurance

↳ **Please tell us:**

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- I didn't have any health insurance during the *month before* I got pregnant

**Insertion point for Standard questions DD7**

**Core 7. During your most recent pregnancy, what kind of health insurance did you have?**

**Check ALL that apply**

- Private health insurance (paid for by me, someone else, or through a job)
  - Medicaid (*site Medicaid name*)
  - Site-specific option (Other government plan or program such as SCHIP/CHIP)*
  - Site-specific option (Other government plan or program not listed above such as MCH program, indigent program or family planning program)*
  - Site-specific option (TRICARE or other military health care)*
  - Site-specific option (I or tribal)*
  - Other health insurance
- ↳ **Please tell us:**
- 
- I didn't have health insurance *during my pregnancy*

**Insertion point for Standard questions DD11**

**Core 8. What kind of health insurance do you have *now*?**

**Check ALL that apply**

- Private health insurance (paid for by me, someone else, or through a job)
  - Medicaid (*state Medicaid name*)
  - State-specific option (Other government plan or program such as SCHIP/CHIP)*
  - State-specific option (Other government plan or program not listed above such as MCH program, indigent program or family planning program)*
  - State-specific option (TRICARE or other military health care)*
  - State-specific option (I or tribal)*
  - Other health insurance
- ↳ **Please tell us:**
- 
- I don't have health insurance *now*

**Insertion point for Standard questions DD20**

**Core 9. 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

**Insertion point for Standard question Q4**

**Insertion point for Preconception Contraception Series E5, E6, E7, E3**

**Insertion point for Fertility & Fertility Treatment Series E5, Q7, A1, A2, A4, A5**

**DURING PREGNANCY**

**The next questions are about your prenatal care. This can include visits to a doctor, nurse, or other healthcare worker before your baby was born to get checkups and advice about pregnancy.** (It may help to look at the calendar to answer these questions.)

**Insertion point for Standard question R19**

**Core 10. Did you get prenatal care during your *most recent* pregnancy?**

- No → **Go to Question [Core 12]**
- Yes

**Insertion point for Standard questions R24, R20, R21**

**Insertion point for Standard question R15**

**Insertion point for Standard questions R6, R7, R8, R12, R14**

**Core 11. During any of your prenatal care visits, did a healthcare provider do any of the following things?**

For each one, check **No** or **Yes**.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| <b>Talk to me about...</b>  |                          |                          |
| a. How much weight I should gain during pregnancy   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Doing tests to screen for birth defects or diseases that run in my family                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What to do if I feel depressed or anxious during my pregnancy or after                   | <input type="checkbox"/> | <input type="checkbox"/> |

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- my baby is born  
**Ask me...**
- |    |  |                          |                          |
|----|--|--------------------------|--------------------------|
| e. | If I planned to breastfeed my new baby   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. | If I planned to use birth control after my baby was born                         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. | If I was taking any prescription medication                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| h. | If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco | <input type="checkbox"/> | <input type="checkbox"/> |
| i. | If I was drinking alcohol  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. | If someone was hurting me emotionally or physically                              | <input type="checkbox"/> | <input type="checkbox"/> |
| k. | If I was using illegal drugs   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. | If I was using marijuana   | <input type="checkbox"/> | <input type="checkbox"/> |
| m. | If I wanted to be tested for HIV   | <input type="checkbox"/> | <input type="checkbox"/> |

**Insertion points for Standard questions R13, K4**  
**Insertion point for HIV Testing Series: I8, I9**  
**Insertion point for Standard questions G5**

**Core 12. During the 12 months before your new baby was born, did a healthcare provider offer you the following shots or vaccinations?**  
 For each one, check **No** or **Yes**.

- |    |  |                          |                          |
|----|--|--------------------------|--------------------------|
|    |  | <b>No</b>                | <b>Yes</b>               |
| a. | Flu shot   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Tdap shot (protects against tetanus, diphtheria, and pertussis (whooping cough))       | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | COVID-19 shot  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | RSV shot (given during pregnancy to protect the baby from respiratory syncytial virus) | <input type="checkbox"/> | <input type="checkbox"/> |

**Core 13. Did you get the following shots or vaccinations before or during your pregnancy?**

For each one, check:  
**B** for **3 Months before** pregnancy  
**D** for **During** pregnancy  
**N** for **Did not** get a shot before or during pregnancy

- |    |               |                          |                          |                          |
|----|---------------|--------------------------|--------------------------|--------------------------|
|    |               | <b>B</b>                 | <b>D</b>                 | <b>N</b>                 |
| a. | Flu shot      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Tdap shot     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | COVID-19 shot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | RSV shot      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Insertion point for Standard questions L19, L14**

**Core 14. During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?**

- No
- Yes

**Insertion point for Oral Health Series: Y7, Y5, Y8, Y6**  
**Insertion point for Childbirth Class & Home Visitation Series: R23, V21, V13, V14, V15, V20**

**Insertion point for Standard question R16, R25**  
**Insertion point for Standard questions B12, B8, B7, B4**

**Core 15. During your most recent pregnancy, did a healthcare provider tell you that you had any of the following health conditions?**  
 For each one, check **No** or **Yes**.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. Gestational diabetes (diabetes that <b>started</b> during <i>this</i> pregnancy)                    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that <b>started</b> during <i>this</i> pregnancy), pre-eclampsia, or eclampsia | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. <b>Insertion point for options from Standard question L11</b>                                       |                          |                          |

**Insertion point for Standard questions N7**

**If you had high blood pressure before or during your pregnancy, go to Question [Core 16]. If not, go to Question [Core 17].**

**Core 16. During your most recent pregnancy, did a healthcare provider do any of the following things to help you manage your high blood pressure?**  
 For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. Refer me to a different healthcare provider  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tell me to regularly check my blood pressure <b>during</b> pregnancy   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about getting to a healthy weight <b>after</b> pregnancy  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about regularly checking my blood pressure <b>after</b> pregnancy   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about the risk for having high blood pressure (chronic hypertension) and heart disease <b>after</b> pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |

**Core 17. During your most recent pregnancy, did you get information about “warning signs” you should watch for during and after your pregnancy that require immediate medical attention?**  
 Some of these “warning signs” include fever, frequent or severe headaches, or severe stomach pain.

- No → **Go to Question [Core 19]**
- Yes

**Core 18. During your most recent pregnancy, did you get information about warning signs from any of the following sources?**  
 For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. A healthcare provider (such as a doctor, nurse, or midwife)  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Websites or social media (such as Facebook, Instagram, or X/Twitter)   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any source of information that used the slogan ‘ <b>Hear Her</b> ’ (such as a website, social media, or paper handout) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Family or friends  | <input type="checkbox"/> | <input type="checkbox"/> |

**Insertion point for Standard questions M4, M9, M8**  
**Insertion point for Standard questions M14, M18, M17**

**Insertion point for Standard questions N9, N1-N4**  
**Insertion point for Standard questions N5, EE3**

**The next questions are about cigarettes, e-cigarettes, and other tobacco products.**

**Core 19. Have you smoked any cigarettes in the *past 2 years*?**

- No → **Go to Question [Core 23]**
- Yes

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

- More than one pack (21 or more cigarettes)
- One-half to one pack (11 to 20 cigarettes)
- Less than half a pack (1 to 10 cigarettes)
- I didn't smoke then

**Core 21. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day?**

- More than one pack (21 or more cigarettes)
- One-half to one pack (11 to 20 cigarettes)
- Less than half a pack (1 to 10 cigarettes)
- I didn't smoke then

**Insertion point for Standard questions AA1, AA3**  
**Insertion point for Standard questions AA2, AA6, AA10**

**Core 22. How many cigarettes do you smoke on an average day *now*?**

- More than one pack (21 or more cigarettes)
- One-half to one pack (11 to 20 cigarettes)
- Less than half a pack (1 to 10 cigarettes)
- I don't smoke now

**Insertion point for Standard questions AA8, AA5**  
**Insertion point for Standard questions AA9, AA7**

**Core 23. In the *past 2 years*, have you used e-cigarettes (“vapes”) or other electronic nicotine products?**

- No → **Go to Question [Core 27]**
- Yes

**Core 24. During the 3 months before you got pregnant, on average, how often did you use e-cigarettes (“vapes”) or other electronic nicotine products?**

- Every day
- Some days
- I didn’t use e-cigarettes or other electronic nicotine products then

**Core 25. During the last 3 months of your pregnancy, on average, how often did you use e-cigarettes (“vapes”) or other electronic nicotine products?**

- Every day
- Some days
- I didn’t use e-cigarettes or other electronic nicotine products then

**Core 26. In the past 2 years, did you ever use e-cigarettes or other electronic nicotine products as a way of cutting down or stopping cigarette smoking?**

- No
- Yes

**The next questions are about drinking alcohol. A drink can be 1 glass of wine, hard seltzer, can or bottle of beer, shot of liquor, or mixed drink.**

**Insertion point for Standard questions JJ5, JJ1**

**Core 27. During your most recent pregnancy, did you have any alcoholic drinks during...**

For each one, check **No** or **Yes**.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. The first 3 months of pregnancy (1st trimester)? <i>This includes the time before knowing you were pregnant</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2nd trimester)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3rd trimester)?   | <input type="checkbox"/> | <input type="checkbox"/> |

**If you didn’t have any alcoholic drinks during your pregnancy, go to Question [Core 29].**

**Core 28. During your most recent pregnancy, did you have 4 or more alcoholic drinks in a 2-hour time span during...**

For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. The first 3 months of pregnancy (1st trimester)? <i>This includes the time</i> | <input type="checkbox"/> | <input type="checkbox"/> |

- before knowing you were pregnant*
- b. The second 3 months of pregnancy (2nd trimester)?
- c. The last 3 months of pregnancy (3rd trimester)?

**Insertion points for Standard questions JJ3, JJ2, JJ6**

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

**Core 29. Did any of the following things happen during the 12 months before your new baby was born?**  
For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. I got separated or divorced  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was evicted or forced to move                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have a regular place to sleep                             | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was homeless, or had to sleep outside, in a car, or in a shelter | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My spouse, partner, or I lost a job                                | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My spouse, partner, or I had a cut in work hours or pay            | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I had problems paying the rent, mortgage, or other bills           | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My spouse or partner went to jail                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I went to jail   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Someone close to me had a problem with drinking or drugs           | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Someone close to me was very sick or died                          | <input type="checkbox"/> | <input type="checkbox"/> |

**Insertion points for Standard questions P14, P17, P20, P21, P22, P15**  
**Insertion point for Standard question BB1**

**Core 30. 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 one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. My spouse or partner                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner                 | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <i>Site option (Another family member)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. <i>Site option (Someone else)</i>          | <input type="checkbox"/> | <input type="checkbox"/> |

**Core 31. 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 one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. My spouse or partner                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner                 | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <i>Site option (Another family member)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. <i>Site option (Someone else)</i>          | <input type="checkbox"/> | <input type="checkbox"/> |

**Insertion point for Standard question Z1**

**AFTER PREGNANCY**

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

**Insertion point for Standard question II4**  
**Insertion point for Labor Interventions Series: K9, K10, K8, K3, K7, K6, K17**  
**Insertion point for Standard questions II1**  
**Insertion point for Standard question K16**

**Core 32. After the delivery, how long did your new baby stay in the hospital?**

- Less than 3 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 → **Go to Question [Core 35]**

**Core 33. Is your baby alive now?**

- No → **We are very sorry for your loss. Go to Question [Core 41]**
- Yes

**Core 34. Is your baby living with you now?**

- No → **Go to Question [Core 41]**
- Yes

**Insertion point for Standard question B9, B17**

**Core 35. How many weeks or months did you breastfeed or feed pumped milk to your new baby?**

**Check ONE answer**

- I didn't breastfeed my baby
- I breastfed my baby for less than 1 week
- I breastfed my baby for:  
\_\_\_\_\_ Week(s) OR  
\_\_\_\_\_ Month(s)
- I'm still breastfeeding or feeding pumped milk to my new baby

**Insertion point for Standard question B1**  
**Insertion point for Standard question B13**  
**Insertion point for Standard questions B2, B14, B16**  
**Insertion point for Standard questions B10, B11, B3**

**Insertion point for Standard questions H2**  
**Insertion point for Standard question S13**

**If your baby is still in the hospital, go to Question [Core 41].**

**Core 36. In the *past 2 weeks*, how did you place your new baby to sleep at night and during naps?**

For each one, check **No** or **Yes**.

- a. On their side
- b. On their back
- c. On their stomach

**No Yes**

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**Core 37. In the *past 2 weeks*, when you were sleeping, how often has your new baby slept alone in their own crib or bed?**

- Always
- Often
- Sometimes
- Rarely
- Never → **Go to Question [Core 39]**

**Insertion point for Standard question F4**

**Core 38. In the *past 2 weeks*, was your baby's crib or bed in the same room where you or another adult slept?**

- No
- Yes

**Core 39. In the *past 2 weeks*, where have you placed your new baby to sleep at night or during naps?**

For each one, check **No** or **Yes**.

- a. In a crib, portable crib, or bassinet
- b. On a twin or larger mattress or bed
- c. On a couch, sofa, or armchair
- d. In an infant car seat
- e. In a swing, rocker, or other inclined sleeper
- f. In an in-bed sleeper
- g. In a baby board or cradle board
- h. Other

**No Yes**

<input type="checkbox"/>	<input type="checkbox"/>

↳ **Please tell us:**

**Core 40. In the *past 2 weeks*, has your new baby been placed to sleep with the following?**

For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. In a sleeping sack or wearable blanket                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In a swaddled blanket                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Comforters, quilts, blankets, or non-fitted sheets         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Soft toys, cushions, or pillows, including nursing pillows | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Crib bumper pads (mesh or non-mesh)                        | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other  | <input type="checkbox"/> | <input type="checkbox"/> |

↳ **Please tell us:**

**Insertion point for Standard question F5, F6, F7**  
**Insertion point for Infant Well Care Visit Series: X10, X9, X2**  
**Insertion point for Infant Sick Care Series: T1, T3, T8**  
**Insertion point for Postpartum Home Visitation Series: V22, V16, V18, V19**

**Core 41. Are you or your spouse or partner doing anything *now* to keep from getting pregnant?** This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

- No
- Yes → Go to Question **Core 43**

**Core 42. What are your reasons for not doing anything to keep from getting pregnant *now*?**

Check ALL that apply

- I'm pregnant now → Go to Question **Core 44**
- I want to get pregnant or don't mind if I do
- I had my tubes tied or blocked
- My spouse or partner had a vasectomy
- I don't want to use birth control
- I'm worried about side effects from birth control
- My spouse or partner doesn't want to use condoms
- My spouse or partner doesn't want me to use birth control
- We are same-sex spouses/partners
- I have problems getting birth control I want
- I don't think I can get pregnant, because I'm breastfeeding
- I'm not having sex
- Other

↳ **Please tell us:**

**If you or your spouse or partner is *not* doing anything to keep from getting pregnant *now*, go to Question **Core 44**.**

**Core 43. What kind of birth control are you or your spouse or partner using *now* to keep from getting pregnant?**

Check ALL that apply

- Tubes tied or blocked
- My spouse or partner had a vasectomy
- Birth control pills
- Condoms
- Shots or injections
- Contraceptive patch or vaginal ring
- IUD
- Contraceptive implant in the arm
- Withdrawal (pulling out)
- Natural family planning or fertility awareness methods (such as rhythm or calendar method, or fertility apps)
- Breastfeeding for birth control (Lactational amenorrhea or LAM)
- Other

↳ **Please tell us:**

**Core 44. Since your new baby was born, have you had a postpartum checkup for yourself?** A postpartum checkup is a regular health checkup you have up to 12 weeks after giving birth.

- No → **Go to Question [Core 46]**
- Yes

**Insertion point for Standard question J3**

**Core 45. During your postpartum checkup, did a healthcare provider do any of the following things?** For each one, check **No** or **Yes**.

	<b>No</b>	<b>Yes</b>
<b>Talk to me about...</b>		
a. Healthy eating, exercise, and losing weight gained during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
b. How long to wait before getting pregnant again	<input type="checkbox"/>	<input type="checkbox"/>
c. Birth control	<input type="checkbox"/>	<input type="checkbox"/>
d. Warning signs of medical problems I might be at risk for due to my pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
e. Regularly checking my blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
f. What to do if I feel depressed or anxious	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ask me...</b>		
g. If I was smoking cigarettes or using e-cigarettes (“vapes”) or other smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>
h. If someone was hurting me emotionally or physically	<input type="checkbox"/>	<input type="checkbox"/>
<b>Did they...</b>		
i. Test for diabetes	<input type="checkbox"/>	<input type="checkbox"/>
j. Prescribe medication for depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>

**Insertion point for Standard question J6, O4**

**Core 46. Since your new baby was born, how often have you felt down,**

**depressed, or hopeless?**

- Always
- Often
- Sometimes
- Rarely
- Never

**Core 47. *Since your new baby was born, how often have you had little interest or little pleasure in doing things?***

- Always
- Often
- Sometimes
- Rarely
- Never

**Core 48. *Since your new baby was born, how often have you felt nervous, anxious, or on edge?***

- Always
- Often
- Sometimes
- Rarely
- Never

**Core 49. *Since your new baby was born, how often have you not been able to stop or control worrying?***

- Always
- Often
- Sometimes
- Rarely
- Never

**Core 50. *Has a healthcare provider asked you a series of questions, in person or on a form, to know if you were feeling down, depressed, anxious, or irritable during the following time periods?***

For each one, check **No** or **Yes**.

- a. During my most recent pregnancy
- b. Since my new baby was born

No	Yes
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**Insertion points for Standard questions M6, M5, M11, M10**  
**Insertion points for Standard questions M16, M15, M20, M19**  
**Insertion points for Standard questions M22, M23, M24**  
**Insertion points for Standard question J7**  
**Insertion points for Standard questions Z13, Z2**

**OTHER EXPERIENCES**

**The next questions are on a variety of topics.**

**Insertion points for Site-Specific Questions**

**Core 51. Please tell us how often each of the following happened during the 12 months before your new baby was born.**

- a. I worried whether my food would run out before I got money to buy more**
  - Often
  - Sometimes
  - Never
- b. The food that I bought just didn't last, and I didn't have money to get more**
  - Often
  - Sometimes
  - Never

**Insertion points for Standard question BB3**

**Core 52. During the 12 months before your new baby was born, did lack of transportation keep you from any of the following?**  
 For each one, check **No** or **Yes**.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. Medical appointments                        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Non-medical appointments, meetings, or work | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Doing errands                               | <input type="checkbox"/> | <input type="checkbox"/> |

**Core 53. While getting healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?** For each item, check **No** if you did not experience discrimination because of it or **Yes** if you did.

- |                                      | <b>No</b>                | <b>Yes</b>               |
|--------------------------------------|--------------------------|--------------------------|
| a. My race, ethnicity, or skin color | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My disability status              | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My immigration status             | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My age                            | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My weight                         | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My income                         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My sex                            | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My sexual orientation             | <input type="checkbox"/> | <input type="checkbox"/> |
| i. My religion                       | <input type="checkbox"/> | <input type="checkbox"/> |
| j. My language or accent             | <input type="checkbox"/> | <input type="checkbox"/> |

- |    |   |                          |                          |
|----|---|--------------------------|--------------------------|
| k. | My type or lack of health insurance                     | <input type="checkbox"/> | <input type="checkbox"/> |
| l. | My use of substances (alcohol, tobacco, or other drugs) | <input type="checkbox"/> | <input type="checkbox"/> |
| m. | My involvement with the justice system (jail or prison) | <input type="checkbox"/> | <input type="checkbox"/> |
| n. | Another reason  | <input type="checkbox"/> | <input type="checkbox"/> |

↳ **Please tell us:**

**Insertion points for Standard question BB6**

**Core 54. During your life until now, how often have you been discriminated against, prevented from doing something, hassled, or made to feel inferior because of your race, ethnicity, or skin color?**

- Very often
- Somewhat often
- Not very often
- Never

**Insertion points for Standard question BB4, BB5**

**Core 55. Have you ever been treated unfairly due to your race, ethnicity, or skin color in any of the following situations?**  
For each one, check **No** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| a. Job (hiring, promotion, firing)        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Housing (renting, buying mortgage)     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Police (stopped, searched, threatened) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In the courts                          | <input type="checkbox"/> | <input type="checkbox"/> |
| e. At school or my child's school         | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Getting medical care                   | <input type="checkbox"/> | <input type="checkbox"/> |

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

**Core 56. During the 12 months before your new baby was born, what was your yearly total household income before taxes?** Include your income, your spouse 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.*

*(Note: Sites can add additional categories as long as the categories are collapsible back to the existing core categories.)*

- \$0 to \$16,000
- \$16,001 to \$20,000
- \$20,001 to \$24,000
- \$24,001 to \$32,000
- \$32,001 to \$48,000
- \$48,001 to \$60,000

- \$60,001 to \$85,000
- \$85,001 or more

**Core 57. During the 12 months before your new baby was born, how many people, including yourself, depended on this income?**

\_\_\_\_\_ Number of People

**Core 58. What is today's date?**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month / Day / Year

**We would love to hear more about your story! Is there anything else you would like to share with us about your experiences around the time of your pregnancy? Please use this space to tell us.**

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**Thank you for answering our questions. Your answers will help us work to make <STATE> mothers and babies healthier.**

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