

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.

1. How tall are *you* without shoes?

Feet Inches

OR Centimeters

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

Pounds OR Kilos

3. What is *your* date of birth?

/ /
Month Day Year

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

4. At any time during the 12 months before you got pregnant with your new baby, did you exercise 3 or more days of the week for fitness outside of your regular job?

- No
 Yes

5. 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 (**not** gestational diabetes or diabetes that starts during pregnancy)
- b. High blood pressure or hypertension
- c. Depression
- d. Asthma
- e. Heart problems

6. 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

7. 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 → **Go to Page 2, Question 10**
- Yes

Go to Page 2, Question 8

8. 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

- Regular checkup at my family doctor's office
- Regular checkup at my OB/GYN's office
- Visit for an illness or chronic condition
- Visit for an injury
- Visit for family planning or birth control
- Visit for depression or anxiety
- Visit to have my teeth cleaned by a dentist or dental hygienist
- Other _____ → Please tell us:

9. 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 |
|------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Talk to me about how I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |

10. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk to you about preparing for a pregnancy?

- No
- Yes

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

11. 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 from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Nevada Health Insurance Marketplace (Nevada Healthlink Website) or HealthCare.gov
- Medicaid
- Nevada Check Up (Nevada Children's Health Insurance Program)
- TRICARE or other military health care
- Indian Health Service (IHS) or tribal
- Other health insurance → Please tell us:

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

12. During your *most recent pregnancy*, what kind of health insurance did you have for your *prenatal care*?

Check ALL that apply

- I did not go for prenatal care → **Go to Question 14**
- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Nevada Health Insurance Marketplace (Nevada Healthlink Website) or HealthCare.gov
- Medicaid
- Nevada Check Up (Nevada Children's Health Insurance Program)
- TRICARE or other military health care
- Indian Health Service (IHS) or tribal
- Other health insurance → Please tell us:

- I did not have any health insurance for my *prenatal care*

If you had health insurance for your *prenatal care*, go to Question 13. Otherwise, go to Question 14.

13. Did the cost of health insurance for your *prenatal care* cause financial problems for you or your family?

- No
- Yes

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

Check ALL that apply

- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Nevada Health Insurance Marketplace (Nevada Healthlink Website) or HealthCare.gov
- Medicaid
- Nevada Check Up (Nevada Children's Health Insurance Program)
- TRICARE or other military health care
- Indian Health Service (IHS) or tribal
- Other health insurance → Please tell us:

- I do not have health insurance *now*

If you do not have health insurance *now*, go to Question 15. Otherwise, go to Page 4, Question 16.

15. What is the reason that you do not have any health insurance *now*?

Check ALL that apply

- Health insurance is too expensive
- I cannot get health insurance from my job or the job of my husband or partner
- I applied for health insurance, but was waiting to get it
- I had problems with the health insurance application or website
- My income is too high to qualify for Medicaid
- My income is too high to qualify for a tax credit from the Nevada Health Insurance Marketplace or HealthCare.gov
- I don't know how to get health insurance
- I am not a US citizen or I don't have the right residency documents
- Other → Please tell us:

16. 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

DURING PREGNANCY

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.)

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

{ _____ Weeks **OR** _____ Months

I didn't go for prenatal care → **Go to Question 19**

18. Did you get prenatal care as early in your pregnancy as you wanted?

No
 Yes → **Go to Question 20**

Go to Question 19

19. Did any of these things keep you from getting prenatal care when you wanted it? For each item, check **No** if it did not keep you from getting prenatal care or **Yes** if it did.

- | | No | Yes |
|-----------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan would not start care as early as I wanted..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid card..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't have anyone to take care of my children | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I didn't know that I was pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I didn't want anyone else to know I was pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I didn't want prenatal care..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not get prenatal care, go to Question 21.

20. 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 |
|-------------------------------------------------------------------------|--------------------------|--------------------------|
| a. If I knew how much weight I should gain during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If I was taking any prescription medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. If I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was using drugs such as marijuana, cocaine, crack, or meth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I wanted to be tested for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I planned to breastfeed my new baby.. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If I planned to use birth control after my baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

21. 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

22. 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

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

- No
 Yes

24. This question is about other care of your teeth during your most recent pregnancy. For each item, check **No** if it is not true or does not apply to you or **Yes** if it is true.

- | | No | Yes |
|-----------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. I knew it was important to care for my teeth and gums during my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A dental or other health care worker talked with me about how to care for my teeth and gums..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had insurance to cover dental care during my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I <u>needed</u> to see a dentist for a problem .. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I <u>went</u> to a dentist or dental clinic about a problem | <input type="checkbox"/> | <input type="checkbox"/> |

25. 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 |
|------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Gestational diabetes (diabetes that started during <i>this</i> pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that started during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heart problems..... | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about smoking cigarettes around the time of pregnancy (before, during, and after).

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

- No → Go to Page 6, Question 30
 Yes

Go to Page 6, Question 27

27. 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

28. 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

29. 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

30. Which of the following statements best describes the rules about smoking *inside* your home now, even if no one who lives in your home is a smoker?

Check ONE answer

- No one is allowed to smoke anywhere inside my home
- Smoking is allowed in some rooms or at some times
- Smoking is permitted anywhere inside my home

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.

A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

31. 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 |
|------------------------------------------------------------|--------------------------|--------------------------|
| a. E-cigarettes or other electronic nicotine products..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hookah | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chewing tobacco, snuff, snus, or dip..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cigars, cigarillos, or little filtered cigars | <input type="checkbox"/> | <input type="checkbox"/> |

If you used e-cigarettes or other electronic nicotine products in the **past 2 years**, go to Question 32. Otherwise, go to Question 34.

32. 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

33. 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

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

34. 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 → **Go to Question 36**
- Yes

35. 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

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

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

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

37. 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 |
|-------------------------------------|--------------------------|--------------------------|
| a. My husband or partner | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Another family member | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone else | <input type="checkbox"/> | <input type="checkbox"/> |

38. 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 |
|-------------------------------------|--------------------------|--------------------------|
| a. My husband or partner | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Another family member | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone else | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

39. When was your new baby born?

| | | | | |
|-------|---|-----|---|------|
| | / | | / | 20 |
| Month | | Day | | Year |

40. 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 → **Go to Question 43**

41. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 10, Question 54**

42. Is your baby living with you now?

- No → **Go to Page 10, Question 54**
- Yes

43. 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 |
|-----------------------------------------------------|--------------------------|--------------------------|
| a. My doctor | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A nurse, midwife, or doula | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A breastfeeding or lactation specialist | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My baby's doctor or health care provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A breastfeeding support group | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A breastfeeding hotline or toll-free number..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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

- No
 Yes

→ **Go to Question 46**

45. What were your reasons for not breastfeeding your new baby?

Check ALL that apply

- I was sick or on medicine
 I had other children to take care of
 I had too many household duties
 I didn't like breastfeeding
 I tried but it was too hard
 I didn't want to
 I went back to work
 I went back to school
 My baby had difficulty latching or nursing
 I did not have support from family or friends
 My partner did not want me to breastfeed
 Other → Please tell us:

If you did not breastfeed your new baby, go to Question 49.

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

- No
 Yes

→ **Go to Question 49**

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

- Less than 1 week

Weeks

OR

Months

48. What were your reasons for stopping breastfeeding?

Check ALL that apply

- My baby had difficulty latching or nursing
 Breast milk alone did not satisfy my baby
 I thought my baby was not gaining enough weight
 My nipples were sore, cracked, or bleeding or it was too painful
 I thought I was not producing enough milk, or my milk dried up
 I had too many other household duties
 I felt it was the right time to stop breastfeeding
 I got sick or I had to stop for medical reasons
 I went back to work
 I went back to school
 My partner did not support breastfeeding
 My baby was jaundiced (yellowing of the skin or whites of the eyes)
 I did not have support from family or friends
 Other → Please tell us:

If your baby is still in the hospital, go to Page 10, Question 54.

49. 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

50. 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

→ **Go to Page 10, Question 52**

Go to Page 10, Question 51

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

- No
 Yes

52. 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 |
|---------------------------------------------------------------------|--------------------------|--------------------------|
| a. In a crib, bassinet, or pack and play | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On a twin or larger mattress or bed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. On a couch, sofa, or armchair | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In an infant car seat or swing | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a sleeping sack or wearable blanket | <input type="checkbox"/> | <input type="checkbox"/> |
| f. With a blanket | <input type="checkbox"/> | <input type="checkbox"/> |
| g. With toys, cushions, or pillows, including nursing pillows | <input type="checkbox"/> | <input type="checkbox"/> |
| h. With crib bumper pads (mesh or non-mesh) | <input type="checkbox"/> | <input type="checkbox"/> |

53. 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 |
|-----------------------------------------------------------------------|--------------------------|--------------------------|
| a. Place my baby on his or her back to sleep | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Place my baby to sleep in a crib, bassinet, or pack and play | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Place my baby's crib or bed in my room .. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What things should and should not go in bed with my baby | <input type="checkbox"/> | <input type="checkbox"/> |

54. 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

→ **Go to Question 56**

55. 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

- I want to get pregnant
 I am pregnant now
 I had my tubes tied or blocked
 I don't want to use birth control
 I am worried about side effects from birth control
 I am not having sex
 My husband or partner doesn't want to use anything
 I have problems paying for birth control
 Other → Please tell us:

If you or your husband or partner is not doing anything to keep from getting pregnant *now*, go to Question 57.

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

Check ALL that apply

- Tubes tied or blocked (female sterilization or Essure®)
- Vasectomy (male sterilization)
- Birth control pills
- Condoms
- Shots or injections (Depo-Provera®)
- Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
- Contraceptive implant in the arm (Nexplanon® or Implanon®)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- Not having sex (abstinence)
- Other _____ → Please tell us:

57. 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 _____ → **Go to Question 59**
- Yes

Go to Question 58

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 |
|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid ... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about healthy eating, exercise, and losing weight gained during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about how long to wait before getting pregnant again | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about birth control methods I can use after giving birth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Ask me if I was smoking cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if I was feeling down or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Test me for diabetes | <input type="checkbox"/> | <input type="checkbox"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

OTHER EXPERIENCES

The next questions are on a variety of topics.

61. During your most recent pregnancy, did you take or use any of the following drugs for any reason? Your answers are strictly confidential. For each item, check **No** if you did not use it or **Yes** if you did.

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

If you did not use prescription pain relievers during your most recent pregnancy, go to Question 63.

62. How would you describe the way you got the prescription pain relievers that you used during your most recent pregnancy?

Check ALL that apply

- I had a current prescription
- I had pain relievers left over from an old prescription
- I got the pain relievers without a prescription

63. During your most recent pregnancy, did you receive any of the following services? For each one, check **No** if you did not receive the service or **Yes** if you received the service.

- | | No | Yes |
|--------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Food stamps or money to buy food | <input type="checkbox"/> | <input type="checkbox"/> |
| b. WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Counseling for family and personal problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help to quit smoking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Help to reduce violence in my home | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Help to quit using drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

64. The following questions refer to the time period before you were 18 years of age. For each item, check **No** if you did not do it or **Yes** if you did.

- | | No | Yes |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Did you live with anyone who was depressed, mentally ill, or suicidal?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did you live with anyone who was a problem drinker or alcoholic?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did you live with anyone who used illegal street drugs or who abused prescription medications?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?..... | <input type="checkbox"/> | <input type="checkbox"/> |

65. During the time period before you were 18 years of age did your parents get separated or divorced?

- No
- Yes
- They were never married
- I don't know

66. During the time period before you were 18 years of age, how often did the following things happen to you?

For each item, check:

- N** if it *never* happened,
- O** if it happened *once*,
- MO** if it happened *more than once*, or
- DK** if you *don't know*.

N O MO DK

- a. How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?.....
- b. Before age 18, how often did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way? Do not include spanking
- c. How often did a parent or adult in your home ever swear at you, insult you, or put you down?.....
- d. How often did anyone at least 5 years older than you or an adult ever touch you sexually?.....
- e. How often did anyone at least 5 years older than you or an adult try to make you touch them sexually?.....
- f. How often did anyone at least 5 years older than you or an adult force you to have sex?.....

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

67. 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

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

People

69. What is today's date?

/ / 20

Month Day Year

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 Nevada.

Thanks for answering our questions!

Your answers will help us work to keep mothers and babies in Nevada healthy.

