

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. 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.

3. 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. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |

4. 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 6.

5. 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 7.

6. 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*.

7. 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)
- Private health insurance from the Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov, or HealthCare.gov
- Medicaid or HealthChoice
- 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

8. 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)
- Private health insurance from the Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov, or HealthCare.gov
- Medicaid or HealthChoice
- TRICARE or other military healthcare
- Other health insurance → Please tell us:

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

If you had health insurance during your most recent pregnancy, go to Question 10.

9. What was the reason that you did not have any health insurance *during* your most recent pregnancy?

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 Maryland Health Insurance Marketplace or HealthCare.gov
- I didn't know how to get health insurance
- Other —————> Please tell us:

10. 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)
- Private health insurance from the Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov, or HealthCare.gov
- Medicaid or HealthChoice
- TRICARE or other military healthcare
- Other health insurance —————> Please tell us:

- I don't have any health insurance *now*

11. 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 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.)

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

- No —————> **Go to Page 4, Question 14**

- Yes



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

- No
- Yes —————> **Go to Page 4, Question 15**



Go to Page 4, Question 14

14. Did any of these things keep you from getting prenatal care when you wanted it?

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

- | | 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 wouldn't 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 HealthChoice 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"/> |
| l. The doctor's office was too far away..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not get prenatal care, go to Question 16.

15. 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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Doing tests to screen for birth defects or diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What to do if I feel depressed or anxious during my pregnancy or after my baby is born..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Ask me... | | |
| e. If I planned to breastfeed my new baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I planned to use birth control after my baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was taking any prescription medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. If I was using illegal drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. If I was using marijuana..... | <input type="checkbox"/> | <input type="checkbox"/> |
| m. If I wanted to be tested for HIV..... | <input type="checkbox"/> | <input type="checkbox"/> |

16. 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**.**

- | | No | Yes |
|--|--------------------------|--------------------------|
| 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"/> |
| d. RSV shot (given during pregnancy to protect the baby from respiratory syncytial virus)..... | <input type="checkbox"/> | <input type="checkbox"/> |

17. 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 | D | N |
|-----------------------|--------------------------|--------------------------|--------------------------|
| 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"/> |
| d. RSV shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

- No
 Yes

19. 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**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| 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"/> |

20. 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 <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"/> |

If you had high blood pressure before or during your pregnancy, go to Question 21. If you didn't, go to Page 6, Question 22.

21. 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..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tell me to regularly check my blood pressure during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about getting to a healthy weight after pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about regularly checking my blood pressure after pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about the risk for having high blood pressure (chronic hypertension) and heart disease after pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |

22. 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 24**

Yes
↓

23. 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 X/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.

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

No —————→ **Go to Question 28**

Yes
↓

25. 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

26. 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

27. 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

28. In the past 2 years, have you used e-cigarettes (“vapes”) or other electronic nicotine products?

No —————→ **Go to Question 32**

Yes
↓

29. 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

30. 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

31. 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.

32. *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 st 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 nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 rd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not have any alcoholic drinks during your pregnancy, go to Question 34.

33. *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 st 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 nd trimester)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The last 3 months of pregnancy (3 rd 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.

34. 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"/> |

35. 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"/> |

36. *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.

37. 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 Question 40**

38. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 10, Question 49**

39. Is your baby living with you now?

- No → **Go to Page 10, Question 49**
- Yes

40. 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
- 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

If you ever breastfed your baby, go to Question 42.

41. 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 other things going on
- 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:

42. What kind of health insurance is your new baby covered by now?

Check ALL that apply

- Private health insurance (paid for by me, someone else, or through a job)
- Private health insurance from the Maryland Health Insurance Marketplace, www.marylandhealthconnection.gov, or HealthCare.gov
- Medicaid or HealthChoice
- TRICARE or other military healthcare
- Other health insurance → Please tell us:

- I don't have any health insurance for my new baby

If your baby is still in the hospital, go to Page 10, Question 49.

43. 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"/> |

44. 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 46**

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

- No
 Yes

46. 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:

47. 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:

48. Did you get information about how to place your baby to sleep during any of the following times? For each one, check **No or **Yes**.**

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. During a prenatal care visit | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In the hospital, when my baby was born.. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. During my baby's healthcare visit | <input type="checkbox"/> | <input type="checkbox"/> |
| d. During a postpartum care visit | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

49. 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 Question 51**
 I'm pregnant now → **Go to Question 52**

50. 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 Question 52.

51. 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:

52. 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 54**

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

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 a postpartum checkup, go to Question 55.

54. 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.....

55. 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).....

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

- Always
 Often
 Sometimes
 Rarely
 Never

57. Since your new baby was born, how often have you had little interest or little pleasure in doing things?

- Always
 Often
 Sometimes
 Rarely
 Never

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

- Always
 Often
 Sometimes
 Rarely
 Never

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

- Always
 Often
 Sometimes
 Rarely
 Never

60. 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

61. 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 Question 63**

Yes

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

- No
 Yes

OTHER EXPERIENCES

The next questions are on a variety of topics.

63. 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

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

- No Yes**
- a. Going to medical appointments
- b. Going to non-medical appointments, meetings, or work
- c. Doing errands

65. At any time during the 3 months before you got pregnant OR during your most recent pregnancy, did you use marijuana or cannabis in any form?

No → **Go to Question 68**

Yes

66. During your most recent pregnancy, on average, about how often did you use marijuana products?

- Daily
- 2-6 days a week
- 1 day a week
- 2-3 days a month
- 1 day a month or less
- I did not use marijuana then → **Go to Question 68**

67. Why did you use marijuana products during pregnancy? For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. To relieve nausea or vomiting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. To relieve stress or anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. To relieve symptoms of a chronic condition | <input type="checkbox"/> | <input type="checkbox"/> |
| d. To help me sleep..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. To relieve pain..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. For fun or to relax | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Some other reason..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

68. Since your new baby was born, have you received information about warning signs of postpartum complications 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) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Websites or social media (such as Facebook, Instagram, or X/Twitter) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any source of information that used the slogan "Hear Her" (such as a website, social media, or paper handout)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |

69. Since your new baby was born, have you had your teeth cleaned by a dentist or dental hygienist?

- No
- Yes

70. 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 | <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:

71. 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

72. 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"/> |

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

73. 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

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

Number of people _____

75. 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 mothers and babies in Maryland healthier.

