

2012-2013

# HAWAII PRAMS

Pregnancy Risk Assessment  
Monitoring System

A HEALTH SURVEY ABOUT YOU & YOUR BABY



With Your Help,  
More Babies Could Be Healthier

STATE OF HAWAII  
 Department of Health  
 Family Health Services Division  
 3652 Kilauea Avenue  
 Honolulu, Hawaii 96816



# 2011

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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

4. *Before you got pregnant with your new baby, did you ever have any other babies who were born alive?*

No → **Go to Question 7**

Yes

5. Did the baby born *just before* your new one weigh 5 pounds, 8 ounces (2.5 kilos) or *less* at birth?

No  
 Yes

6. Was the baby *just before* your new one born *earlier* than 3 weeks before his or her due date?

No  
 Yes

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

7. 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 .....	<input type="checkbox"/>	<input type="checkbox"/>
c. I was regularly taking prescription medicines other than birth control .....	<input type="checkbox"/>	<input type="checkbox"/>
d. I visited a health care worker and was checked for diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
e. I visited a health care worker and was checked for high blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
f. I visited a health care worker and was checked for depression or anxiety .....	<input type="checkbox"/>	<input type="checkbox"/>
g. I talked to a health care worker about my family medical history .....	<input type="checkbox"/>	<input type="checkbox"/>
h. I had my teeth cleaned by a dentist or dental hygienist .....	<input type="checkbox"/>	<input type="checkbox"/>

8. During the *month before* you got pregnant with your new baby, what kind of *health insurance* did you have?

**Check ALL that apply**

- Private health insurance from my job or the job of my husband, partner, or parents
- Private health insurance purchased directly from an insurance company
- Medicaid or QUEST
- TRICARE or other military health care
- Some other kind of health insurance → Please tell us:

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

9. 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

10. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk to you about how to improve your health before pregnancy?

- No
- Yes

11. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker tell you that you had 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 the same as gestational diabetes or diabetes that starts during pregnancy) ...
- b. High blood pressure or hypertension.....
- c. Depression .....

12. 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. Asthma.....
- b. Anemia (poor blood, low iron).....
- c. Heart problems.....
- d. Epilepsy (seizures).....
- e. Thyroid problems.....
- f. Anxiety .....

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

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

**Go to  
Question 15**

**Go to Question 14**

**14. How much longer did you want to wait to become pregnant?**

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to 5 years
- More than 5 years

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

- No
- Yes

Go to Page 4, Question 19

**16. 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 using birth control pills, condoms, withdrawal, or natural family planning.

- No
- Yes

Go to Question 18

Go to Question 17

**17. What were your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant?**

Check ALL that apply

- I didn't mind if I got pregnant
- I thought I could not get pregnant at that time
- I had side effects from the birth control method I was using
- I had problems getting birth control when I needed it
- I thought my husband or partner or I was sterile (could not get pregnant at all)
- My husband or partner didn't want to use anything
- I forgot to use a birth control method
- Other → Please tell us:

If you or your husband or partner was **not doing anything to keep from getting pregnant**, go to Page 4, Question 19.

**18. What method of birth control were you using when you got pregnant?**

Check ALL that apply

- Birth control pill
- Condoms
- Injection (Depo-Provera®)
- Contraceptive implant (Implanon®)
- Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- IUD (including Mirena® or ParaGard®)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- Other → Please tell us:



## 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.)

**19. How many weeks or months pregnant were you when you had your first visit for prenatal care?** Do not count a visit that was only for a pregnancy test or only for WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children).

Weeks **OR**  Months  
 I didn't go for prenatal care → **Go to Question 22**

**20. During your most recent pregnancy, what kind of health insurance did you have to pay for your prenatal care?**

**Check ALL that apply**

- Private health insurance from my job or the job of my husband, partner, or parents  
 Private health insurance purchased directly from an insurance company  
 Medicaid or QUEST  
 TRICARE or other military health care  
 Some other kind of health insurance → Please tell us:  
  
 I did not have any health insurance to pay for my prenatal care

**21. 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. For each item, check **No** if no one talked with you about it or **Yes** if someone did.

- |                                                                                                  | No                       | Yes                      |
|--------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. How much weight I should gain during my pregnancy .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. How smoking during pregnancy could affect my baby.....                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Breastfeeding my baby .....                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. How drinking alcohol during pregnancy could affect my baby.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Using a seat belt during my pregnancy.....                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Medicines that are safe to take during my pregnancy .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| g. How using illegal drugs could affect my baby .....                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Doing tests to screen for birth defects or diseases that run in my family .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Getting tested for HIV (the virus that causes AIDS) .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| k. What to do if I feel depressed during my pregnancy or after my baby is born.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Physical abuse to women by their husbands or partners .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |

**22. 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

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  $\longrightarrow$  **Go to Question 26**  
 Yes, before my pregnancy  
 Yes, during my pregnancy

25. During what month and year did you get the flu shot?

\_\_\_\_ / \_\_\_\_ 20\_\_\_\_

Month            Year

- I don't remember

26. This question is about the care of your teeth *during your most recent pregnancy*.

For each item, check **No** if it is not true or does not apply to you or **Yes** if it is true.

No Yes

- a. I knew it was important to care for my teeth and gums during my pregnancy.....
- b. A dental or other health care worker talked with me about how to care for my teeth and gums .....
- c. I had my teeth cleaned by a dentist or dental hygienist.....
- d. I had insurance to cover dental care during my pregnancy .....
- e. I needed to see a dentist for a **problem** .....
- f. I went to a dentist or dental clinic about a **problem** .....

27. During *your most recent pregnancy*, did you take a class or classes to prepare for childbirth and learn what to expect during labor and delivery?

- No  
 Yes

28. During *your most recent pregnancy*, did a home visitor come to your home to help you prepare for your new baby? A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps pregnant women.

- No  
 Yes

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

- No  
 Yes

30. During *your most recent pregnancy*, were you told by a doctor, nurse, or other health care worker that you had gestational diabetes (diabetes that started during *this pregnancy*)?

- No  
 Yes

**31. Did you have any of the following problems during your *most recent* pregnancy?** For each item, check **No** if you did not have the problem or **Yes** if you did.

- |                                                                                                                       | No                       | Yes                      |
|-----------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Kidney or bladder (urinary tract) infection (UTI).....                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure, hypertension (including pregnancy-induced hypertension [PIH]), preeclampsia, or toxemia ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Labor pains more than 3 weeks before my baby was due (preterm or early labor) .....                                | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

No → Go to Question 36

Yes

**33. 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

**34. 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

**35. 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



The next questions are about drinking alcohol around the time of pregnancy (before and during).

36. Have you had any alcoholic drinks in the *past 2 years*? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

No → **Go to Question 40**

Yes

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

14 drinks or more a week

7 to 13 drinks a week

4 to 6 drinks a week

1 to 3 drinks a week

Less than 1 drink a week

I didn't drink then → **Go to Question 39**

38. 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

39. 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

7 to 13 drinks a week

4 to 6 drinks a week

1 to 3 drinks a week

Less than 1 drink a week

I didn't drink then

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

40. 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 ....
- b. I got separated or divorced from my husband or partner .....
- c. I moved to a new address.....
- d. I was homeless or had to sleep outside, in a car, or in a shelter .....
- e. My husband or partner lost his job ....
- f. I lost my job even though I wanted to go on working.....
- g. My husband, partner, or I had a cut in work hours or pay .....
- h. I was apart from my husband or partner due to military deployment or extended work-related travel .....
- i. I argued with my husband or partner more than usual.....
- j. My husband or partner said he didn't want me to be pregnant .....
- k. I had problems paying the rent, mortgage, or other bills.....
- l. My husband, partner, or I went to jail .....
- m. Someone very close to me had a problem with drinking or drugs .....
- n. Someone very close to me died .....

41. During the *12 months before you got pregnant* with your new baby, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?

- No  
 Yes

42. During *your most recent* pregnancy, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?

- No  
 Yes

The next questions are about your labor and delivery.

43. When was your new baby born?

/  / 20  
 Month Day Year

44. Did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)?

- No → **Go to Question 46**  
 Yes  
 I don't know → **Go to Question 46**

**Go to Question 45**

45. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)?

**Check ALL that apply**

- My water broke and there was a fear of infection  
 I was past my due date  
 My health care provider worried about the size of the baby  
 My baby was not doing well and needed to be born  
 I had a complication in my pregnancy (such as low amniotic fluid or preeclampsia)  
 Labor stopped or was not progressing  
 I wanted to schedule my delivery  
 I wanted to give birth with a specific health care provider  
 Other → Please tell us:

46. How was your new baby delivered?

- Vaginally → **Go to Question 48**  
 Cesarean delivery (c-section)

**Go to Question 47**

47. What was the reason that your new baby was born by cesarean delivery (c-section)?

Check ALL that apply

- I had a previous cesarean delivery (c-section)
- My baby was in the wrong position (such as breech)
- I was past my due date
- My health care provider worried that my baby was too big
- I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)
- I had a complication in my pregnancy (such as preeclampsia, placental problems, infection, preterm labor)
- My health care provider tried to induce my labor, but it didn't work
- Labor was taking too long
- The fetal monitor showed that my baby was having problems before or during labor (fetal distress)
- I wanted to schedule my delivery
- I didn't want to have my baby vaginally
- Other \_\_\_\_\_ → Please tell us:

---

48. By the end of *your most recent* pregnancy, how much weight had you gained?

Check ONE answer and fill in blank if needed

- I gained \_\_\_\_\_ pounds
- I didn't gain any weight, but I lost \_\_\_\_\_ pounds
- My weight didn't change during my pregnancy
- I don't know

## AFTER PREGNANCY

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

49. After your baby was delivered, was he or she put in an intensive care unit (NICU)?

- No
- Yes
- I don't know

50. 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 53**

51. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 11, Question 63**

52. Is your baby living with you now?

- No → **Go to Page 11, Question 62**
- Yes

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

- No → **Go to Page 11, Question 59**
- Yes

**Go to Page 10, Question 54**

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

No

Yes → **Go to Question 57**

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

\_\_\_\_\_ Weeks **OR** \_\_\_\_\_ Months

Less than 1 week

56. What were your reasons for stopping breastfeeding?

**Check ALL that apply**

- My baby had difficulty latching or nursing
- Breast milk alone did not satisfy my baby
- I thought my baby was not gaining enough weight
- My nipples were sore, cracked, or bleeding
- It was too hard, painful, or too time consuming
- I thought I was not producing enough milk, or my milk dried up
- I had too many other household duties
- I felt it was the right time to stop breastfeeding
- I got sick or I had to stop for medical reasons
- I went back to work or school
- My baby was jaundiced (yellowing of the skin or whites of the eyes)
- Other → Please tell us:

\_\_\_\_\_

**If your baby was not born in a hospital, go to Question 58.**

57. 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 happen.

**No Yes**

- a. Hospital staff gave me information about breastfeeding.....
- b. My baby stayed in the same room with me at the hospital.....
- c. Hospital staff helped me learn how to breastfeed.....
- d. I breastfed in the first hour after my baby was born.....
- e. I breastfed my baby in the hospital.....
- f. My baby was fed only breast milk at the hospital.....
- g. Hospital staff told me to breastfeed whenever my baby wanted.....
- h. The hospital gave me a breast pump to use.....
- i. The hospital gave me a gift pack with formula.....
- j. The hospital gave me a telephone number to call for help with breastfeeding.....
- k. Hospital staff gave my baby a pacifier.....

58. How old was your new baby the first time he or she drank liquids other than breast milk (such as formula, water, juice, tea, 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

59. 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

60. Since your new baby was born, 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. For each item, check No if no one talked with you about it or Yes if someone did.

- |                                                                                                                | No                       | Yes                      |
|----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Help with or information about breastfeeding.....                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| b. How long to wait before getting pregnant again.....                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Birth control methods that I can use after giving birth.....                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Postpartum depression.....                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Support groups for new parents.....                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Resources in my community such as nurse home visitation programs, telephone hotlines, counseling, etc. .... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Getting to and staying at a healthy weight after delivery.....                                              | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is still in the hospital, go to Question 62.

61. 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

62. Since your new baby was born, has a home visitor come to your home to help you learn how to take care of yourself or your new baby? A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps mothers of newborns.

- No
- Yes

63. 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 using birth control pills, condoms, withdrawal, or natural family planning.

- No
- Yes

Go to Page 12, Question 65

64. 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 am not having sex
- I want to get pregnant
- I don't want to use birth control
- I am worried about side effects from birth control
- My husband or partner doesn't want to use anything
- I have problems getting birth control when I need it
- I had my tubes tied or blocked
- My husband or partner had a vasectomy
- I am pregnant now
- Other \_\_\_\_\_ → Please tell us:

**If you or your husband or partner is not doing anything to keep from getting pregnant *now*, go to Question 66.**

**65. 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, Essure<sup>®</sup>, Adiana<sup>®</sup>)
- Vasectomy (male sterilization)
- Birth control pill
- Condoms
- Injection (Depo-Provera<sup>®</sup>)
- Contraceptive implant (Implanon<sup>®</sup>)
- Contraceptive patch (OrthoEvra<sup>®</sup>) or vaginal ring (NuvaRing<sup>®</sup>)
- IUD (including Mirena<sup>®</sup> or ParaGard<sup>®</sup>)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- Not having sex (abstinence)
- Other \_\_\_\_\_ → Please tell us:

---

**66. *Since your new baby was born, have you had a postpartum checkup for yourself?* A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.**

- No
- Yes

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

**69. 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, partner, or parents
- Private health insurance purchased directly from an insurance company
- Medicaid or QUEST
- TRICARE or other military health care
- Some other kind of health insurance \_\_\_\_\_ → Please tell us:

---

- I do not have health insurance *now*



**OTHER EXPERIENCES**

**The next questions are on a variety of topics.**

**If you did not smoke during the 3 months before you got pregnant with your new baby, go to Question 71.**

**70. Listed below are some things that can make it hard for some people to quit smoking.** For each item, check **No** if it is not something that makes it hard for you or **Yes** if it is.

- |                                                             | No                       | Yes                      |
|-------------------------------------------------------------|--------------------------|--------------------------|
| a. Cost of medicines or products to help with quitting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cost of classes to help with quitting...                 | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Fear of gaining weight.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Loss of a way to handle stress .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other people smoking around me.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cravings for a cigarette.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Lack of support from others to quit ....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Worsening depression .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Worsening anxiety .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Some other reason.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us: \_\_\_\_\_ →

**71. Did you use any of these drugs in the month before you got pregnant?** For each item, check **No** if you did not use it or **Yes** if you did.

- |                                                                                             | No                       | Yes                      |
|---------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. Prescription drugs .....                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what kinds? _____ → Please tell us:                                                 |                          |                          |
|                                                                                             |                          |                          |
| b. Marijuana (pot, bud) or hashish (hash) .....                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Amphetamines (uppers, ice, speed, crystal meth, crank) .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cocaine (rock, coke, crack) or heroin (smack, horse).....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Tranquilizers (downers, ludes) or hallucinogens (LSD/acid, PCP/angel dust, ecstasy)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sniffing gasoline, glue, hairspray, or other aerosols.....                               | <input type="checkbox"/> | <input type="checkbox"/> |

**72. This question is about things that may have happened during *your most recent pregnancy*.** For each thing, check **No** if it did not happen to you or **Yes** if it did.

- |                                                                                                                                      | No                       | Yes                      |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. My husband or partner threatened me or made me feel unsafe in some way.....                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was frightened for my safety or my family's safety because of the anger or threats of my husband or partner .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My husband or partner tried to control my daily activities, for example, controlling who I could talk to or where I could go..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My husband or partner forced me to take part in touching or any sexual activity when I did not want to .....                      | <input type="checkbox"/> | <input type="checkbox"/> |

**73. This question is about things that may have happened *since your new baby was born*.** For each thing, check **No** if it did not happen to you or **Yes** if it did.

- |                                                                                                                                      | No                       | Yes                      |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| a. My husband or partner threatened me or made me feel unsafe in some way.....                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I was frightened for my safety or my family's safety because of the anger or threats of my husband or partner.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My husband or partner tried to control my daily activities, for example, controlling who I could talk to or where I could go..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My husband or partner forced me to take part in touching or any sexual activity when I did not want to .....                      | <input type="checkbox"/> | <input type="checkbox"/> |

**If your baby is not alive or is not living with you, go to Question 75.**

**74. In the last month, where did your new baby usually sleep?**

- In a crib, cradle, or bassinet
- On an adult bed or mattress with me and/or another person(s)
- On an adult bed or mattress alone
- On a sofa or couch
- In a car seat or infant seat
- Someplace else → Please tell us:

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

**75. 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 \$17,000
- \$17,001 to \$21,000
- \$21,001 to \$26,000
- \$26,001 to \$30,000
- \$30,001 to \$34,000
- \$34,001 to \$43,000
- \$43,001 to \$51,000
- \$51,001 to \$60,000
- \$60,001 to \$64,000
- \$64,001 to \$77,000
- \$77,001 to \$90,000
- \$90,001 or more

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

People

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

/  /


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 Hawaii.**

*Thanks for answering our questions!*

*Your answers will help us work to make Hawaii mothers and babies healthier.*





Mahalo for completing this questionnaire!

All answers you provide are confidential, and will be kept private.

**NONDISCRIMINATION IN SERVICES:**

We provide access to our activities without regard to race, color, national origin (including language), age, sex, religion or disability.

Write or call the Hawaii PRAMS program office at  
3652 Kilauea Avenue, Honolulu, HI 96816,  
(808)733-4060 within 180 days of any problem.





# HAWAII PRAMS

Pregnancy Risk Assessment Monitoring System

OAHU: 808-733-4060

BIG ISLAND: 808-974-4000 ext. 34060#

MAUI: 808-984-2400 ext. 34060#

KAUAI: 808-274-3141 ext. 34060#

LANAI & MOLOKAI: 1-800-468-4644 ext. 34060#

