

New Hampshire PRAMS

Pregnancy Risk Assessment Monitoring System



A survey of the health of mothers and babies in New Hampshire



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 (**not** gestational diabetes or diabetes that starts during pregnancy)
- b. High blood pressure or hypertension
- c. Depression

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 2, Question 9**
- Yes

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"/> |

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 New Hampshire Health Insurance Marketplace or HealthCare.gov
- Medicaid or any insurance provided through NH Medicaid
- Community Health Center, local hospital program
- TRICARE, TRICARE Prime, Martins Point Prime, 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

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 New Hampshire Health Insurance Marketplace or HealthCare.gov
- Medicaid or any insurance provided through NH Medicaid
- Community Health Center, local hospital program
- TRICARE, TRICARE Prime, Martins Point Prime, or other military health care
- 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 New Hampshire Health Insurance Marketplace or HealthCare.gov
- Medicaid or any insurance provided through NH Medicaid
- Community Health Center, local hospital program
- TRICARE, TRICARE Prime, Martins Point Prime, or other military health care
- 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

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.)

13. 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 Page 4, Question 15**

Go to Page 4, Question 14

14. 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"/> |

15. 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

16. 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

17. 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

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

- No
 Yes

19. 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"/> |

If you did not have any problems with your teeth or gums during your pregnancy, go to Question 21.

20. During your most recent pregnancy, what kind of problem did you have with your teeth or gums? For each item, check **No** if you did not have this problem during pregnancy or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I had cavities that needed to be filled..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I had painful, red, or swollen gums | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had a toothache..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I needed to have a tooth pulled..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had an injury to my mouth, teeth, or gums | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I had some other problem with my teeth or gums | <input type="checkbox"/> | <input type="checkbox"/> |
- Please tell us:

21. 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 to go to a dentist during pregnancy or **Yes** if it was.

No Yes

- a. I could not find a dentist or dental clinic that would take pregnant patients
- b. I could not find a dentist or dental clinic that would take Medicaid patients
- c. I did not think it was safe to go to the dentist during pregnancy
- d. I could not afford to go to the dentist or dental clinic

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

- No
 Yes

23. 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 *this* pregnancy)
- b. High blood pressure (that **started** during *this* pregnancy), pre-eclampsia or eclampsia
- c. Depression
- d. Lyme Disease

If you had depression during your most recent pregnancy, go to Question 24. Otherwise, go to Question 25.

24. 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

25. During your most recent pregnancy, did a doctor, nurse, or other health care worker give you a series of weekly shots of a medicine called progesterone, Makena®, or 17P (17 alpha-hydroxyprogesterone) to try to keep your new baby from being born too early?

- No
 Yes
 I don't know

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

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

- No → **Go to Page 6, Question 32**
 Yes

27. In the 3 months before you got pregnant, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- 41 cigarettes or more
 21 to 40 cigarettes
 11 to 20 cigarettes
 6 to 10 cigarettes
 1 to 5 cigarettes
 Less than 1 cigarette
 I didn't smoke then

28. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- 41 cigarettes or more
 21 to 40 cigarettes
 11 to 20 cigarettes
 6 to 10 cigarettes
 1 to 5 cigarettes
 Less than 1 cigarette
 I didn't smoke then

If you did not smoke at any time during the 3 months before you got pregnant, go to Question 31.

29. 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 31**

30. 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"/> |

31. 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

32. 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.

33. 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"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 34. Otherwise, go to Question 36.

34. 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

35. 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.

36. 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 38**
- Yes

37. 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.

38. 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"/> |

39. 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"/> |

AFTER PREGNANCY

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

40. When was your new baby born?

<input style="width: 100%; height: 20px;" type="text"/> /	<input style="width: 100%; height: 20px;" type="text"/> /	<input style="width: 100%; height: 20px;" type="text"/> 20
Month	Day	Year

41. 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 44**

42. Is your baby alive now?

- No → *We are very sorry for your loss.*
Go to Question 55
- Yes

43. Is your baby living with you now?

- No → **Go to Question 55**
- Yes

44. 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:

45. 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 47**

46. 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 50.

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

- No
- Yes → **Go to Question 50**

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

- Less than 1 week

Weeks **OR** Months

49. 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 55.

50. 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

51. 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 53

Go to Question 52

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

- No
- Yes

53. 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"/> |

54. 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"/> |

55. 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 10, Question 57

Go to Page 10, Question 56

56. 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 58.

57. 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:

58. 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 60

59. 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"/> |

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

- Always
- Often
- Sometimes
- Rarely
- Never

61. 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

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

- No
- Yes

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

- No
- Yes

OTHER EXPERIENCES

The next questions are on a variety of topics.

64. During the 12 months before the delivery of your new baby, did you get your household tap water from a private water system such as a well?

- No → **Go to Question 67**
- Yes

65. During the 12 months before the delivery of your new baby, did your doctor, nurse, or other health care worker talk to you about getting your household water tested for any of the following things? For each one, check **No** if they did not talk to you about it or **Yes** if they did.

No Yes

- a. Arsenic.....
- b. Lead

66. During the 12 months before the delivery of your new baby, did you have your well tested for any of the following things? For each one, check **No** if your water was not tested for it or **Yes** if it was.

No Yes

- a. Arsenic.....
- b. Lead

67. During any of the following time periods, did you use marijuana or hash in any form? 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
- b. During my most recent pregnancy
- c. Since my new baby was born.....

If you did not use marijuana or hash, go to Question 69.

68. Why did you use marijuana or hash?

Check ALL that apply

- To relieve nausea
- To relieve vomiting
- To relieve stress or anxiety
- To relieve a chronic condition
- For fun or to relax
- Other reason → Please tell us:

69. Is smoking allowed in the car that your baby most often rides in?

- No
- Yes
- I don't know

70. Have you ever been diagnosed with Lyme disease?

- No
 Yes
 I don't know

71. Have you used any of the following sources to find information on pregnancy issues?

Check ALL that apply

- Internet search (such as Google)
 Text messages
 Email
 Social media (such as Facebook, Twitter)
 Online discussion forum (sometimes called a bulletin board)
 Magazine
 Book
 DVD Video
 Online video (such as YouTube)
 Cell phone apps
 Other _____ → Please tell us:

72. At any time during your most recent pregnancy, did you work at a job for pay?

- No _____ → **Go to Question 79**
 Yes

Go to Question 73

73. Please tell us about your MAIN job during your most recent pregnancy. What was your job title and what were your usual activities or duties?

Job title:

Job duties:

74. Thinking about your MAIN job during your most recent pregnancy, what type of company did you work for (what did the company do or make)?

Type of company:

- I don't know

75. Have you returned to the job you had during your most recent pregnancy?

Check ONE answer

- No, and I do not plan to return _____ → **Go to Question 79**
 No, but I will be returning
 Yes

Go to Question 76

76. Did you take leave from work *after* your new baby was born?

Check ALL that apply

- I took *paid* leave from my job
 I took *unpaid* leave from my job
 I did not take any leave

Go to Question 78

77. How many weeks or months of leave, in total, did you take or will you take?

Weeks **OR** Months

- Less than 1 week

78. Did any of the things listed below affect your decision about taking leave from work *after* your new baby was born? For each item, check **No** if it does not apply to you or **Yes** if it does.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I could not financially afford to take leave | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was afraid I'd lose my job if I took leave or stayed out longer | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had too much work to do to take leave or stay out longer | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My job does not have paid leave | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My job does not offer a flexible work schedule..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I had not built up enough leave time to take any or more time off | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is not alive or is not living with you, go to Page 14, Question 83.

79. *Since your new baby was born, have you used WIC services for yourself or your new baby?*

- No
 Yes, both my new baby and I use WIC services
 Yes, only my new baby uses WIC services
 Yes, only I am using WIC services

If your baby is still in the hospital, go to Page, 14, Question 83.

80. Listed below are some statements about safety. For each one, check **No** if it does not apply to you or **Yes** if it does.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I always used a seatbelt during my most recent pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My home has a working smoke alarm | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My new baby always rides in a rear-facing car seat..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The Poison Control Center phone number (1-800-222-1222) is accessible in my home..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I know how to perform baby CPR..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My home has a working carbon monoxide alarm..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. A health care worker talked with me about what happens if a baby is shaken.. | <input type="checkbox"/> | <input type="checkbox"/> |
| h. A health care worker talked with me about what to do for a crying baby to quiet him or her..... | <input type="checkbox"/> | <input type="checkbox"/> |

81. Do you have an infant car seat(s) that you can use for your new baby?

- No —————→ **Go to Page 14, Question 83**
 Yes

82. How did you learn to install and use your infant car seat(s)?

Check ALL that apply

- I read the instructions
 A friend or family member showed me
 A health or safety professional showed me
 I figured it out myself
 I already knew how to install it because I have other children
 Some other way —————→ Please tell us:

83. After your recent pregnancy, did you get follow-up care for any of the following? For each item, check **No** if you did not get it, check **Yes** if you did get it, or check **DH** if you didn't have this condition.

- | | No | Yes | DH |
|----------------------|--------------------------|--------------------------|--------------------------|
| a. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hypertension..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Lyme Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

84. In the past 12 months, 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. Your race or ethnic group | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your age | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Your language or accent | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Substance addiction..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Insurance type (Medicaid, other)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Body weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Income level | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Religion | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Sexual orientation | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Some other reason | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

85. Counting yourself, how many people live in your house, apartment, or trailer?

- Adults (people aged 18 years or older)
- Babies, children, or teenagers (people aged 17 years or younger)

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

Thanks for answering our questions!

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

**Your answers will help us improve
the health of mothers and babies.
Thank you!**



www.cdc.gov/prams

**For more information, please call:
1-800-852-3345 x2081**

**New Hampshire Department of Health & Human Services
Division of Public Health Services
Maternal & Child Health Section
29 Hazen Drive
Concord, NH 03301
www.dhhs.nh.gov**