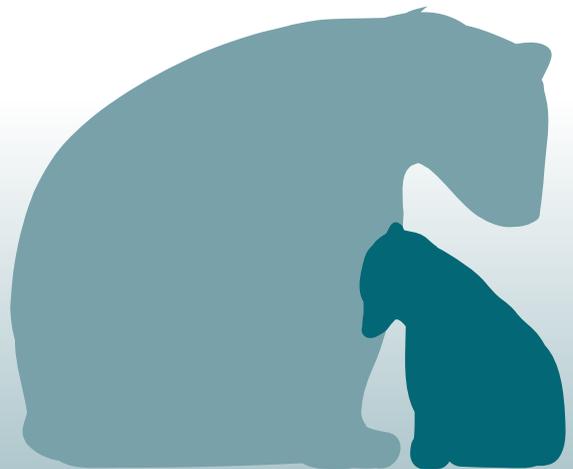




Alaska PRAMS

Pregnancy Risk Assessment Monitoring System

*A survey of the health of
mothers and babies in Alaska*



Questions Commonly Asked About PRAMS

What is PRAMS?

PRAMS (Pregnancy Risk Assessment Monitoring System) is a joint research project between the Alaska 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 recent mothers questions about their behaviors and experiences around the time of their pregnancy. Each year in Alaska there are hundreds of babies born with serious health problems. Some of these babies will not survive their first year of life. 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 Alaska.

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 Alaska mothers of new babies. 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 Alaska, 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 Alaska. 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 may affect her pregnancy. These questions try to get the best picture of the 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 1-888-269-3470 , or e-mail mch-epi@alaska.gov, 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.

Please check the box next to your answer or follow the directions included with the question. You may be asked to skip some questions that do not apply to you.

BEFORE PREGNANCY

The first questions are about you.

1. How tall are *you* without shoes?

Feet Inches

OR Centimeters

2. *Just before you got pregnant with your new baby, how much did you weigh?*

Pounds OR Kilos

3. What is *your* date of birth?

/ /
Month Day Year

The next questions are about the time ***before you got pregnant with your new baby.***

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

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

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes (not gestational diabetes or diabetes that starts during pregnancy) | <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. PCOS (polycystic ovarian syndrome)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |

6. During the *month before* you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

- I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the *month before* I got pregnant
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week

7. In the *12 months before* you got pregnant with your new baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?

- No → **Go to Question 10**
- Yes



8. What type of health care visit did you have in the *12 months before* you got pregnant with your new baby?

Check ALL that apply

- Regular checkup at my family doctor's office
- Regular checkup at my OB/GYN's office
- Visit for an illness or chronic condition
- Visit for an injury
- Visit for family planning or birth control
- Visit for depression or anxiety
- Visit to have my teeth cleaned by a dentist or dental hygienist
- Other → Please tell us:

9. During any of your health care visits in the *12 months before* you got pregnant, did a doctor, nurse, or other health care worker do any of the following things? For each item, check **No if they did not or **Yes** if they did.**

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Talk to me about how I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

10. 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 Health Insurance Marketplace or HealthCare.gov
- Medicaid or Denali KidCare
- TRICARE or other military health care
- Alaska Tribal Health System or IHS
- Other health insurance —→ Please tell us:

- I did not have any health insurance during the *month before* I got pregnant

11. 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 12**
- 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 Health Insurance Marketplace or HealthCare.gov
- Medicaid or Denali KidCare
- TRICARE or other military health care
- Alaska Tribal Health System or IHS
- Other health insurance —→ Please tell us:

- I did not have any health insurance for my *prenatal care*

12. 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 Health Insurance Marketplace or HealthCare.gov
- Medicaid or Denali KidCare
- TRICARE or other military health care
- Alaska Tribal Health System or IHS
- Other health insurance —→ Please tell us:

- I do not have health insurance *now*

13. 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

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

- No
- Yes —→ **Go to Page 4, Question 16**

15. 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

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.)

16. 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 18

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

No

Yes

Go to Question 19

Go to Question 18

18. Did any of these things keep you from getting prenatal care when you wanted it? For each item, check **No** if it did not keep you from getting prenatal care or **Yes** if it did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan would not start care as early as I wanted..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid or Denali KidCare card..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't have anyone to take care of my children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I didn't know that I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I didn't want anyone else to know I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I didn't want prenatal care..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not have prenatal care, go to Question 21.

19. 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"/> |

20. During any of your prenatal care visits, did a doctor, nurse, or other health care worker advise you not to drink alcohol while you were pregnant?

- No
 Yes

21. At any time during your most recent pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)?

- No
 Yes
 I don't know

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

- No
 Yes

23. 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

24. 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

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

- No
 Yes

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

- No
 Yes

27. During your most recent pregnancy, did you have any of the following health conditions?

For each one, check **No** if you did not have the condition or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Gestational diabetes (diabetes that started during <i>this</i> pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that started during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

- No → **Go to Question 32**
 Yes

29. 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

30. 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

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. How many cigarette smokers, not including yourself, live in your home now?

Number of smokers

33. 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 → **Go to Question 36**
 Smoking is allowed in some rooms or at some times
 Smoking is permitted anywhere inside my home

34. Does your husband or partner smoke inside your home?

- No
 Yes

35. Not including yourself or your husband or partner, does anyone else smoke cigarettes inside your home?

- No
 Yes

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.

36. 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 37. Otherwise, go to Question 39.

37. 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

38. 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.

39. 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 44**
- Yes

40. During the 3 months before you got pregnant, how many alcoholic drinks did you have in an average week?

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then → **Go to Page 8, Question 42**

41. During the 3 months before you got pregnant, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span?

- 6 or more times
- 4 to 5 times
- 2 to 3 times
- 1 time
- I didn't have 4 drinks or more in a 2 hour time span

42. 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

→ **Go to Question 44**

43. During the *last 3 months* of your pregnancy, how many times did you drink 4 alcoholic drinks or more in a 2 hour time span?

- 6 or more times
- 4 to 5 times
- 2 to 3 times
- 1 time
- I didn't have 4 drinks or more in a 2 hour time span

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

44. 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"/> |

45. 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"/> |

46. 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.

47. When was your new baby born?

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

48. 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

49. 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 52**

50. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 12, Question 65**

51. Is your baby living with you now?

- No → **Go to Page 12, Question 65**
- Yes

52. 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:

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

- No —————→ **Go to Question 58**
 Yes

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

- No —————→ **Go to Question 56**
 Yes

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

- Less than 1 week

Weeks **OR** Months

If your baby was not born in a hospital, go to Question 57.

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

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

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

Weeks **OR** Months

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

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

Weeks **OR** Months

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

If your baby is still in the hospital, go to Page 12, Question 65.

59. 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

60. In the *past 2 weeks*, how often has your new baby slept alone in his or her own crib or bed?

- Always → **Go to Question 62**
 Often
 Sometimes
 Rarely
 Never

61. Who does your new baby *usually* sleep with when he or she is not sleeping alone?

Check ALL that apply

- Me
 My husband or partner
 Someone else → Please tell us:

If your baby never sleeps alone in his or her own crib or bed, go to Question 63.

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

- No
 Yes

63. 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"/> |

64. 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"/> |

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

Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- No
 Yes

→ **Go to Question 67**

66. 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 68.

67. 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:

68. *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 70**
 Yes

↓
Go to Question 69

69. 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"/> |

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

- Always
 Often
 Sometimes
 Rarely
 Never

71. 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.

72. 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 | <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"/> |

73. During the month before you got pregnant, did you take or use any of the following drugs for any reason? For each item, check **No** if you did not use it or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Methadone, naloxone, subutex, or Suboxone® | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Heroin (smack, junk, black tar) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Amphetamines (speed, crystal meth, crank, ice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cocaine or crack..... | <input type="checkbox"/> | <input type="checkbox"/> |

74. During your most recent pregnancy, did you take or use any of the following drugs for any reason? For each item, check **No** if you did not use it or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Methadone, naloxone, subutex, or Suboxone® | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Heroin (smack, junk, black tar) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Amphetamines (speed, crystal meth, crank, ice)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cocaine or crack..... | <input type="checkbox"/> | <input type="checkbox"/> |

75. During your most recent pregnancy, did you ever use smokeless tobacco products such as chewing tobacco, snuff, snus, or iqmik?

- No → **Go to Question 77**
 Yes

76. Which smokeless tobacco product(s) did you use during your pregnancy?

Check ALL that apply

- Chewing tobacco, snuff, or snus
 Iqmik (also known as blackbull)

If you do not smoke cigarettes now, go to Question 78.

77. Are you planning to stop smoking cigarettes?

Check ONE answer

- Yes, within the next 30 days
 Yes, more than 30 days from now but within the next 6 months
 Yes, but not within the next 6 months
 No, I don't plan to stop

If your baby is not alive, is not living with you, or is still in the hospital, go to Question 79.

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

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

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

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

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

80. 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 \$20,000
 \$20,001 to \$25,000
 \$25,001 to \$30,000
 \$30,001 to \$36,000
 \$36,001 to \$40,000
 \$40,001 to \$50,000
 \$50,001 to \$60,000
 \$60,001 to \$71,000
 \$71,001 to \$75,000
 \$75,001 to \$91,000
 \$91,001 to \$107,000
 \$107,001 or more

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

People

82. 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 Alaska.

Thanks for answering our questions!

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



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