

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. What is your date of birth?

	/		/	
--	---	--	---	--

Month

Day

Year

### 2. How would you describe your gender?

- Female  
 Male  
 Transgender  
 Genderqueer or gender nonconforming  
 Prefer to self-describe → Please tell us:

### 3. Before you got pregnant, did you...?

For each one, check **No** or **Yes**.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Have serious difficulty hearing, or are you deaf? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have serious difficulty seeing, even when wearing glasses, or are you blind? ..   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have serious difficulty walking or climbing stairs?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition? .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have difficulty with dressing or bathing yourself? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about the time **before** you got pregnant.

### 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. Anxiety .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma .....  | <input type="checkbox"/> | <input type="checkbox"/> |

### 5. In the 12 months before you got pregnant with your new baby, did you have any of the following healthcare visits?

For each one, check **No** or **Yes**.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Regular checkup with a family doctor.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regular checkup with an OB/GYN .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Visit for an injury, illness, or chronic condition ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Visit to urgent care or the emergency room.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Visit for family planning or to get birth control .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Visit for depression or anxiety .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Visit to have my teeth cleaned .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other .....  | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

If you **had** any healthcare visits in the **12 months before you got pregnant**, go to **Page 2, Question 7**.

**6. Why didn't you have any healthcare visits in the 12 months before you got pregnant with your new baby?**

**Check ALL that apply**

- I didn't know I needed one
- I didn't have enough money or insurance to pay for the visit
- I felt fine and didn't 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 other things going on
- I couldn't take time off from work or school
- I didn't have anyone to take care of my children
- The doctor's office was too far away
- Other \_\_\_\_\_ → Please tell us:  
\_\_\_\_\_

**If you did not have any healthcare visits, go to Question 8.**

**7. During any of your healthcare visits in the 12 months before you got pregnant, did a healthcare provider do any of the following things? For each one, check **No** or **Yes**.**

**No Yes**

**Talk to me about...**

- a. My weight.....
- b. Regularly checking my blood pressure....
- c. My desire to have or not have children....
- d. Birth control methods .....
- e. How I could improve my health before a pregnancy .....
- f. Sexually transmitted infections such as chlamydia, gonorrhea, syphilis, or HIV.....

**Ask me...**

- g. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco.....
- h. If someone was hurting me emotionally or physically.....
- i. If I felt depressed or anxious .....

**The next questions are about your *health insurance*.**

**8. 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 (paid for by me, someone else, or through a job)
- Medicaid
- Other public health insurance (such as the Essential Plan or Child Health Plus)
- TRICARE or other military healthcare
- Other health insurance → Please tell us:  
\_\_\_\_\_
- I didn't have any health insurance during the *month before* I got pregnant

**If you had health insurance during the month before you got pregnant, go to Question 10.**

**9. What was the reason that you did not have any health insurance during the month before you got pregnant with your new baby?**

**Check ALL that apply**

- Health insurance was too expensive
- I couldn't get health insurance from my job or the job of my spouse or partner
- I applied for health insurance but was waiting to get it
- I had problems with the health insurance application or website
- My income was too high to qualify for Medicaid
- My income was too high to qualify for a tax credit from the New York State of Health Marketplace or HealthCare.gov
- I didn't know how to get health insurance
- Other \_\_\_\_\_ → Please tell us:  
\_\_\_\_\_

**10. *During* your most recent pregnancy, what kind of health insurance did you have?**

**Check ALL that apply**

- Private health insurance (paid for by me, someone else, or through a job)
- Medicaid
- Other public health insurance (such as the Essential Plan or Child Health Plus)
- TRICARE or other military healthcare
- Other health insurance → Please tell us:

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- I didn't have any health insurance *during my pregnancy*

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

**Check ALL that apply**

- Private health insurance (paid for by me, someone else, or through a job)
- Medicaid
- Other public health insurance (such as the Essential Plan or Child Health Plus)
- TRICARE or other military healthcare
- Other health insurance → Please tell us:

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- I don't have any 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 16**

**14. When you got pregnant with your new baby, were you or your spouse or partner doing anything to keep from getting pregnant?** This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

No

Yes →

**Go to Page 4, Question 16**

**15. What were your 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 couldn't get pregnant at that time
- I didn't want to use birth control
- I had side effects from the birth control method I was using
- I had problems getting birth control I wanted
- I thought my spouse or partner or I was sterile (couldn't get pregnant at all)
- My spouse or partner didn't want to use condoms
- My spouse or partner didn't want me to use birth control
- I forgot to use a birth control method
- Other → Please tell us:

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## DURING PREGNANCY

**The next questions are about your prenatal care. This can include visits to a doctor, nurse, or other healthcare worker before your baby was born to get checkups and advice about pregnancy. (It may help to look at the calendar to answer these questions.)**

### 16. Did you get prenatal care during your *most recent* pregnancy?

- No  
 Yes

Go to Question 18

### 17. *During any of your prenatal care visits, did a healthcare provider do any of the following things?* For each one, check **No** or **Yes**.

**No Yes**

#### Talk to me about...

- a. How much weight I should gain during pregnancy.....
- b. Doing tests to screen for birth defects or diseases that run in my family.....
- c. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due).....
- d. What to do if I feel depressed or anxious during my pregnancy or after my baby is born.....

#### Ask me...

- e. If I planned to breastfeed my new baby..
- f. If I planned to use birth control after my baby was born.....
- g. If I was taking any prescription medication.....
- h. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco.....
- i. If I was drinking alcohol.....
- j. If someone was hurting me emotionally or physically.....
- k. If I was using illegal drugs.....
- l. If I was using marijuana.....
- m. If I wanted to be tested for HIV.....

### 18. During the 12 months before your new baby was born, did a healthcare provider offer you the following shots or vaccinations?

For each one, check **No** or **Yes**.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. Flu shot.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot.....  | <input type="checkbox"/> | <input type="checkbox"/> |

### 19. Did you get the following shots or vaccinations before or during your pregnancy?

For each shot, check ALL that apply:

**B** for 3 months before pregnancy

**D** for **During** pregnancy

or check **N** if you **Did not** get the shot in the 3 months before or during pregnancy

- |                       | <b>B</b>                 | <b>D</b>                 | <b>N</b>                 |
|-----------------------|--------------------------|--------------------------|--------------------------|
| a. Flu shot.....      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot.....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

- No  
 Yes

### 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 one, check **No** or **Yes**.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. I couldn't find a dentist or dental clinic that would take pregnant patients..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I couldn't find a dentist or dental clinic that would take Medicaid patients..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't think it was safe to go to the dentist during pregnancy.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I couldn't afford to go to a dentist or dental clinic.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I couldn't find a dentist or dental clinic close by that I could get to.....      | <input type="checkbox"/> | <input type="checkbox"/> |

**22. During your most recent pregnancy, did a healthcare provider tell you that you had any of the following health conditions?**

For each one, check **No** or **Yes**.

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. Anxiety .....

**If you had high blood pressure before or during your pregnancy, go to Question 23. If you didn't, go to Question 24.**

**23. During your most recent pregnancy, did a healthcare provider do any of the following things to help you manage your high blood pressure? For each one, check No or Yes.**

No Yes

- a. Refer me to a different healthcare provider.....
- b. Tell me to regularly check my blood pressure **during** pregnancy.....
- c. Talk to me about getting to a healthy weight **after** pregnancy.....
- d. Talk to me about regularly checking my blood pressure **after** pregnancy .....
- e. Talk to me about the risk for having high blood pressure (chronic hypertension) and heart disease **after** pregnancy.....

**24. During your most recent pregnancy, did you get information about “warning signs” you should watch for during and after your pregnancy that require immediate medical attention? Some of these “warning signs” include fever, frequent or severe headaches, dizziness, or severe stomach pain.**

- No —————→ **Go to Question 26**
- Yes

**25. During your most recent pregnancy, did you get information about warning signs from any of the following sources?**

For each one, check **No** or **Yes**.

No Yes

- a. A healthcare provider (such as a doctor, nurse, or midwife) .....
- b. Websites or social media (such as Facebook, Instagram, or Twitter).....
- c. Any source of information that used the slogan “**Hear Her**” (such as websites, social media, or paper handouts).....
- d. Family or friends .....

**The next questions are about cigarettes, e-cigarettes, and other tobacco products.**

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

- No —————→ **Go to Page 6, Question 30**
- Yes

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

- More than one pack (21 or more cigarettes)
- One-half to one pack (11 to 20 cigarettes)
- Less than half a pack (1 to 10 cigarettes)
- I didn't smoke then

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

- More than one pack (21 or more cigarettes)
- One-half to one pack (11 to 20 cigarettes)
- Less than half a pack (1 to 10 cigarettes)
- I didn't smoke then

**29. How many cigarettes do you smoke on an average day *now*?**

- More than one pack (21 or more cigarettes)
- One-half to one pack (11 to 20 cigarettes)
- Less than half a pack (1 to 10 cigarettes)
- I don't smoke now

**30. In the *past 2 years*, have you used e-cigarettes ("vapes") or other electronic nicotine products?**

- No → Go to Question 34
- Yes

**31. During the *3 months before* you got pregnant, on average, how often did you use e-cigarettes ("vapes") or other electronic nicotine products?**

- Every day
- Some days
- I didn't use e-cigarettes or other electronic nicotine products then

**32. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes ("vapes") or other electronic nicotine products?**

- Every day
- Some days
- I didn't use e-cigarettes or other electronic nicotine products then

**33. In the *past 2 years*, did you ever use e-cigarettes ("vapes") or other electronic nicotine products as a way of cutting down or stopping cigarette smoking?**

- No
- Yes

**The next questions are about drinking alcohol. A drink can be 1 glass of wine, can or bottle of beer or hard seltzer, shot of liquor, or mixed drink.**

**34. During your most recent pregnancy, did you have any alcoholic drinks during...?**

For each one, check **No** or **Yes**.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. The first 3 months of pregnancy (1 <sup>st</sup> trimester)? <i>This includes the time before knowing you were pregnant</i> ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2 <sup>nd</sup> trimester)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 <sup>rd</sup> trimester)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**If you did not have any alcoholic drinks during your pregnancy, go to Question 36.**

**35. During your most recent pregnancy, did you have 4 or more alcoholic drinks in a 2-hour time span during...?**

For each one, check **No** or **Yes**.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. The first 3 months of pregnancy (1 <sup>st</sup> trimester)? <i>This includes the time before knowing you were pregnant</i> ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The second 3 months of pregnancy (2 <sup>nd</sup> trimester)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 <sup>rd</sup> trimester)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

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

**36. Did any of the following things happen during the 12 months before your new baby was born?** For each one, check **No** or **Yes**.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. I got separated or divorced.....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was evicted or forced to move .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have a regular place to sleep.....                            | <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 spouse, partner, or I lost a job.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My spouse, partner, or I had a cut in work hours or pay.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I had problems paying the rent, mortgage, or other bills.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My spouse or partner went to jail/prison..                             | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I went to jail/prison .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Someone close to me had a problem with drinking or drugs .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Someone close to me was very sick or died.....                         | <input type="checkbox"/> | <input type="checkbox"/> |

**37. In the 12 months before you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?** For each one, check **No** or **Yes**.

- |                                     | No                       | Yes                      |
|-------------------------------------|--------------------------|--------------------------|
| a. My spouse or partner.....        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**38. During your most recent pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?** For each one, check **No** or **Yes**.

- |                                     | No                       | Yes                      |
|-------------------------------------|--------------------------|--------------------------|
| a. My spouse or partner.....        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner ..... | <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?**

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

**40. Overall, during the delivery of my baby, I felt...** For each one, check **No** or **Yes**.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Comfortable asking questions about the labor and delivery care that I received ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Comfortable declining care if I didn't want it.....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Comfortable accepting the options for care that my provider recommended .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was able to choose the care options that I received .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My providers treated me with respect.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Satisfied with the labor and delivery care that I received .....                     | <input type="checkbox"/> | <input type="checkbox"/> |

**41. After the delivery, how long did your new baby stay in the hospital?**

- Less than 3 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 8, Question 44**

**42. Is your baby alive now?**

- No → **We are very sorry for your loss. Go to Page 9, Question 54**
- Yes → **Go to Page 8, Question 43**

**43. Is your baby living with you now?**

- No → **Go to Question 52**
- Yes

**44. How many weeks or months did you breastfeed or feed pumped milk to your new baby?****Check ONE answer**

- I didn't breastfeed my baby → **Go to Question 46**
- I breastfed my baby for less than 1 week
- I breastfed my baby for:
- \_\_\_\_\_ week(s) OR \_\_\_\_\_ month(s)
- I'm still breastfeeding or feeding pumped milk to my new baby

**45. How old was your new baby the first time they had liquids other than breast milk (such as formula, water, juice, or cow's milk)?****Check ONE answer**

- My baby has not had any liquids other than breast milk
- My baby was less than 1 week old
- My baby was:
- \_\_\_\_\_ week(s) OR \_\_\_\_\_ month(s)

**46. How old was your new baby the first time they ate food (such as baby cereal, baby food, or any other food)?****Check ONE answer**

- My baby has not eaten any foods
- My baby was less than 1 week old
- My baby was:
- \_\_\_\_\_ week(s) OR \_\_\_\_\_ month(s)

**If your baby is still in the hospital, go to Question 52.**

**47. In the past 2 weeks, how did you place your new baby to sleep at night and during naps?**  
For each one, check **No** or **Yes**.

- |                           | No                       | Yes                      |
|---------------------------|--------------------------|--------------------------|
| a. On their side .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On their back.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. On their stomach ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**48. In the past 2 weeks, when you were sleeping, how often has your new baby slept alone in their own crib or bed?**

- Always
- Often
- Sometimes
- Rarely
- Never → **Go to Question 50**

**49. In the past 2 weeks, was your baby's crib or bed in the same room where you or another adult slept?**

- No
- Yes

**50. In the past 2 weeks, where have you placed your new baby to sleep at night or during naps?** For each one, check **No** or **Yes**.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. In a crib, portable crib, or bassinet .....         | <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.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a swing, rocker, or other inclined sleeper ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. In an in-bed sleeper .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| g. In a baby board or cradleboard .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other .....   | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:



**51. In the *past 2 weeks*, has your new baby been placed to sleep with the following?**

For each one, check **No** or **Yes**.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. In a sleeping sack or wearable blanket.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In a swaddled blanket.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Comforters, quilts, blankets, or non-fitted sheets.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Soft toys, cushions, or pillows, including nursing pillows..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Crib bumper pads (mesh or non-mesh)...                          | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other.....  | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

**52. *Since your new baby was born*, has a home visitor come to your home to help you learn how to take care of yourself or your new baby?**

A home visitor is a nurse, healthcare provider, doula, social worker, or another person who works for a program that helps families with newborns.

- No → **Go to Question 54**
- Yes

**53. Who was the home visitor that came to your home *since your new baby was born*?**

**Check ALL that apply**

- A nurse, nurse's aide, or midwife
- A teacher or health educator
- A doula or childbirth educator
- Someone from the Nurse Family Partnership
- Someone from the NYC Department of Health's Newborn Home Visiting Program
- Someone else → Please tell us:

- I don't know

**54. Are you or your spouse or partner doing anything *now* to keep from getting pregnant?**

This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

- No
- Yes → **Go to Page 10, Question 56**
- I'm pregnant now → **Go to Page 10, Question 57**

**55. What are your reasons for not doing anything to keep from getting pregnant *now*?**

**Check ALL that apply**

- I want to get pregnant or don't mind if I do
- I had my tubes tied or blocked
- My spouse or partner had a vasectomy
- I don't want to use birth control
- I'm worried about side effects from birth control
- My spouse or partner doesn't want to use condoms
- My spouse or partner doesn't want me to use birth control
- We are same-sex spouses/partners
- I have problems getting birth control I want
- I don't think I can get pregnant because I'm breastfeeding
- I'm not having sex
- Other → Please tell us:

**If you're not doing anything to keep from getting pregnant now, go to Page 10, Question 57.**

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

**Check ALL that apply**

- Tubes tied or blocked
- My spouse or partner had a vasectomy
- Birth control pills
- Condoms
- Shots or injections
- Contraceptive patch or vaginal ring
- IUD
- Contraceptive implant in the arm
- Withdrawal (pulling out)
- Natural family planning or fertility awareness methods (such as rhythm or calendar method or fertility apps)
- Breastfeeding for birth control (Lactational Amenorrhea Method or LAM)
- Other \_\_\_\_\_ → Please tell us:

**57. Since your new baby was born, have you had a postpartum checkup for yourself? A postpartum checkup is a regular health checkup you have up to 12 weeks after giving birth.**

- No \_\_\_\_\_ →
- Yes

**Go to Question 59**

**Go to Question 58**

**58. During your postpartum checkup, did a healthcare provider do any of the following things? For each one, check No or Yes.**

**No Yes**

**Talk to me about...**

- a. Healthy eating, exercise, and losing weight gained during pregnancy.....
- b. How long to wait before getting pregnant again.....
- c. Birth control methods.....
- d. Warning signs of medical problems I might be at risk for due to my pregnancy.....
- e. Regularly checking my blood pressure....
- f. What to do if I feel depressed or anxious.....

**Ask me...**

- g. If I was smoking cigarettes or using e-cigarettes (“vapes”) or other smokeless tobacco.....
- h. If someone was hurting me emotionally or physically.....

**A healthcare provider...**

- i. Tested me for diabetes.....
- j. Prescribed me medication for depression or anxiety.....

**59. Since your new baby was born, have you received follow-up care for any of the following health conditions? For each item, check No if you didn’t get it, Yes if you did get it, or N/A if you didn’t have the condition.**

**No Yes N/A**

- a. Diabetes.....
- b. Hypertension (high blood pressure).....
- c. Depression.....
- d. Anxiety.....
- e. Heart conditions (e.g., birth defects of the heart, fast or skipped heartbeat, heart failure, enlarged heart, heart attack, chest pain, heart transplant, pacemaker).....

**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?**

- Always
- Often
- Sometimes
- Rarely
- Never

**62. Since your new baby was born, how often have you felt nervous, anxious, or on edge?**

- Always
- Often
- Sometimes
- Rarely
- Never

**63. Since your new baby was born, how often have you not been able to stop or control worrying?**

- Always
- Often
- Sometimes
- Rarely
- Never

**64. Has a healthcare provider asked you a series of questions, in person or on a form, to know if you were feeling down, depressed, anxious, or irritable during the following time periods? For each one, check No or Yes.**

**No Yes**

- a. During my most recent pregnancy .....
- b. Since my new baby was born .....

**65. Since your new baby was born, have you felt that you've needed mental health services such as counseling, medications, or support groups to help with feelings of anxiety, depression, grief, or other issues?**

No → **Go to Page 12, Question 68**

Yes

**66. Were you able to get the mental health services that you needed?**

No

Yes → **Go to Page 12, Question 68**

**67. Which of these statements explains why you did not get the mental health services you needed?**

**Check ALL that apply**

- I couldn't afford the cost
- I couldn't get an appointment as soon as I needed
- My health insurance doesn't cover any type of mental health services
- My health insurance doesn't pay enough for mental health services
- I didn't know where to go to get services
- I was concerned that the information I shared might not be kept confidential
- I didn't want others to find out that I needed treatment
- I was concerned that I might be committed to a psychiatric hospital
- I was concerned that I might have to take medicine
- I had no transportation, treatment was too far away, or the hours were not convenient
- I didn't have time (because of a job, childcare, or other commitments)
- Other → Please tell us:

\_\_\_\_\_

## OTHER EXPERIENCES

The next questions are on a variety of topics.

**68. Please tell us how often each of the following happened during the 12 months before your new baby was born.**

a. I worried whether my food would run out before I got money to buy more

Often     Sometimes     Never

b. The food that I bought just didn't last, and I didn't have money to get more

Often     Sometimes     Never

**69. During the 12 months before your new baby was born, did lack of transportation keep you from any of the following?**

For each one, check **No** or **Yes**.

a. Going to medical appointments .....  **No**     **Yes**

b. Going to non-medical appointments, meetings, or work .....  **No**     **Yes**

c. Doing errands .....  **No**     **Yes**

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

No → **Go to Question 74**

Yes

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

**Check ALL that apply**

- Yes, I took *paid* leave from my job
- Yes, I took *unpaid* leave from my job
- Yes, I took leave using New York State Paid Family Leave
- Yes, I took leave using Temporary Disability Insurance (TDI)
- No, I didn't take any leave → **Go to Question 73**

**Go to Question 72**

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

**Write ONE answer**

Less than 1 week

week(s) **OR**  month(s)

**73. Did any of the following things affect your decision about taking leave from work after your new baby was born?**

For each one, check **No** or **Yes**.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. I couldn't 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 doesn't have paid leave.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My job doesn't offer a flexible work schedule.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I hadn't built up enough leave time to take any or more time off .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**74. During any of the following time periods, did you use marijuana or cannabis in any form?** Please do not include hemp or CBD-only products. For each time period, check **No** or **Yes**.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. During the 3 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"/> |

**75. During any of the following time periods, did your spouse 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** or **Yes**.

- |   | <b>No</b>                | <b>Yes</b>               |
|---|--------------------------|--------------------------|
| 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. The following questions are about the people in your life and the support they provide you now.** For each one, check **No** or **Yes**.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Do you have someone you can go to if you're feeling lonely?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you have someone you can talk with about things that are important to you or how you're feeling?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you have someone you can count on to listen to your problems, worries, and fears? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you have someone who shows you love and affection?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Do you have someone who does things with you to relax or have fun? .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Do you have someone you can count on to loan you money for things like food or bills?.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Do you have someone who can take care of your children if you need help?....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Do you have someone who can help with daily chores if you're sick? .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Do you have someone who can take you to the clinic or doctor's office if you need a ride? .....          | <input type="checkbox"/> | <input type="checkbox"/> |

**77. While *getting* healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?**

For each one, check **No** if you did not experience discrimination because of it or **Yes** if you did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. My race, ethnicity, or skin color .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My disability status .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My immigration status.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My age .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My weight.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My income.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My sex or gender .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My sexual orientation.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| i. My religion .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. My language or accent .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. My type or lack of health insurance.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| l. My use of substances (alcohol, tobacco, or other drugs).....  | <input type="checkbox"/> | <input type="checkbox"/> |
| m. My involvement with the justice system (jail or prison) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Another reason.....   | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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**78. During your life until now, how often have you been discriminated against, prevented from doing something, hassled, or made to feel inferior because of your race, ethnicity, or skin color?**

- Very often  
 Somewhat often  
 Not very often  
 Never

**79. During your life until now, how often have you worried that you might be treated or judged unfairly because of your race, ethnicity, or skin color?**

- Very often  
 Somewhat often  
 Not very often  
 Never

**80. Have you ever been treated unfairly due to your race, ethnicity, or skin color in any of the following situations?**

For each one, check **No** or **Yes**.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Job (hiring, promotion, firing).....       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Housing (renting, buying, mortgage) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Police (stopped, searched, threatened).... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In the courts .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| e. At school or my child's school .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Getting medical care.....                  | <input type="checkbox"/> | <input type="checkbox"/> |

**81. What is your living situation today?**

Check ONE answer

- I have a steady place to live  
 I have a place to live today, but I'm worried about losing it in the future  
 I don't have a steady place to live (I'm temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

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

**82. During the 12 months before your new baby was born, what was your yearly total household income before taxes?** Include your income, your spouse 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 getting now.*

- \$0 to \$18,000  
 \$18,001 to \$23,000  
 \$23,001 to \$27,000  
 \$27,001 to \$32,000  
 \$32,001 to \$37,000  
 \$37,001 to \$42,000  
 \$42,001 to \$48,000  
 \$48,001 to \$60,000  
 \$60,001 to \$85,000  
 \$85,001 or more

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

Number of people \_\_\_\_\_

**84. What is today's date?**

/  /   
 Month                      Day                      Year

**We would love to hear more about your story!  
Is there anything else you would like to share with us about your experiences  
around the time of your pregnancy? Please use this space to tell us.**

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

***Your answers will help us work to make families in New York City healthier.***

