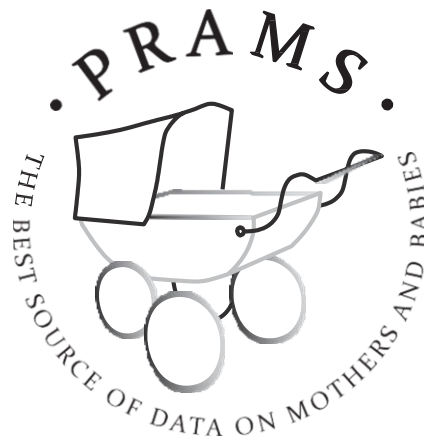




A survey to improve the health of babies and mothers in Washington State.



# Questions Commonly Asked About PRAMS

## What is PRAMS?

PRAMS (Pregnancy Risk Assessment Monitoring System) is a joint research project between the Washington State Department of Health and the Centers for Disease Control and Prevention (CDC). Our purpose is to find out why some babies are born healthy and others are not. To do this, our questionnaire asks new mothers questions about their behaviors and experiences around the time of their pregnancy. Each year in Washington there are hundreds of babies born with serious health problems. Many of these babies die. We need your help to find out why. No matter how your pregnancy went, your answers will help us learn more about ways to improve the chances for future mothers and babies in Washington.

## Will my answers be kept private?

Yes all answers are kept completely private to the extent permitted by law. All answers given on the questionnaires will be grouped together to give us information on Washington mothers of new babies. Your answers will be used for research purposes only. Your answers may be shared only with a limited number of researchers who have signed confidentiality agreements with the Department of Health. The number on the survey lets us link your answers to your child’s birth record information and to other databases. In reports from this survey, no woman will be identified by name.

## Is it really important that I answer these questions?

Yes! Because of the small number of mothers picked, it is important to have everyone’s answers.

Every pregnancy is different. To get a better overall picture of the health of mothers and babies in Washington, we need each mother selected to answer the questions. From the information you give us, we may be able to improve health care for women and children in Washington. We need to know what went right as well as what went wrong during your pregnancy. Your help is really important to the success of our program.

## Some of the questions do not seem related to health care. Why are they asked?

Many things in a mother’s life and pregnancy may affect her pregnancy. These questions try to get the best picture of the new mother’s health care and things that happened to her during pregnancy.

## How was I chosen to participate in PRAMS?

Your name was picked by chance, like in a lottery, from the state birth certificate registry. You are one of a small number of women who were chosen to help us in this study.

## What if I want to ask more questions about PRAMS?

Please call us at our toll-free number, 1-877-867-7267, and we will be happy to answer any other questions that you may have about PRAMS. If you prefer to complete the questionnaire over the telephone, please call us on the same number.

See inside back cover for calendar.

|                                                                                                                                                                |                                                                                                                                                          |                                                                                                                                                              |                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>January (Enero) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>               | <b>February (Febrero) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28</div>         | <b>March (Marzo) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>         | <b>April (Abril) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div>                       |
| <b>May (Mayo) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>                  | <b>June (Junio) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div>       | <b>July (Julio) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>                  | <b>August (Agosto) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>            |
| <b>September (Septiembre) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div> | <b>October (Octubre) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>       | <b>November (Noviembre) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div>     | <b>December (Diciembre) 2019</b> <div>Su Mo Tu We Th Fr Sa</div> <div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div> |
| <b>January (Enero) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>             | <b>February (Febrero) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29</div>    | <b>March (Marzo) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>     | <b>April (Abril) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div>                   |
| <b>May (Mayo) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>              | <b>June (Junio) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>              | <b>July (Julio) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>              | <b>August (Agosto) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>        |
| <b>September (Septiembre) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div>           | <b>October (Octubre) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>   | <b>November (Noviembre) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div> | <b>December (Diciembre) 2020</b> <div>Su Mo Tu We Th Fr Sa</div> <div>6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>           |
| <b>January (Enero) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>         | <b>February (Febrero) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28</div>                 | <b>March (Marzo) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>                 | <b>April (Abril) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>              |
| <b>May (Mayo) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>            | <b>June (Junio) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 30</div>                  | <b>July (Julio) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>            | <b>August (Agosto) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>      |
| <b>September (Septiembre) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div>         | <b>October (Octubre) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div> | <b>November (Noviembre) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30</div>             | <b>December (Diciembre) 2021</b> <div>Su Mo Tu We Th Fr Sa</div> <div>5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>         |

2019

2020

2021

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. During the 3 months before you got pregnant with your new baby, did you have any of the following health conditions? For each one, check **No** if you did not have the condition or **Yes** if you did.

|                                                                                                                | No                       | Yes                      |
|----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes ( <b>not</b> gestational diabetes or diabetes that starts during pregnancy) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension .....                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression .....                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Asthma .....                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Thyroid problems .....                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Anxiety .....                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |

5. 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

6. 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 3, Question 9**

☐ Yes

Go to Page 2, Question 7

7. 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:

8. 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"/> |
| m. Ask me if birth defects or diseases run in my family .....                                        | <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*.

**9. 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 Washington Healthplanfinder (wahealthplanfinder.org) or HealthCare.gov
- ☐ Medicaid or Apple Health
- ☐ TRICARE or other military health care
- ☐ Indian Health Service and/or Tribal Health Services
- ☐ Other health insurance —→ Please tell us:  
\_\_\_\_\_
- ☐ I did not have any health insurance during the *month before* I got pregnant

**10. 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 11**
- ☐ 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 Washington Healthplanfinder (wahealthplanfinder.org) or HealthCare.gov
- ☐ Medicaid or Apple Health
- ☐ TRICARE or other military health care
- ☐ Indian Health Service and/or Tribal Health Services
- ☐ Other health insurance —→ Please tell us:  
\_\_\_\_\_
- ☐ I did not have any health insurance for my *prenatal care*

**11. 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 Washington Healthplanfinder (wahealthplanfinder.org) or HealthCare.gov
- ☐ Medicaid or Apple Health
- ☐ TRICARE or other military health care
- ☐ Indian Health Service and/or Tribal Health Services
- ☐ Other health insurance —→ Please tell us:  
\_\_\_\_\_
- ☐ I do not have health insurance *now*

**12. 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

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

- ☐ No
- ☐ Yes —→ **Go to Page 4, Question 17**

**14. 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 Page 4, Question 16**

**Go to Page 4, Question 15**

**15. 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 17.**

**16. 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)
- ☐ Emergency contraceptives ("morning after pills" such as Plan B)
- ☐ 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.)

**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**

**Go to Question 18**

**18. 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"/> |
| k. About how eating fish containing high levels of mercury could affect my baby ... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. If I knew what to do if my labor starts early .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| m. If birth defects or diseases run in my family .....                              | <input type="checkbox"/> | <input type="checkbox"/> |

**19. During the 12 months before the delivery of your new baby, did a doctor, nurse, or other health care worker offer you a flu shot or tell you to get one?**

- ☐ No  
☐ Yes

**20. During the 12 months before the delivery of your new baby, did you get a flu shot?**

**Check ONE answer**

- ☐ No  
☐ Yes, before my pregnancy  
☐ Yes, during my pregnancy

**Go to  
Question 22**

**Go to Question 21**

**21. What were your reasons for not getting a flu shot during the 12 months before the birth of your new baby?** For each item, check **No** if it was not a reason for you or **Yes** if it was.

- |                                                                 | No                       | Yes                      |
|-----------------------------------------------------------------|--------------------------|--------------------------|
| a. My doctor didn't mention anything about a flu shot .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was worried about side effects of the flu shot for me..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I was worried that the flu shot might harm my baby.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was not worried about getting sick with the flu .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I do not think the flu shot works .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I don't normally get a flu shot .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Other .....                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:

---

**22. 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

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

- ☐ No  
☐ Yes

24. 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 <b>started</b> during <i>this</i> pregnancy) .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that <b>started</b> during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression .....                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

☐ No →

Go to Question 29

☐ Yes

26. 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

27. 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

28. 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.

29. 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. Chew .....                                              | <input type="checkbox"/> | <input type="checkbox"/> |

**If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 30. Otherwise, go to Question 32.**

**30. 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

**31. 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.**

**32. 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 Page 8, Question 35**

☐ Yes  


**33. 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

**34. 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.**

**35. 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"/> |

**36. 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"/> |

**37. 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"/> |

**38. During your most recent pregnancy, did any of the following things happen to you?** For each thing, check **No** if it did not happen to you or **Yes** if it did.

- |                                                                                                                                      | No                       | Yes                      |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. My husband or partner threatened me or made me feel unsafe in some way .....                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was frightened for my safety or my family's safety because of the anger or threats of my husband or partner .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My husband or partner tried to control my daily activities, for example, controlling who I could talk to or where I could go..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My husband or partner forced me to take part in touching or any sexual activity when I did not want to .....                      | <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. How was your new baby delivered?

- ☐ Vaginally → **Go to Question 42**  
☐ Cesarean delivery (c-section)

### 41. What was the reason that your new baby was born by cesarean delivery (c-section)?

**Check ALL that apply**

- ☐ I had a previous cesarean delivery (c-section)  
☐ My baby was not head down  
☐ I was past my due date  
☐ My health care provider worried that my baby was too big  
☐ I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)  
☐ I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)  
☐ My health care provider tried to induce my labor, but it didn't work  
☐ Labor was taking too long  
☐ The fetal monitor showed that my baby was having problems before or during labor (fetal distress)  
☐ I wanted to schedule my delivery  
☐ I didn't want to have my baby vaginally  
☐ Other → Please tell us:

\_\_\_\_\_

### 42. How much weight did you gain during your most recent pregnancy?

**Check ONE answer and fill in blank if needed**

- ☐ I gained  pounds **OR**  kilos  
☐ I didn't gain any weight during my pregnancy  
☐ I don't know

### 43. 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 Page 10, Question 46**

### 44. Is your baby alive now?

- ☐ No → **We are very sorry for your loss. Go to Page 11, Question 56**  
☐ Yes

### 45. Is your baby living with you now?

- ☐ No → **Go to Page 11, Question 56**  
☐ Yes

**Go to Page 10, Question 46**

**46. 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:

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

- ☐ No —————→ **Go to Question 51**
- ☐ Yes



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

- ☐ No
- ☐ Yes —————→ **Go to Question 51**



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

- ☐ Less than 1 week

\_\_\_\_\_ Weeks **OR** \_\_\_\_\_ Months

**50. 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 is still in the hospital, go to Question 56.**

**51. 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

**52. 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 54**

**Go to Question 53**

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

- ☐ No  
☐ Yes

**54. 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"/> |

**55. 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"/> |

**56. 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 58**

**57. 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 59.

58. 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:

59. 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 61

☐ Yes

Go to Question 60

60. 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 ... ☐ ☐
- b. Talk to me about healthy eating, exercise, and losing weight gained during pregnancy..... ☐ ☐
- c. Talk to me about how long to wait before getting pregnant again ..... ☐ ☐
- d. Talk to me about birth control methods I can use after giving birth..... ☐ ☐
- e. Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms..... ☐ ☐
- f. Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®) ..... ☐ ☐
- g. Ask me if I was smoking cigarettes ..... ☐ ☐
- h. Ask me if someone was hurting me emotionally or physically ..... ☐ ☐
- i. Ask me if I was feeling down or depressed ..... ☐ ☐
- j. Test me for diabetes ..... ☐ ☐

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

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

62. 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.

**63. Did any of the following things make it hard for you to go to a dentist or dental clinic during your most recent pregnancy?** For each item, check **No** if it was not something that made it hard for you or **Yes** if it was.

- |                                                                                        | No                       | Yes                      |
|----------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. I could not find a dentist or dental clinic that would take pregnant patients ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I could not find a dentist or dental clinic that would take Medicaid patients ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I did not think it was safe to go to the dentist during pregnancy .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I could not afford to go to the dentist or dental clinic .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I did not need to see a dentist for a problem .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**64. During any of the following time periods, did you use marijuana?** For each time period, check **No** if you did not use then or **Yes** if you 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"/> |

**65. During the 12 months before your new baby was born, did you experience discrimination, harassment, or were you made to feel inferior because of the things listed below?** For each item, check **No** if you did not experience these things or **Yes** if you did experience them.

- |                                          | No                       | Yes                      |
|------------------------------------------|--------------------------|--------------------------|
| a. My race, ethnicity, or culture .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My insurance or Medicaid status ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My weight .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My marital status .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other .....                           | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

---

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

**66. 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

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

People

68. 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 Washington.**

***Thanks for answering our questions!***

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

