

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

No Yes

→ **Go to Question 7**

5. Did the baby born *just before* your new one weigh 5 pounds, 8 ounces (2.5 kilos) or less at birth?

No
 Yes

6. Was the baby *just before* your new one born *earlier* than 3 weeks before his or her due date?

No
 Yes

7. At any time during the 12 months before you got pregnant with your new baby, did you do any of the following things? For each item, check **No** if you did not do it or **Yes** if you did it.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I was dieting (changing my eating habits) to lose weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was exercising 3 or more days of the week for fitness outside of my regular job | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I was regularly taking prescription medicines other than birth control..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A health care worker checked me for diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I talked to a health care worker about my family medical history | <input type="checkbox"/> | <input type="checkbox"/> |

8. 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) | <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"/> |

9. 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

10. 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 Question 13**

Yes

11. 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:

12. 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"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight..... | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

13. 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 → **Go to Question 15**

Yes

Go to Question 14

14. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk with you about any of the things listed below about preparing for a pregnancy? *Please count only discussions, not reading materials or videos.* For each item, check **No** if no one talked with you about it or **Yes** if someone did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Getting my vaccines updated before pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Visiting a dentist or dental hygienist before pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Getting counseling for any genetic diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Getting counseling or treatment for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The safety of using prescription or over-the-counter medicines during pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. How smoking during pregnancy can affect a baby | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How drinking alcohol during pregnancy can affect a baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. How using illegal drugs during pregnancy can affect a baby | <input type="checkbox"/> | <input type="checkbox"/> |

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

15. 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 Nebraska Health Insurance Marketplace or marketplacenebraska.com or HealthCare.gov
- Medicaid or Medicaid Managed Care
- TRICARE or other military health care
- Indian Health Services or Tribal Clinic
- Other health insurance ———> Please tell us:
- I did not have any health insurance during the *month before* I got pregnant

16. 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 Page 4, Question 17**
- 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 Nebraska Health Insurance Marketplace or marketplacenebraska.com or HealthCare.gov
- Medicaid or Medicaid Managed Care
- TRICARE or other military health care
- Indian Health Services or Tribal Clinic
- Other health insurance ———> Please tell us:
- I did not have any health insurance for my *prenatal care*

17. What kind of health insurance did you have to pay for your *delivery*?

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 Nebraska Health Insurance Marketplace or marketplacenebraska.com or HealthCare.gov
- Medicaid or Medicaid Managed Care
- TRICARE or other military health care
- Indian Health Services or Tribal Clinic
- Other health insurance → Please tell us:

- I did not have any health insurance to pay for my *delivery*

18. 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 Nebraska Health Insurance Marketplace or marketplacenebraska.com or HealthCare.gov
- Medicaid or Medicaid Managed Care
- TRICARE or other military health care
- Indian Health Services or Tribal Clinic
- Other health insurance → Please tell us:

- I do not have health insurance *now*

19. 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

20. When you got pregnant with your new baby, were you trying to get pregnant?

- No
- Yes → **Go to Question 24**

21. When you got pregnant with your new baby, were you or your husband or partner doing anything 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 23**

22. What were your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant?

Check ALL that apply

- I didn't mind if I got pregnant
- I thought I could not get pregnant at that time
- I had side effects from the birth control method I was using
- I had problems getting birth control when I needed it
- I thought my husband or partner or I was sterile (could not get pregnant at all)
- My husband or partner didn't want to use anything
- I forgot to use a birth control method
- Other → Please tell us:

If you or your husband or partner was *not* doing anything to keep from getting pregnant, go to Question 24.

23. What method of birth control were you using when you got pregnant?

Check ALL that apply

- Birth control pills
- Condoms
- Shots or injections (Depo-Provera®)
- Contraceptive implant in the arm (Nexplanon® or Implanon®)
- Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- Other _____ → Please tell us:

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.)

24. 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 26

Go to Question 25

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

No

Yes →

Go to Question 27

26. 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 or Medicaid Managed Care 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 Page 6, Question 30.

27. Where did you go *most of the time* for your prenatal care visits? Do not include visits for WIC.

Check ONE answer

- Private doctor's office
- Hospital clinic
- Health department clinic
- Indian Health Service or Tribal Clinic
- Community health center
- Other _____ → Please tell us:

28. 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"/> |

29. How did you feel about the prenatal care you got during your most recent pregnancy? If you went to more than one place for prenatal care, answer for the place where you got *most* of your care. For each item, check **No** if you were not satisfied or **Yes** if you were satisfied.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. The amount of time I had to wait | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The amount of time the doctor, nurse, or midwife spent with me | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The advice I got on how to take care of myself..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The understanding and respect shown toward me as a person | <input type="checkbox"/> | <input type="checkbox"/> |

30. 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

31. 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

32. 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

33. During your most recent pregnancy, did you get a Tdap shot or vaccination? A Tdap vaccination is a tetanus booster shot that also protects against pertussis (whooping cough).

- No
 Yes
 I don't know

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

- No
 Yes

35. 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"/> |

36. During your most recent pregnancy, did you take a class or classes to prepare for childbirth and learn what to expect during labor and delivery?

- No
 Yes

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

- No Go to Question 39
 Yes

38. Who was the home visitor that came to your home during your most recent pregnancy?

- A nurse or nurse's aide
 A teacher or health educator
 A doula or midwife
 Someone else Please tell us:

- I don't know

39. During your most recent pregnancy, were you on WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)?

- No
 Yes

40. 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"/> |

If you had depression during your most recent pregnancy, go to Question 41. Otherwise, go to Question 42.

41. At any time during your most recent pregnancy, did you ask for help for depression from a doctor, nurse, or other health care worker?

- No
 Yes

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

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

- No Go to Page 8, Question 46
 Yes

43. 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

44. 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

45. 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

46. 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.

47. 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.....
- b. Hookah

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 48. Otherwise, go to Question 50.

48. 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

49. 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.

50. 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 54**
 Yes

51. 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 —————→ **Go to Question 53**

52. 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

53. 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

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

54. 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"/> |
| b. I got separated or divorced from my husband or partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I moved to a new address..... | <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 husband or partner lost their job..... | <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"/> |
| g. My husband, partner, or I had a cut in work hours or pay..... | <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"/> |
| i. I argued with my husband or partner more than usual..... | <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"/> |
| k. I had problems paying the rent, mortgage, or other bills..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. My husband, partner, or I went to jail..... | <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"/> |
| n. Someone very close to me died..... | <input type="checkbox"/> | <input type="checkbox"/> |

55. 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. Someone else | <input type="checkbox"/> | <input type="checkbox"/> |

56. 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. Someone else | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

57. When was your new baby born?

<input type="text"/> / <input type="text"/> / <input type="text"/> 20
Month Day Year

58. 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 61**

Go to Question 59

59. Is your baby alive now?

- No → **We are very sorry for your loss. Go to Page 12, Question 75**
- Yes

60. Is your baby living with you now?

- No → **Go to Page 12, Question 75**
- Yes

61. 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:

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

- No → **Go to Question 68**
- Yes

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

- No
- Yes → **Go to Question 66**

Go to Question 64

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

Less than 1 week

Weeks **OR** Months

65. 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)
- Other _____ → Please tell us:

If your baby was not born in a hospital, go to Question 67.

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Hospital staff gave me information about breastfeeding..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I breastfed my baby in the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hospital staff helped me learn how to breastfeed | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I breastfed in the first hour after my baby was born | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My baby was placed in skin-to-skin contact within the first hour of life..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My baby was fed only breast milk at the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. The hospital gave me a gift pack with formula | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The hospital gave me a telephone number to call for help with breastfeeding..... | <input type="checkbox"/> | <input type="checkbox"/> |

67. How old was your new baby the first time he or she had liquids other than breast milk (such as formula, water, juice, or cow's milk)?

Weeks **OR** Months

- My baby was less than 1 week old
- My baby has not had any liquids other than breast milk

68. How old was your new baby the first time he or she ate food (such as baby cereal, baby food, or any other food)?

Weeks **OR** Months

- My baby was less than 1 week old
- My baby has not eaten any foods

If your baby is still in the hospital, go to Question 75.

69. 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

70. 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 Question 72

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

- No
 Yes

72. 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"/> |

73. 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"/> |

74. Has your new baby had a well-baby checkup?

A well-baby checkup is a regular health visit for your baby usually at 1, 2, 4, and 6 months of age.

- No
 Yes

75. 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 77

76. 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 78.

77. 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:

78. 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 80**

Yes

Go to Question 79

79. 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"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

81. 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

82. Since your new baby was born, have you asked for help for depression from a doctor, nurse, or other health care worker?

- No
 Yes

OTHER EXPERIENCES

The next questions are on a variety of topics.

83. Since your new baby was born, how many alcoholic drinks do 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 don't drink

If your baby is not alive, is not living with you, or is still in the hospital, go to Question 86.

84. Are you currently in school or working?

- No, I don't go to school or work → **Go to Question 86**
 Yes, I go to school or work outside the home
 Yes, I go to school or work from home

85. 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 day care center
 Other → Please tell us:

- The baby is with me while I am at school or work

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

86. 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

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

People

88. 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 Nebraska.

Thanks for answering our questions!

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

