

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 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.....
- b. I was exercising 3 or more days of the week for fitness outside of my regular job
- c. I was regularly taking prescription medicines other than birth control.....
- d. A health care worker checked me for diabetes.....
- e. I talked to a health care worker about my family medical history

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

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 Question 10**

Yes

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 → **Go to Question 12**

Yes

Go to Question 11

11. **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**.

12. 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 Illinois Health Insurance Marketplace or GetcoveredIllinois.gov or HealthCare.gov
- Medicaid
- CHIP or All Kids
- TRICARE or other military health care
- Other health insurance —→ Please tell us:
- I did not have any health insurance during the *month before* I got pregnant

13. 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 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 Illinois Health Insurance Marketplace or GetcoveredIllinois.gov or HealthCare.gov
- Medicaid
- CHIP, All Kids, or Moms & Babies
- TRICARE or other military health care
- Other health insurance —→ Please tell us:
- I did not have any health insurance for my *prenatal care*

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 Illinois Health Insurance Marketplace or GetcoveredIllinois.gov or HealthCare.gov
- Medicaid
- CHIP, All Kids, or Moms & Babies
- TRICARE or other military health care
- Other health insurance → Please tell us:
- I do not have health insurance *now*

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

Check ONE answer

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

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

- No
- Yes →

Go to Question 19

17. 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 19

Go to Question 18

18. 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:

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.)

19. 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 21

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

- No
- Yes →

Go to Question 22

Go to Question 21

21. 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 Page 6, Question 25.

22. 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
 Community health clinic
 Other _____ → Please tell us:

23. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? 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. How smoking during pregnancy could affect my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Breastfeeding my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. How drinking alcohol during pregnancy could affect my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Using a seat belt during my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Medicines that are safe to take during my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. How using illegal drugs could affect my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Doing tests to screen for birth defects or diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. What to do if I feel depressed during my pregnancy or after my baby is born..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Physical abuse to women by their husbands or partners..... | <input type="checkbox"/> | <input type="checkbox"/> |

24. 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"/> |

25. Have you ever heard or read that taking a vitamin with folic acid can help prevent some birth defects?

- No → **Go to Question 27**
- Yes

26. Have you ever heard about folic acid from any of the following?

Check ALL that apply

- Magazine or newspaper article
- Radio or television
- Doctor, nurse, or other health care worker
- Book
- Family or friends
- Other → Please tell us:

27. 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

28. 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

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

- No
- Yes

30. 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"/> |

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

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

- No → **Go to Page 8, Question 37**
 Yes

32. 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

33. 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

If you did not smoke at any time during the *3 months before* you got pregnant, go to Question 36.

34. During any of your prenatal care visits, did a doctor, nurse, or other health care worker advise you to quit smoking?

- No
 Yes
 I didn't go for prenatal care → **Go to Question 36**

Go to Question 35

35. Listed below are some things about quitting smoking that a doctor, nurse, or other health care worker might have done *during any of your prenatal care visits*. For each thing, check **No if it was not done or **Yes** if it was.**

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Spend time with me discussing how to quit smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Suggest that I set a specific date to stop smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Suggest I attend a class or program to stop smoking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Provide me with booklets, videos, or other materials to help me quit smoking on my own | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Refer me to counseling for help with quitting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Ask if a family member or friend would support my decision to quit..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Refer me to a national or state quit line ... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Recommend using nicotine gum | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Recommend using a nicotine patch..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Prescribe a nicotine nasal spray or nicotine inhaler | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Prescribe a pill like Zyban® (also known as Wellbutrin® or bupropion) to help me quit..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Prescribe a pill like Chantix® (also known as varenicline) to help me quit | <input type="checkbox"/> | <input type="checkbox"/> |

36. 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

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.

37. 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 38. Otherwise, go to Question 40.

38. 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

39. 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.

40. 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 42**
- Yes

41. 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.

42. 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"/> |

43. During the 12 months before your new baby was born, how often did you feel unsafe in the neighborhood where you lived?

- Always
 Often
 Sometimes
 Rarely
 Never

44. 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"/> |

45. 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.

46. When was your new baby born?

	/		/	20
Month		Day		Year

47. 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 50**

48. Is your baby alive now?

- No → *We are very sorry for your loss.*
Go to Question 62
- Yes

49. Is your baby living with you now?

- No → **Go to Question 62**
- Yes

50. 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:

51. 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 53**

52. 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
- Other → Please tell us:

If you did not breastfeed your new baby, go to Question 56.

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

- No
- Yes → **Go to Question 55**

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

- Less than 1 week
- Weeks **OR** Months

55. 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

56. 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 62.

57. 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

58. 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 60

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

- No
 Yes

60. 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"/> |

61. 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"/> |

62. 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 Page 12, Question 64

Go to Page 12, Question 63

63. 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 65.

64. 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:

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

- No
- Yes _____ → **Go to Question 67**

66. Did any of these things keep you from having a postpartum checkup?

Check ALL that apply

- I didn't have health insurance to cover the cost of the visit
- I felt fine and did not think I needed to have a visit
- I couldn't get an appointment when I wanted one
- I didn't have any transportation to get to the clinic or doctor's office
- I had too many things going on
- I couldn't take time off from work
- Other _____ → Please tell us:

If you did not have a postpartum checkup, go to Question 69.

67. Where did you go for your postpartum checkup?

- My family doctor's office
- My OB/GYN's office
- Hospital clinic
- Health department clinic
- Community health clinic
- Other _____ → Please tell us:

68. 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"/> |

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

- Always
 Often
 Sometimes
 Rarely
 Never

70. 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

71. Since your new baby was born, has a doctor, nurse, or other health care worker told you that you had depression?

- No → **Go to Question 74**
 Yes

72. Since your new baby was born, have you taken prescription medicine for your depression?

- No
 Yes

73. Since your new baby was born, have you gotten counseling for your depression?

- No
 Yes

OTHER EXPERIENCES

The next questions are on a variety of topics.

If your baby is not alive, is not living with you, or is still in the hospital, go to Page 14, Question 75.

74. Since you delivered your new baby, would you have the kinds of help listed below if you needed them? For each one, check **No** if you would not have it or **Yes** if you would.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Someone to loan me \$50..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Someone to help me if I were sick and needed to be in bed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Someone to talk with about my problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Someone to take care of my baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Someone to help me if I were tired and feeling frustrated with my new baby | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. During the 12 months before I got pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During my most recent pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Since my new baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

76. During pregnancy, you probably had to get different kinds of health-related services. These may have included clinic visits, doctor’s or nurse’s office visits, applying for health insurance, applying for Medicaid, or getting help for a family problem. Did you ever feel you were treated unfairly in getting these kinds of services because of any of the following? For each item, check **No** if you were not treated unfairly or **Yes** if you were treated unfairly.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. My race, ethnicity, or culture | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My age | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The language I speak..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My citizenship | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My insurance or Medicaid status | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I felt unfairly treated for other reasons..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us: _____ →

If your baby is not alive or is not living with you, go to Question 78.

77. When your new baby’s father is with your baby, how often does he hug, kiss, hold, or play with the baby?

- Always
- Often
- Sometimes
- Rarely
- Never
- My new baby’s father doesn’t regularly spend time with my baby

78. Since your new baby was born, how often does your husband or partner provide you with encouragement and emotional support?

- Always
- Often
- Sometimes
- Rarely
- Never

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

79. 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

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

People

81. What is today’s date?

<input style="width: 40px; height: 25px;" type="text"/>	/	<input style="width: 40px; height: 25px;" type="text"/>	/	<input style="width: 40px; height: 25px; text-align: center;" type="text"/>
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 Illinois.

Thanks for answering our questions!

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

