

LAMB Calendar

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STAFF USE ONLY:

ID: _____

Date Received: ____/____/____

Date Entered: ____/____/____

Missing questions: _____

Need to telephone: ____ Yes ____ No Phone number: _____

Comments: _____

The Los Angeles Mommy and Baby Project



*Your Voice
Your Experiences*

Our Healthy Mommies & Babies

Complete the survey and get a \$20 Ralphs/Food4Less gift certificate and a chance to win a \$100 gift certificate!

For more information, or to complete the survey by telephone, please call the LAMB Project at 1-866-706-LAMB (1-866-706-5262)

Los Angeles County Department of Health Services
 • Maternal, Child, and Adolescent Health Programs •

Important Information About LAMB

Please Read Before Starting the Survey

- The Los Angeles Mommy and Baby Survey (LAMB) is a research project sponsored by the Los Angeles County Department of Health Services, Maternal, Child, and Adolescent Health Programs.
- We are asking women who live in Los Angeles County to answer the same questions. All of your names were picked by chance by a computer from recent birth certificates.
- It is your choice whether or not to do the survey. Whether or not you answer the survey will not affect your health care, immigration status, or any benefits you may be receiving.
- If you choose to do the survey, your answers will be kept private to the extent allowed by law and will be used only for research.
- Your name will not be used in any reports from LAMB. The survey has a number on it, so we will know when it is returned.
- Your answers will be grouped with those from other women. What we learn from this survey will be used to help mothers and babies in Los Angeles County.

If you have questions about LAMB or if you want to answer the questions by telephone, please call 1-866-706-LAMB (1-866-706-5262).

Frequently Asked Questions about LAMB

What is LAMB?

LAMB (Los Angeles Mommy and Baby Survey) is a project sponsored by the Los Angeles County Department of Health Services. Our survey asks mothers who recently had a baby questions about things that happened around the time of their pregnancy. Your answers will help us learn more about ways to improve the health of future mothers and babies.

Will my answers be kept private?

Yes—all answers are kept completely private to the extent permitted by law. All answers given on the surveys will be grouped together to give us information on Los Angeles County mothers of new babies. In reports from this survey, no woman will be identified by name. Each survey has a number on it, so we will know when it is returned.

Why should I participate in this survey?

LAMB is a very important survey that will help improve the health of future mothers and babies. The survey will help us to better understand and meet the health needs of Los Angeles County mothers and babies. Your answers will help us to improve services for women, infants, and families. To get a better overall picture of the health of mothers and babies in Los Angeles County, we need each mother selected to answer the questions.

Some of the questions do not seem related to pregnancy—why are they asked?

Many things in a mother's life may affect her pregnancy. These questions try to get the best picture of things that happened before, during, and after pregnancy. The questions also allow us to group you with other women. Although some of the questions may be personal, please remember that all your answers will be kept private.

How was I chosen to participate in LAMB?

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.

Will I receive results of the survey?

If you would like us to send you the results of the survey, please tell us at the end of the survey.

What if I want to ask more questions about LAMB?

We will be happy to answer any other questions that you may have about LAMB. Please call us at 1-866-706-LAMB (1-866-706-5262). If you prefer to complete the survey on the telephone, please call us at the same number.

← Check here if you want someone to call you to do the survey over the telephone.

In the spaces below, please write your name, address, and telephone number and the name, address, and telephone number of a friend or family member who would know how to reach you in case you move. We ask for this in case we need to reach you to clarify answers on your survey and to make sure we have your current address to mail your Ralphs/Food4Less certificate. **You will receive a Ralphs/Food4Less certificate whether you mail in your survey or take it over the telephone.**

Your name: _____

Address: _____

Phone: () _____

When is the best time to call you? _____

Friend/family name: _____

Address: _____

Phone: () _____



****Attention LAMB Staff: Tear out this page before entering data****

If you would like to write any comments about this survey, your prenatal care experiences, your pregnancy, or anything else, please do so in the space below.

This is the end of the survey.

Please place the survey in the pre-addressed, postage-paid envelope that is provided and mail it to:

Los Angeles Mommy and Baby Survey
Maternal, Child and Adolescent Health Programs
600 S. Commonwealth, Suite 800
Los Angeles, CA 90005

Thank you very much for your help.

Your valuable contribution will help us make
 Los Angeles County mothers and babies healthier!

**** You will receive your \$20 Ralpins/Food4Less Gift Certificate in about 2 to 3 weeks after we receive your survey. We will also contact you if you win the \$100 gift certificate. ****

Today's Date
 ____ / ____ / ____
 month day year

Your Date of Birth
 ____ / ____ / ____
 month day year

First, we would like to ask you a few questions about you and the time before you got pregnant with your new baby. Please answer questions 1-20 in this survey.

1. Just before your most recent pregnancy, did you have health insurance?

- ₁ Yes **→ ANSWER QUESTION #2**
₀ No **→ SKIP TO QUESTION #3**

2. Just before your most recent pregnancy, what type of health insurance did you have?

- Medi-Cal ₁
 Medi-Cal/Kaiser ₂
 Kaiser—Not Medi-Cal ₃
 Blue Cross/Blue Shield ₄
 Other government program ₅
 Private Insurance Company ₆
 Please tell us: _____
 Other HMO ₇
 Please tell us: _____
 Other ₈
 Please tell us: _____

3. Just before your most recent pregnancy, was there a doctor, nurse, or clinic that you had been going to regularly for your medical care?

- ₁ Yes **→ ANSWER QUESTION #4**
₀ No **→ SKIP TO QUESTION #5**

4. What kind of place did you go to most often? CHECK ONE ANSWER.

- Doctor's office/
 Kaiser/other HMO..... ₁
 Clinic/health center ₂
 Urgent care ₃
 Emergency room ₄
 Some other place ₅
 Please tell us: _____
 No one place ₆
 Don't know ₇

****NOW SKIP TO QUESTION #6****

5. What is the one main reason you did not have one place to go to receive medical care? CHECK ONE ANSWER.

- Seldom or never get sick ₁
 Recently moved
 into the area ₂
 Don't know where
 to go for care ₃
 Usual place in this area
 no longer available ₄
 Can't find doctor who speaks
 my language ₅
 Like different places for
 health care needs ₆
 No insurance
 or lost insurance ₇
 Don't use doctor/treat myself..... ₈
 Cost of medical care ₉
 Other reason ₁₀
 Please tell us: _____
 Don't know ₁₁

6. When you got pregnant with your new baby, were you using any birth control method to prevent pregnancy?

1 Yes, all the time

2 Yes, sometimes

3 No → ANSWER QUESTION #7

SKIP TO QUESTION #8

7. What are the reasons you or your husband or partner were **not** doing anything to prevent a pregnancy? **CHECK ALL THAT APPLY.**

a. It was okay if I got pregnant.....

b. I wanted to have a baby/I was trying to get pregnant.....

c. I didn't think I could get pregnant at that time

d. The birth control method I was using had side effects

e. I had trouble obtaining contraceptives when I needed it

f. I thought my husband or partner or I were sterile (that it was impossible to become pregnant).....

g. My husband or partner did not want to use any method of contraception.

h. Other.....

Please tell us: _____

****NOW SKIP TO QUESTION #9****

8. What were you or your husband or partner doing to keep from getting pregnant? **CHECK ALL THAT APPLY**

a. Pill.....

b. Condoms

c. Foam, jelly, cream

d. Norplant

e. Shots (Depo-Provera).....

f. Withdrawal.....

g. Tubes tied/Vasectomy (sterilization)

h. Other.....

Please tell us: _____

9. Did you receive treatment from a doctor, nurse, or other health care worker to help you get pregnant with your new baby? (This may include infertility treatments such as fertility-enhancing drugs or assisted reproductive technology.)

Yes1

No.....0

10. **Before you were pregnant with your new baby**, how many times have you been pregnant? Please include ALL pregnancies, even those that were miscarried or aborted.

_____ times

11. **Before your new baby was born**, how many children did you give birth to?

_____ total number of children

What are their ages: _____

12. When did you give birth to your **first** child?

_____/_____/_____
month day year

13. **Just before** you got pregnant with your new baby, how did you feel about becoming pregnant?

I wanted to be pregnant sooner ..1

I wanted to be pregnant later2

I wanted to be pregnant then3

I didn't want to be pregnant then or at any time in the future4

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The next questions ask about the types of discrimination you may have experienced.

88. If you feel you've been treated unfairly how do you usually respond? Do you:

- a. Accept it as a fact of life? Never Rarely Sometimes Always
- b. Try to do something about it? Never Rarely Sometimes Always
- c. Talk to other people about it? Never Rarely Sometimes Always
- d. Keep it to yourself? Never Rarely Sometimes Always

89. Have you ever experienced discrimination (for example, been prevented from doing something, or been hassled or made to feel inferior) in any of the following situations because of your race or skin color, immigration status, age, income, because you are a woman, or because you were pregnant? **CHECK ALL THAT APPLY**

	Race/Color	Immigration Status	Age	Income	Being a Woman	Because You Were Pregnant
a. At school.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Getting a job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. At work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. At home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Getting medical care ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Getting housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. From police or in the courts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Did not experience discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check here if you would like to receive the findings of this survey.

14. **Just before** you got pregnant with your new baby, how did your husband or partner feel about you becoming pregnant?

- He wanted me to be pregnant sooner..... 1
- He wanted me to be pregnant later..... 2
- He wanted me to be pregnant then..... 3
- He didn't want me to be pregnant then or at any time in the future..... 4
- I don't know..... 5
- I didn't have a husband or partner..... 6

15. **Before your most recent pregnancy**, did you **ever** have the following? Check **Yes** if it happened to you, **No**, if it did not.

- | | <u>YES</u> | <u>NO</u> |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
| a. A baby that was born prematurely or early (before you reached 37 weeks or 8 ¼ months of pregnancy).. | <input type="checkbox"/> Y ... | <input type="checkbox"/> N |
| b. A baby that weighed less than 5 ½ lbs (2500 grams) at birth | <input type="checkbox"/> Y ... | <input type="checkbox"/> N |
| c. A baby that was delivered by cesarean section (when a doctor cut through your belly to bring out your baby) ... | <input type="checkbox"/> Y ... | <input type="checkbox"/> N |
| d. Miscarriage | <input type="checkbox"/> Y ... | <input type="checkbox"/> N |
| e. Abortion..... | <input type="checkbox"/> Y... | <input type="checkbox"/> N |
| f. Stillbirth | <input type="checkbox"/> Y.... | <input type="checkbox"/> N |
| g. A baby under 1 year old who passed away | <input type="checkbox"/> Y.... | <input type="checkbox"/> N |

16. In the **three months before** you got pregnant, did you have any of the following health problems? For each item, check **Yes** if you had the problem or **No** if you did not have the problem.

- | | <u>YES</u> | <u>NO</u> |
|--------------------------------------------------------|----------------------------------|----------------------------|
| a. Asthma | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| b. High blood pressure (hypertension) | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| c. High blood sugar (diabetes). .. | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| d. Anemia (poor blood, low iron)..... | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| e. Sickle-cell anemia/disease... .. | <input type="checkbox"/> Y..... | <input type="checkbox"/> N |
| f. Heart problems | <input type="checkbox"/> Y..... | <input type="checkbox"/> N |
| g. Problems with your gums (periodontal disease) | <input type="checkbox"/> Y | <input type="checkbox"/> N |

17. This question is about things that may have happened during the **12 months before you were pregnant with your new baby**. For each item, check **Yes** if it happened to you or **No** if it did not.

- a. Your husband or partner pushed, hit, slapped, kicked, choked, or physically hurt you in any way Yes.... No
- b. Your husband or partner tried to control your daily activities, for example controlling who you could talk to or where you could go Yes.... No
- c. You felt afraid of your husband or partner Yes.... No
- d. You were repeatedly called names, told that you were worthless, ugly, or verbally threatened by your husband or partner Yes.... No
- e. Your husband or partner forced you to take part in any sexual activity when you did not want to (including touch that made you uncomfortable)..... Yes.... No

If you would like help with domestic violence, please call the Domestic Violence Hotline: 1-800-978-3600. You can also call the National 24-hour Toll-free Hotline numbers: 1-800-799-SAFE (7233) and 1-800-787-3224 (TDD). If you need immediate help, call 9-1-1.

These toll-free numbers will NOT appear on your phone bill.

18. In the **month before you got pregnant** with your new baby, how many times a week did you take a multivitamin (a vitamin pill that contains many different vitamins and minerals) or a prenatal vitamin?

- I did not take a multivitamin/prenatal vitamin (a vitamin pill) 1
- 1 to 3 times a week..... 2
- 4 to 6 times a week..... 3
- Every day of the week 4

19. In the **6 months before** you found out you were pregnant this time, how many cigarettes did you smoke a day, on average?

- None 1
- About one cigarette a day or less.. 2
- Just a few cigarettes a day (2-4) ... 3
- About half a pack a day (5-14) 4
- About a pack a day (15-24) 5
- About 1 ½ packs a day (25-34) 6
- About 2 packs a day (35-44) 7
- More than 2 packs a day (45 or more) 8

20. **During the 12 months before you were pregnant with your new baby**, did you ever eat less than you felt you should because there wasn't enough money to buy food?

- Yes..... 1
- No 0

81. At the time your baby was born, what was your marital status?

- Married 1
- Separated or divorced..... 2
- Widowed..... 3
- Single (never married)..... 4
- Living with a partner 5

82. How safe from crime do you consider your neighborhood to be?

- Very safe 1
- Somewhat safe 2
- Somewhat unsafe 3
- Not at all safe 4
- Don't know..... 5

83. What type of housing do you live in?

- House 1
- Apartment..... 2
- Mobile home..... 3
- Public housing/
Section 8 housing..... 4
- Other 5

Please tell us: _____

84. Counting you, how many people live in your house, apartment, or trailer?

_____ total number of people

85. Who lives in your house, apartment, or trailer (not including your new baby)? **CHECK ALL ANSWERS THAT APPLY.**

- Husband or partner.....
- Other children
- Mother/mother-in-law
or father/father-in law.....
- Sister or brother
- Grandmother or grandfather
- Other

Please tell us: _____

86. What was your family income in **2004** before taxes? Please check the number below that includes your total family income, including your income and the income of your husband or partner (if living with you in 2004) and your children.

- Please include income from all sources, including jobs, welfare, disability, unemployment, child support, interest, dividends, and support from family members.
- Less than \$10,000 1
- \$10,000-\$19,999..... 2
- \$20,000-\$29,999..... 3
- \$30,000-\$39,999..... 4
- \$40,000-\$49,999..... 5
- \$50,000-\$75,000..... 6
- More than \$75,000..... 7

87. How many people lived on this income in **2004**?

_____ total number of people

73. After your baby was born, was he or she put in an intensive care unit?

1 Yes ... 0 No... 89 Don't know

74. Is your baby alive now?

1 Yes

0 No

If your baby has passed away, we would like to extend our condolences to both you and your family. Please know that we are here to offer support during your time of need. If you need any support, please call us: 1-866-706-LAMB (5262).

75. In the months **after your new baby was born**, would you say that you were...

Not depressed at all 1

A little depressed 2

Moderately depressed 3

Very depressed..... 4

The next questions give us a general idea of the types of people who have taken part in this important survey. Again, all information about you will be kept private.

76. How tall are you without shoes?

_____ feet and _____ inches

OR

_____ centimeters

77. **Just before you got pregnant**, how much did you weigh?

_____ pounds

OR

_____ kilos

78. **Just before your baby was born**, how much did you weigh?

_____ pounds **OR** _____ kilos

79. How many years have you lived in the United States?

_____ years **OR** _____ months

80. What language do you usually speak at home?

English 1

Spanish..... 2

English and Spanish equally 3

Asian language..... 4

Please tell us: _____

English and Asian language equally 5

Other language 6

Please tell us: _____

English and other language equally 7

Thank you for completing the last section. Now, please answer questions about things that may have happened DURING your most recent pregnancy.

21. How would you describe the time **during your most recent pregnancy**?

One of the happiest times of my life 1

A happy time with few problems ... 2

A moderately hard time 3

A very hard time 4

One of the worst times of my life .. 5

22. Pregnancy can be a difficult time for some women. These next questions are about events that may have happened to you during your most recent pregnancy. Choose **Yes** if it happened to you, **No** if it did not. *It may be helpful to look at the calendar on the back of the survey.*

YES NO

- a. A close family member was very sick and had to go into the hospital Y..... N
- b. You got separated or divorced from your husband or partner Y..... N
- c. You moved to a new address Y..... N
- d. You were homeless Y..... N
- e. Your husband or partner lost his job..... Y..... N
- f. You lost your job even though you wanted to go on working..... Y..... N
- g. You had a long commute to work Y..... N
- h. You argued with your husband or partner more than usual..... Y..... N

YES NO

- i. Your husband or partner pushed, slapped, hit, kicked, choked, or physically hurt you Y N
- j. You had a lot of bills you could not pay Y N
- k. You were in a physical fight ... Y N
- l. You or your husband or partner went to jail Y N
- m. Someone very close to you had a problem with drinking or drugs..... Y N
- n. Someone close and important to you died Y N
- o. Have any other serious events happened during your pregnancy?

23. **During your most recent pregnancy**, how did you feel about breastfeeding your baby?

It was very important; formula-feeding was not an option 1

I wanted to try to breastfeed, but I was ok with formula feeding..... 2

I did not want to breastfeed; I wanted to formula-feed..... 3

I was undecided 4

24. During your most recent pregnancy did you
- YES** **NO**
- a. Work 40 or more hours per week? _Y _N
 - b. Stand or walk for more than 3 hours a day at work? _Y _N
 - c. Lift or carry more than 25 pounds regularly at work? _Y _N
 - d. Work a night shift or overnight shift at least once a week? ... _Y _N
 - e. Skip a meal because you were too busy at work at least once a week? _Y _N

25. **During your most recent pregnancy,** how many children under 10 years old lived in the same house as you?
 _____ children

26. During **the last 3 months** of your most recent pregnancy, how often did you participate in any physical activities or exercise for 30 minutes or more? (For example, walking for exercise, swimming, cycling, dancing, or gardening.) Do not count exercise you may have done as part of your regular job.

- I didn't exercise ₁
- I didn't exercise, because I was told by a doctor, nurse, or health care worker not to exercise ₂
- Less than 1 day per week ₃
- 1 to 4 days per week ₄
- 5 or more days per week ₅

27. Did you douche at any time during your most recent pregnancy (for example, using products such as Summer's Eve, Massengill, or vinegar/water solution)?

- ₁ Yes → **ANSWER QUESTION #28**
- ₀ No → **SKIP TO QUESTION #29**

28. How often did you douche during your most recent pregnancy?

- Daily ₁
- 4-6 times a week ₂
- 2-3 times a week ₃
- Once a week ₄
- 2-3 times a month or less often .. ₅

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. **If you went to more than one place for prenatal care, answer for the place where you got most of your care.** It may help to look at the calendar on the back of the survey when you answer these questions.

29. When did you think you should begin prenatal care?

- 1-3 months of pregnancy ₁
- 4-6 months of pregnancy ₂
- 7-9 months of pregnancy ₃
- I didn't think I needed prenatal care ₄

64. **After your baby was born,** did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any way?

- Yes ₁
- No ₀

65. How have you fed your baby **since you left the hospital**?

- Breast milk only ₁
→ **SKIP TO QUESTION #67**
- Formula only ₂
- Both breast milk and formula... ₃

66. How many days, weeks, or months old was your baby when you began feeding him/her formula?

- _____ days **OR** _____ weeks
- OR** _____ months

67. If you are no longer breastfeeding, how old was your baby when you stopped?

- ____ days **OR** ____ weeks
- OR** ____ months
- OR**
- Not applicable (I am still breastfeeding)

68. How do you put your new baby down to sleep **most** of the time? **CHECK ONLY ONE ANSWER**

- On his/her side ₁
- On his/her back ₂
- On his/her stomach ₃

69. How often does your new baby sleep in the same bed as you or with another person?

- ₁ Always
 - ₂ Frequently
 - ₃ Sometimes
 - ₄ Rarely
 - ₅ Never
- } **GO TO QUESTION #70**
 } **SKIP TO QUESTION #71**

70. What are the reasons your baby sleeps with you or with another person? **CHECK ALL THAT APPLY.**

- I do not have a crib for my baby
- Part of my culture/tradition
- I want a closer bond with my baby
- It is easier to breastfeed my baby
- Other: _____

71. Has your new baby had a well-baby checkup? (A well-baby checkup is a regular health visit for your baby usually at 2, 4, and 6 months of age).

- ₁ Yes → **SKIP TO QUESTION #73**
- ₀ No → **GO TO QUESTION #72**

72. Did any of these things keep your baby from having a well-baby checkup?

- I didn't have enough money or insurance to pay for it ₁
- I had no way to get my baby to the clinic or office ₂
- I didn't have anyone to take care of my other children ₃
- I couldn't get an appointment ₄
- My baby was too sick to go for routine care ₅
- Other → Please tell us: _____

58. During the **last 3 months** of your pregnancy, how many times did you drink 5 or more alcoholic drinks in one sitting?
 _____ times

Thank you for completing the last section. In the next section we would like to know about your experiences with the DELIVERY of your most recent birth.

59. How did you feed your baby while you were in the hospital?

- Breast milk only..... ₁
 Formula only ₂
 Both breast milk and formula..... ₃

60. We would like to know how you felt about the care you received at the hospital during your most recent birth. Overall, how would you rate the hospital where you delivered your most recent baby?

- Excellent..... ₁
 Very good..... ₂
 Good ₃
 Fair ₄
 Poor..... ₅

61. Would you recommend this hospital to your friends or family?

- Yes ₁
 No..... ₀

Please tell us the reason(s) why you would not recommend it:

Thank you for completing the last section. In the next section we would like to know about things that may have happened AFTER your baby was born.

62. Since your new baby was born, have you had a postpartum check-up for yourself? (A postpartum check-up is the regular check-up a woman has after she gives birth.)

- ₁ Yes → **GO TO QUESTION #63**
₀ No → **SKIP TO QUESTION #64**

63. At that visit, did a doctor, nurse, or other health care worker discuss family planning or birth control with you?

- Yes ₁
 No..... ₀

30. Did you get any prenatal care **during your most recent pregnancy?** **Please do not count a visit just for a pregnancy test.**

- ₁ Yes → **GO TO QUESTION #31**
₀ No → **SKIP TO QUESTION #42**

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

- ₁ Yes → **SKIP TO QUESTION #33**
₀ No → **GO TO QUESTION #32**

32. Did any of these things keep you from getting prenatal care as early as you wanted? For each problem or reason, check **Yes** if it was a problem/reason or **No** if it was not a problem for you.

- | | YES | NO |
|-----------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------|
| a. I could not get an appointment earlier..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| c. I had problems finding a place that would accept my insurance or Medi-Cal..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| d. I didn't know where to go for prenatal care..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| e. I had problems getting through on the phone to make an appointment..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| f. I had no way to get to the clinic or office..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| g. There was no one to take care of my children..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |

- | | YES | NO |
|-------------------------------------------------------------------|---------------------------------------------|---------------------------------------|
| h. I had too many other problems to deal with..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| i. I couldn't take time off from work..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| j. The doctor or my health plan would not start care earlier..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| k. I didn't want anyone to know I was pregnant..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| l. I didn't know I was pregnant..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| m. Language problems..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |
| n. Other problems getting prenatal care..... | <input type="checkbox"/> _Y | <input type="checkbox"/> _N |

Please tell us: _____

33. About how many weeks or months pregnant were you when you **had** your first prenatal care visit? **Please do not count a visit just for a pregnancy test.**

_____ Weeks **OR** _____ Months

34. How far did you travel (one way) to receive prenatal care?

- Less than 5 miles..... ₁
 5-14 miles ₂
 15-29 miles ₃
 30-50 miles ₄
 More than 50 miles ₅

35. What were your reasons for going to this doctor/clinic for prenatal care? **CHECK ALL ANSWERS THAT APPLY.**

- The only doctor in my area that would accept me as a patient
- The office was the most convenient for me.....
- I selected this office from a list given to me by my insurance company.....
- A relative or friend referred me
- They offered specialized services
- A doctor referred me
- I went to this doctor for my past pregnancies.....
- They gave the best gift items
- Other

Please tell us: _____

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

- Yes 1
- No..... 0
- Don't know 89

PLEASE CONTINUE TO NEXT PAGE →

53. On average, how many cigarettes did you smoke per day **after you found out that you were pregnant?**

- None..... 1
- About one cigarette a day or less . 2
- Just a few cigarettes a day (2-4)... 3
- About half a pack a day (5-14)..... 4
- About a pack a day (15-24)..... 5
- About 1 ½ packs a day (25-34)..... 6
- About 2 packs a day (35-44)..... 7
- More than 2 packs a day (45 or more) 8

54. Did you use any of these drugs **when you were pregnant?** For each item, Check **Yes** if you did or **No** if you did not use these drugs.

YES NO

- a. Prescription drugs not prescribed by your doctor..... Y.. N
- b. Marijuana (pot, bud) or Hashish (hash) Y.. N
- c. Amphetamines (uppers, ice, speed, crystal, crank) Y.. N
- d. Cocaine (rock, coke, crack) or Heroin (smack, horse) Y.. N
- e. Tranquilizers (downers, ludes) or hallucinogens (LSD/acid, PCP/angel dust ecstasy) Y... N
- f. Sniffing gasoline, hairspray, or other aerosols Y... N

The next questions are about drinking alcohol. By “alcohol” we mean any kind of drink with alcohol in it (beer, wine, wine cooler, hard liquor, or a mixed drink made with hard liquor). One drink is equal to one glass of wine, one wine cooler, one can or bottle of beer, one shot of liquor, or one mixed drink.

55. Did you drink any alcohol **during your most recent pregnancy?**

1 Yes → **ANSWER QUESTION #56**

0 No → **SKIP TO QUESTION #59**

56. During the **first 3 months** of your pregnancy, about how many drinks with alcohol did you have in an average week?

- I didn't drink at all during the first 3 months of my pregnancy .. 1
- Less than one drink per week..... 2
- 1 to 3 per week 3
- 4 to 6 per week 4
- 7 or more drinks per week 5

57. During the **last 3 months** of your pregnancy, about how many drinks containing alcohol did you have in an average week?

- I didn't drink at all during the last 3 months of my pregnancy... 1
- SKIP TO QUESTION #59**
- Less than one drink per week..... 2
- 1 to 3 per week 3
- 4 to 6 per week 4
- 7 or more drinks per week 5

In the next section, we would like to know about problems that may have occurred DURING pregnancy. Please answer the following questions.

48. Did you have any of these problems during your **most recent pregnancy**? For each item, check **Yes** if you had the problem and **No** if you did not.

- YES NO**
- a. Labor pains more than 3 weeks before your baby was due (preterm or early labor) Y N
 - b. High blood pressure (including pre-eclampsia or toxemia) Y N
 - c. Vaginal bleeding Y N
 - d. Problems with the placenta (such as abruptio placentae, or placenta previa) Y N
 - e. Severe nausea, vomiting or dehydration Y N
 - f. High blood sugar (diabetes) ... Y N
 - g. Kidney or bladder (urinary tract) infection Y N
 - h. Water broke more than 3 weeks before your baby was due (premature rupture of membranes, PROM)..... Y N
 - i. Cervix had to be sewn shut (incompetent cervix, cerclage) Y N
 - j. You were hurt in a car accident Y N
 - k. A sexually transmitted disease such as chlamydia, gonorrhea, herpes, human papilloma virus (HPV), trichomoniasis Y N
 - l. Bacterial Vaginosis Y N
 - m. Group B Streptococcus Y N
 - n. Problems with your gums (periodontal disease) Y N

49. For two weeks or longer during your **most recent pregnancy**, did you

YES NO

- a. Feel sad, empty or depressed for most the day..... Y .. N
- b. Lose interest in most things like work, hobbies, and other things you usually enjoyed..... Y .. N

50. **During your most recent pregnancy**, did you have a diagnosed mental health problem (for example, depression, schizophrenia, etc)?

- 1 Yes → **ANSWER QUESTION #51**
- 0 No → **SKIP TO QUESTION #52**

51. **During your most recent pregnancy**, did you receive medication or counseling for this mental health problem?

- Yes 1
- No..... 0

Please answer the next questions about smoking and drug use DURING pregnancy.

52. During your most recent pregnancy, about how many hours a day, on average, were you in the same room with another person who was smoking?

_____ hours

37. During your **first** or **second** prenatal care visit, were these part of your visit? For each item, check Yes if it was and No if it was not.

- a. Your blood pressure was measured Yes No Don't know
- b. You gave a sample of your urine Yes No Don't know
- c. Your blood was taken..... Yes No Don't know
- d. Your height and weight was measured Yes No Don't know
- e. You had a pelvic exam..... Yes No Don't know
- f. Your doctor asked about your health history Yes No Don't know
- g. Other things that the doctor/nurse did..... Yes No Don't know

Please tell us: _____

38. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos.

- a. How smoking during pregnancy could affect your baby Yes No Don't know
 - b. How breastfeeding is good for your baby Yes No Don't know
 - c. How drinking alcohol during pregnancy could affect your baby Yes No Don't know
 - d. Using a seat belt during your pregnancy Yes No Don't know
 - e. Birth control methods to use after your pregnancy Yes No Don't know
 - f. Medicines that are safe to take during your pregnancy Yes No Don't know
 - g. How using illegal drugs could affect your baby..... Yes No Don't know
 - h. Doing tests to screen for birth defects or diseases that run in your family Yes No Don't know
 - i. What to do if your labor starts early Yes No Don't know
 - j. Getting tested for HIV (the virus that causes AIDS) Yes No Don't know
 - k. Physical abuse to women by their husbands or partners .. Yes No Don't know
 - l. Types of food to eat during pregnancy Yes No Don't know
 - m. Not touching your mouth or eyes while handling raw meat, not washing hands after contact with cat feces, or not feeding cats raw or undercooked meat..... Yes No Don't know
 - n. Appropriate amount of weight to gain Yes No Don't know
- HOW MANY POUNDS WERE RECOMMENDED?** _____ Pounds **OR** _____ Kilos
- o. Asked me if I felt anxious or depressed Yes No Don't know
 - p. Other Yes No Don't know

Please tell us: _____

39. We would like to know how you felt about the prenatal care you received during your most recent pregnancy. If you went to more than one place for prenatal care, answer for the place where you received most of your care. Please answer **Yes** if you were satisfied, **No** if you were not.

YES NO

- a. The amount of time you had to wait after you arrived for your visits Y.....N
- b. The amount of time the doctor or nurse spent with you during your visits Y.....N
- c. The advice you got on how to take care of yourself Y.....N
- d. The understanding and respect that the staff showed toward you as a person Y.....N

40. Overall, how satisfied were you with the prenatal care you received? **CHECK ONLY ONE ANSWER**

- ₁ Not at all satisfied
 - ₂ Somewhat dissatisfied
- } **GO TO QUESTION # 41**
- ₃ No opinion/Neutral
 - ₄ Somewhat satisfied
 - ₅ Satisfied
 - ₆ Not applicable
- } **SKIP TO QUESTION #42**

41. Did you do any of the following things because you were not satisfied? **CHECK ALL ANSWERS THAT APPLY**

- I did not do anything
 - I complained to the staff
 - Changed doctor or office
 - Went for care less often/ stopped going
 - Didn't change doctor/office because it was too hard to find another doctor.....
 - Other
- Please tell us:** _____

42. Other than your primary medical doctor or nurse, did you see or visit any other person(s) about your health during your most recent pregnancy?

- ₁ Yes → **ANSWER QUESTION #43**
- ₀ No → **SKIP TO QUESTION #44**

43. Who did you see or visit about your health during your pregnancy? **CHECK ALL ANSWERS THAT APPLY.**

- Licensed Acupuncturist (L.Ac./O.M.D.) (including all herbal prescriptions)
 - Botanica or Health Food Stores (for all non-prescribed herbal formulas only) .
 - Other professional healers (for example, chiropractors)
 - Spiritualist or Spiritual Healer
 - Midwife.....
 - Pharmacist.....
 - Family or friend
 - Other person
- Please tell us:** _____

44. Did you follow any special cultural or religious traditions related to pregnancy, such as eating or avoiding special foods, doing or avoiding special activities, etc.? These activities may include special dances/body movements, special prayers, rituals, etc.

- Yes ₁
- Please tell us:** _____
- _____
- _____
- No ₀

45. **During your most recent pregnancy**, would you have been able to receive the kinds of help listed below **if you had needed them?** For each item, check **Yes** if you would have been able to receive help if you needed it or check **No** if you could not have received such help.

YES NO

- a. Someone to loan me money Y.... N
- b. Someone to help me if I were sick and needed to be in bed... Y.... N
- c. Someone to listen to me about my problems Y.... N
- d. Someone to take me to the clinic or doctor's office if I needed a ride..... Y.... N
- e. Someone to help with things I had to do (errands, household tasks, child care) ... Y.... N
- f. Someone to give me advice or information..... Y.... N

46. **During your most recent pregnancy**, did you receive any of the following services? For each item, check **Yes** if you received the service or **No** if you did not receive the service.

YES NO

- a. Money to buy food, food stamps, or WIC vouchers..... Y....N
 - b. Help with an alcohol or drug problem Y....N
 - c. Help to reduce violence in your home Y....N
 - d. Counseling information for family and personal problems Y....N
 - e. Help to quit smoking..... Y....N
 - f. Help with or information about breastfeeding Y....N
 - g. Other service Y....N
- Please tell us:** _____

47. Overall, how satisfied were you with the support given by your baby's father **during your most recent pregnancy?**

- Not at all satisfied ₁
- Somewhat dissatisfied ₂
- Somewhat satisfied..... ₃
- Very satisfied ₄
- Not applicable..... ₅