Supplemental Table 1. Enrollment survey ('E' = enrollment survey, 'S' = subsequent trimester surveys).

Are you still pregnant? (S)

□ Yes

□ No

1a. How did your pregnancy end?

□ Livebirth

□ Stillbirth

□ Miscarriage

□ Abortion

1b. When did your pregnancy end (if livebirth, what is your baby's birthdate)?

MM/DD/YYYY

1c. Was this an abortion:

□ By choice

□ Due to maternal or fetal condition,

What was the maternal or fetal condition? _____

What is your due date? (E, S) MM/DD/YY

How many weeks pregnant are you? (E, S) _____

Section #1

1. Race/ethnicity (choose up to 3) (E)

□ White

Please specify origin for White race/ethnicity checked (select up to three)

□ Europe

□ Middle East

□ North African

□ Other, Please specify other race/ethnicity: _____

□ Decline to state

□ Unknown

□ Hispanic

Please specify origin for Hispanic race/ethnicity (select up to three)

□ Mexico

□ Central America

□ South America

□ Puerto Rico

□ Cuba

□ Other, Please specify other race/ethnicity: _____

□ Decline to state

□ Unknown

□ Black or African American

Please specify origin for Black or African American race/ethnicity (select up to three)

□ Jamaica
□ Haiti
□ Nigeria
□ Ethiopia
□ Somalia
□ Other, Please specify other race/ethnicity: _____
□ Decline to state
□ Unknown

□ American Indian or Alaska Native

Please specify origin for American Indian or Alaska Native race/ethnicity (select up to three)

□ Navajo Nation
□ Blackfeet Tribe
□ Mayan
□ Native Village of Barrow Inupiat Traditional Government
□ Other, Please specify other race/ethnicity: _____
□ Decline to state
□ Unknown

□ Asian

Please specify origin for Asian race/ethnicity (select up to three)

□ China
□ Philippines
□ India
□ Vietnam
□ Korea
□ Japan
□ Other, Please specify other race/ethnicity: _____
□ Decline to state
□ Unknown

□ Native Hawaiian or Pacific Islander

Please specify origin for Native Hawaiian or Pacific Islander race/ethnicity (select up to three)

□ Hawaii
□ Samoa
□ Tonga
□ Fiji
□ Guam
□ Other, Please specify other race/ethnicity: _____
□ Decline to state
□ Unknown

□ Other, Please specify other race/ethnicity: _____

□ Decline to state

□ Unknown

2. What is your place of birth? (E)

□ United States □ Mexico
□ Canada □ China
□ India □ Russia
□ Other, Please specify other place of birth: _____
□ Decline to state

2a. How long have you lived in the United States? (E)

□ < 1 year □ 1- 5 years
□ 5-10 years □ 10-15 years
□ 15-20 years □ 20+ years
□ Decline to state

3. What language do you usually speak at home (check all that are regularly spoken)? (E)

□ English □ Spanish
□ French □ Vietnamese
□ Cantonese □ Ukrainian
□ Russian □ Arabic
□ Other, Please describe other language regularly spoken at home: _____
□ Decline to state

4. Relationship status: (E)

□ Married or living with partner
□ Significantly involved, but not living with partner
□ Single
□ Decline to state

5. Highest level of completed education: (E)

□ 8th grade or less □ 9th through 12th grade, no diploma
□ High school graduate/ GED completed □ Some college credit, no degree
□ Associate degree □ Bachelor's degree
□ Master's degree □ Doctorate/ Medical/ Law Degree
□ Decline to state

6. Not counting you, how many people currently live with you? (E)

□ None □ 1-2
□ 3-4 □ 5 or more
□ Decline to state

7. Do you currently reside in public funded housing or receive Section 8 housing or housing assistance? (E)

□ Yes
□ No

8. What kind of places have you lived in during your pregnancy thus far (check all that apply)? (E)
□ House/condo that I/my family owns
□ House/condo that I/my family rents
□ Apartment/flat
□ Trailer/mobile home
□ With friends at no cost (couch, floor, extra bedroom)
□ With friends sharing costs
□ Shelter
□ Car/Van
□ On the street or in a tent
□ SRO/Motel/Hotel
□ Other, Please describe the other place you have lived during your pregnancy thus far: _____
□ Decline to state

9. What was your total family income before taxes this past year (including all sources of income – salary, unemployment, other benefits or payments): (E)

□ $0 to $4,999	□ $5,000 to $14,999
□ $15,000 to $24,999	□ $25,000 to $39,999
□ $40,000 to $49,999	□ $50,000 to $74,999
□ $75,000 to $99,999	□ $100,000 to $149,999
□ $150,000 to $199,999	□ $200,000 or higher

10. Which of the following categories best describes the total income that you and your household received from all sources, before taxes and deductions, in the past month (including salary, unemployment, other benefits or payments)? (E)

□ Less than $500	□ $500 to $1,000
□ $1,000 to $2,000	□ $2,000 to $3,000
□ $3,000 to $4,000	□ Over $4,000

11. How many people, including you, depend on that income? (E)
___ Adults
___ Children under 18

12. In the past year, which one of the following best describes how your income changes from month to month, if at all? (E)
□ Roughly the same amount each month
□ Roughly the same most months, but some unusually high or low months during the year
□ Often varies quite a bit from one month to the next

13. During the next 12 months, do you expect your total household income to be higher, about the same, or lower than during the past 12 months? (E)

□ Higher
□ About the same
□ Lower

13a. If you expect that your family will earn less this year than last, what is the reason for this? (check all that apply) (E)
□ Taking time off for the birth
□ I lost my job/ my hours were cut
□ Someone else in my family lost their job/ hours were cut
□ Other

14. Overall, which one of the following best describes how well you are managing financially these days: (E, S)
□ Living comfortably □ Doing okay
□ Just getting by □ Finding it difficult to get by

15. Compared to 12 months ago, would you say that you (and your family living with you) are better off, the same, or worse off financially? (E, S)
□ Much better off □ Somewhat better off
□ About the same □ Somewhat worse off
□ Much worse off

16. Based on your current financial situation, what is the largest emergency expense that you could pay right now using cash or money in your checking/savings account? (E, S)
□ Under $50 □ $50-$99
□ $100 to $199 □ $200 to $299
□ $300 to $399 □ Over $400

17. How many hours do you work a week at your job or jobs? (E, S)
□ None
□ < 20 hours
□ 20-40 hours
□ More than 40 hours

17a. During your pregnancy have you had to regularly do any of the following as a requirement of your job (check all that apply)? (E, S)
□ Stand for more than 3 hours in a row
□ Work around smoke or exhaust fumes
□ Lift or carry more than 25 pounds
□ Use chemicals like cleaning products
□ Work a night shift more than once a week
□ Bend or stoop multiple times a day
□ None

17b. When do you expect to stop working in anticipation of your delivery? (E, S)
□ Not able to stop working/unable to take leave
□ Plan to work until go into labor
□ < 1 week before your expected due date
□ 1 week to one month before your expected due date
□ > 1 month before your expected due date
□ 1 week to one month before your expected due date
□ Unknown

17c. When do you expect to return to work after your delivery? (E, S)
□ < 3-weeks
□ 6-weeks
□ 7-weeks to 3 months
□ > 3 months
□ Not planning on working
□ Unknown

Section #2

1. Adverse Childhood Experiences Revised Questionnaire (E)

Modifications to Adverse Childhood Experiences Revised Questionnaire.
1a. To what degree do you believe that the childhood experiences described in #1 above have affected your physical or mental health since they happened? (E)
□ Not much
□ Some
□ A lot

Modifications to Philadelphia Expanded Adverse Childhood Experiences Revised Questionnaire.
2. Please answer the following questions as they relate to your experiences before 18-years of age.

	Most of the time	Some of the time	Rarely	Never
Did you feel safe in your neighborhood while growing up?	□	□	□	□
Did you feel people in your neighborhood looked out for each other, stood up for each other, and could be trusted?	□	□	□	□
How often, if ever did you see or hear about someone being beaten up, stabbed, or shot in real life?	□	□	□	□
While growing up, how often did you feel that you were being treated badly or unfairly because of your race or ethnicity?	□	□	□	□
While growing up, how often did you feel that you were being treated badly or unfairly because of your gender or sexual orientation?	□	□	□	□
How often were you bullied by a peer or classmate?	□	□	□	□
Were you ever in foster care?	□	□	□	□

2a. To what degree do you believe that the other childhood experiences described in question #4 above have affected your physical or mental health since it/they happened? (E)
□ Not much

□ Some
□ A lot

Section #3

1. How many times have you been pregnant previously? (E) ____

1a. How many of your previous pregnancies ended in live birth? (E) ____

1b. How many of your previous pregnancies did not end in live birth? (E) ____

1c. Please complete the following as it relates to any pregnancies not ending in live birth.

Pregnancy end date: MM/DD/YY **(E)**

How many weeks gestation were you when this pregnancy ended? (E)
□ < 20
□ 20 or more
□ Unknown

Was this: (E)
□ An abortion by choice
□ An abortion because of a condition
□ Miscarriage
□ Stillbirth
□ Decline to state

1d. What is the date of your last live birth? (E) MM/DD/YY

1e. Was your last child born prematurely (before 37 weeks or 3 or more weeks before your expected due date)? (E)
□ Yes
□ No
□ Do not know

1f. Did your last child spend more than 7-days in the hospital right after birth? (E)
□ Yes
□ No

Do you know the reason for his/her longer stay in the hospital?
□ Yes
□ No

Please provide the reason for his/her longer stay in the hospital _____

1g. Were any of your other children born prematurely (before 37 weeks or 3 or more weeks before your expected due date)? (E)
□ Yes

□ No
□ Do not know

1h. Did any of your previously liveborn children spend more than 7-days in the hospital right after birth? (E)
□ Yes, What was the reason for his/her/their longer stay(s) in the hospital? _____
□ No

1i. Were any of your previous children born with any kind of genetic or physical abnormality (for example Down Syndrome or a heart defect) (E)
□ Yes, What was the type of genetic or physical abnormality _____
□ No

1j. Have you experienced any of the following in <u>previous</u> pregnancies (check all that apply) (E)
□ Gestational diabetes
□ Gestational hypertension (high blood pressure)
□ Preeclampsia (generally diagnosed as very high blood pressure and some risk of having a seizure)
□ Too much amniotic fluid (polyhydramnios)
□ Too little amniotic fluid (oligohydramnios)
□ Problems with your placenta (placental previa, placental abruption, placental accreta)
Please explain the problem with your placenta: _____
□ Early (premature) rupture of the membranes (leaking of amniotic fluid 3 weeks or more before your expected due date)
□ Early contractions/labor pains (3 weeks or more before your expected due date)
□ Cesarean delivery (C-section)

2. Were any of the following diagnosed or present in the 3-months prior to <u>your current pregnancy</u>? Skip if does not apply. (E)

	Yes	No
Type I Diabetes	□	□
Type II Diabetes	□	□
Hypertension/ High Blood Pressure	□	□
Asthma	□	□
Anemia (not sickle cell)	□	□
Sickle cell anemia	□	□
Insomnia	□	□
Sleep Apnea	□	□
Allergies, Please describe: _____	□	□
Anxiety Disorder	□	□
Depression	□	□
Other diagnosed mental illness, Please describe: _____	□	□
Urinary Tract Infection	□	□
Other Infection, Please describe: _____	□	□
Other Medical Condition(s), Please describe: _____	□	□

3. In the <u>three months prior to your current pregnancy</u>, did you take any prescription medication? (E)
□ Yes
□ No

How many medications did you take (provide space for up to 5)?

What is the name of medication #1?
Why did you take medication #1?
What are the approximate dates of use (if currently taking, do not enter end date)?
Start: MMDDYYYY End: MMDDYYYY

If you took additional medications, please describe:_____

4. <u>In the three months before becoming pregnant</u> did you take or use any of the following*? (E)
**Reminder: All information is confidential and will not be shared with anyone outside of the study or be stored in the same computer location or file with your identifying information (name, birth date, address, email address, phone number).*

	Yes	No	How often?	How many?
Tobacco/cigarettes or vaping	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more
Alcohol	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more
Smoke Marijuana (e.g. pot, weed)	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more
Used marijuana (e.g. THC, CBD, edibles. Please do not include lotions, creams, or gels)	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more
Other Street Drug(s) (e.g. cocaine, methamphetamine, heroin, unprescribed pain killers, other), What type?: _____	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more

5. How tall are you? (E) ____ Feet ____ inches

6. How much did you weigh right before becoming pregnant? (E) ___ pounds

7. On average, during the three months before you got pregnant, how many days a week did you exercise for at least twenty-minutes (hard enough to cause heavy breathing) (E) ____ days

8. On average, during the three months before you got pregnant, how many nights a week did you get at least 7-hours of sleep? (E) ____nights

Section #4

1. Please describe your current healthcare/prenatal care insurance coverage: (E, S)
□ MediCal/MediCaid
□ City provided healthcare (e.g. Healthy San Francisco)
□ Private Insurance (e.g. Blue Cross, Anthem, Sutter, Kaiser)
□ TRICARE (military insurance)
□ Other, Please list the type of healthcare/prenatal care insurance coverage: _____
□ None

2. Do you have a current doctor or clinic that you usually go to for prenatal care? (E, S)
□ Yes
□ No

2a. Do you participate in group prenatal care? (E, S)
□ Yes
□ No

2b. In general do you trust your prenatal care provider? (E, S)
□ Rarely/never
□ Sometimes
□ Most of the time
□ Always

2c.Overall how happy/satisfied are you with the prenatal care you receive? (E, S)
□ Not at all happy/not at all satisfied
□ Somewhat happy/satisfied
□ Neutral/no opinion
□ Somewhat happy/satisfied
□ Satisfied

2d. How likely are you to refer your prenatal care provider to your close friends, coworker, or family member? (E, S)
□ Not at all likely
□ Somewhat unlikely
□ Neutral/no opinion
□ Somewhat likely
□ Very likely

2e. When did you have your first prenatal care appointment (if you don't know the exact date, please approximate)? (E) MMDDYYYY

2f. How many prenatal care appointments have you attended since becoming pregnant (including your first appointment)? (E, S) ____

Section #5

1. Did you receive treatment from a care provider to get pregnant (have infertility treatment)? (E)
□ Yes
□ No

1a. What type of treatment to get pregnant did you receive? (E)
□ Intrauterine insemination (IUI)
□ In vitro fertilization (IVF)
□ Other, What type of infertility treatment did you receive? _____

2. Were you breastfeeding one of your other children when you got pregnant? (E)
□ Yes
□ No

3. Were you using any birth control when you got pregnant? (E)
□ Yes
□ No

3a. What type of birth control were you using when you got pregnant? (E)
□ Condom
□ IUD
□ Depo-Provera (shot)
□ Oral contraceptive pill (the pill)
□ Nuva Ring
□ Patch
□ Implant under the skin
□ Withdrawal
□ Other, What other type of birth control were you using: _____

4. Thinking back to just before you got pregnant, how did you feel about getting pregnant? (E)
□ I wanted to get pregnant then
□ I wanted to get pregnant later
□ I didn't want to get pregnant then or in the future
□ I wasn't sure what I wanted

5. Before you got pregnant, did you typically get a period every month? (E)
□ Yes
□ No

6. Do you know the approximate date of your first ultrasound? (E, S)
□ Yes,
What is the date of your first ultrasound (if you don't know the exact date, please approximate)?
MMDDYY
□ No
□ I have not had an ultrasound

7. During your pregnancy so far, would you say that your health has been usually: (E)
□ Excellent □ Very Good
□ Good □ Fair
□ Poor

8. What is your current weight: (E, S) ____ pounds

9. Over the past month, on average, how many days a week have you exercised for at least twenty-minutes (hard enough to cause heavy breathing) since becoming pregnant? (E, S) ____ days

10. Over the past month, on average how many nights a week do you get at least 7-hours of sleep? (E, S) ____nights

11. Have any of the following been newly diagnosed SINCE becoming pregnant? (E, S)

	Yes	No
Gestational Diabetes	☐	☐
Gestational Hypertension/ High Blood Pressure	☐	☐
Preeclampsia (generally diagnosed as very high blood pressure and some risk of having a seizure)	☐	☐
Too much amniotic fluid (polyhydramnios)	☐	☐
Too little amniotic fluid (oligohydramnios)	☐	☐
Problems with your placenta (placental previa, placental abruption, placental accreta), Please describe: _____	☐	☐
Early (premature) rupture of the membranes (3 weeks or more before your expected due date (if known))	☐	☐
Early contractions/labor pains (3 weeks or more before your expected due date)	☐	☐
Asthma	☐	☐
Anemia (not sickle cell)	☐	☐
Sickle cell anemia		
Insomnia	☐	☐
Sleep Apnea	☐	☐
Allergies, Please describe: _____	☐	☐
Anxiety Disorder	☐	☐
Depression	☐	☐
Other diagnosed mental illness, Please describe: _____	☐	☐
Urinary Tract Infection	☐	☐
Other Infection, Please describe: _____	☐	☐
Other Medical Condition(s), Please describe: _____	☐	☐

12. Since becoming pregnant have you taken any prescription medication? (E, S)

☐ Yes

☐ No

How many prescription medications do you currently take (provide up to 5)?

What is the name of prescription medication #1?
Why did you take prescription medication #1?
What are the approximate dates of use of prescription medication #1 (if currently taking, do not enter end date)?

Start: MMDDYYYY End: MMDDYYYY

If you took additional medications, please describe:_____

13. Since becoming pregnant, have you taken any over the counter medication (do not include vitamins or herbal supplements)? (E, S)

□ Yes
□ No

13a. Did your prenatal provider or anyone else suggest that you take baby aspirin at any time during pregnancy? (E, S)

□ Yes
□ No

What was the reason for the recommendation to take baby aspirin? (E, S)_____

Are you currently taking baby aspirin? (E, S)

□ Yes
□ No

How often do you take baby aspirin? (E, S)

□ Daily
□ Sometimes but not daily

When did you begin taking aspirin? (E, S)

□ Prior to pregnancy
□ Between 3 to 4 months (12 to 15 weeks) of your pregnancy
□ After 3 to 4 months (12 to 15 weeks) of your pregnancy
□ I don't remember

13b. What type of other over the counter medications are you taking (check all that apply)? (E, S)

	Yes	No	Start date	End date
Tylenol	□	□		
Other pain reliever	□	□		
Allergy medication	□	□		
Cough medication	□	□		
Other over the counter medication, Please describe: _____	□	□		

14. Since becoming pregnant, have you taken or use any of the following*? (E, S)

**Reminder: All information is confidential and will not be shared with anyone outside of the study or be stored in the same computer location or file with your identifying information (name, birth date, address, email address, phone number).*

	Yes	No	How often?	How many?
Tobacco/cigarettes or vaping	□	□	□ Daily □ Weekly □ Monthly	□ 1 □ 2 – 4 □ 5 or more

			□ Less than once a month	
Alcohol	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more
Smoke Marijuana (e.g. pot, weed)	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more
Used marijuana (e.g. THC, CBD, edibles. Please do not include lotions, creams, or gels)	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more
Other Street Drug(s) (e.g. cocaine, methamphetamine, heroin, unprescribed pain killers, other), What type?: _____	□	□	□ Daily □ Weekly □ Monthly □ Less than once a month	□ 1 □ 2 – 4 □ 5 or more

15. Does any other person in your home use tobacco? (E, S)
□ Yes
□ No

16. Does any other person in your home smoke marijuana (e.g. pot, weed)? (E, S)
□ Yes
□ No

17. Does any other person in your home use other forms of marijuana (e.g. THC, CBD, edibles. Please do not include lotions, creams, or gels)? (E, S)
□ Yes
□ No

18. Does any other person in your home use a street drug (e.g. cocaine, methamphetamine, heroin, unprescribed pain killers, other) (E, S)
□ Yes, What type of street drug is used in your home? _____
□ No

19. Have you been receiving progesterone shots or any other treatments to prevent preterm labor? (E, S)
□ Yes
□ No

Have you been receiving (check all that apply):
□ Progesterone shots
□ Other treatment(s) to prevent preterm labor, please describe: _____

Section #6

Modifications to: Promoting Food Security for All Children. (Questions 1 and 2)

1. During your pregnancy to this point, how often was the following statement true: "We worried whether our food would run out before we got money to buy more." (E, S)
□ Often true
□ Sometimes true
□ Never true

2. During your pregnancy to this point, how often was the following statement true: "The food we bought just didn't last, and we didn't have money to get more." (E, S)
□ Often true
□ Sometimes true
□ Never true

3. During your pregnancy to this point, how often was the following statement true: "We worried whether our medicine would run out before we got money to buy more." (E, S)
□ Often true
□ Sometimes true
□ Never true

4. During your pregnancy to this point, how often was the following statement true: "The medicine we bought just didn't last, and we didn't have money to get more." (E, S)
□ Often true
□ Sometimes true
□ Never true

5. During your pregnancy to this point, how often was the following statement true: "My family and I worried about where we would sleep for the following month or about losing our housing." (E, S)
□ Often true
□ Sometimes true
□ Never true

6. Here are a few things that might happen to some people or their partners during pregnancy. Have any of these things happened to you during this pregnancy (Check all that apply)? (E, S)
□ I got separated or divorced from my partner
□ My partner or I were arrested or went to jail
□ Someone very close to me had a problem with drinking or drugs
□ A close family member was very sick and had to go to the hospital
□ I argued with my spouse or partner more than usual
□ I was physically hurt by my spouse, partner or a family member
□ I physically hurt my spouse, partner or a family member
□ I was in a physical fight
□ A close family member or friend was shot and killed by police.
□ A close family member or friend was shot and killed by someone other than the police.

7. Everyday Discrimination Scale (short version) (E, S)
Modification to: Everyday Discrimination Scale (short version) (question #7a)

> **7a. What do you think the main reasons are for these experiences (check all that apply)? (E, S)**
> □ Xenophobia
> □ Gender oppression

□ Racism
□ Ageism (older folks)
□ Adultism (younger folks)
□ Fat phobia
□ Sexism
□ Homo/trans phobia
□ Class exploitation
□ Colorism
□ Tribalism
□ Other, What other reason do you think for these experiences? _____

8. During pregnancy how satisfied have you been with the support given to you by the baby's father? (E, S)
□ Not at all satisfied
□ Somewhat dissatisfied
□ Somewhat satisfied
□ Very satisfied
□ Does not apply/ decline to state

9. Satisfaction With Life Scale (E, S)

10. Please list three things you enjoy doing to feel relaxed and feel good. (E, S)
#1 _____
#2 _____
#3 _____

11. Currently, how many times a week are you able to do at least one of these things? (E, S)
□ More than 5 times a week
□ 2 to 4 times a week
□ 1 time a week
□ < 1 time a week

12. Do you have any additional thoughts you would like to share with us about how satisfied you are or are not with your life and your ability to do the things you like to do to relax and feel good? (E, S)_____

13. Generalized Anxiety Disorder 7-item (GAD-7) scale (E, S)

13a. Do you have any additional thoughts you would like to share with us about any stress you are currently experiencing related to general life stressors? (E, S)_____

14. Perceived Stress Scale 4 (PSS-4) (E, S)

15. Do you have any additional thoughts you would like to share with us about any anxiety or fear you are currently experiencing related to your labor, delivery, or baby health? If so, please provide them in the box below. (E, S) _____

16. Pregnancy-Related Anxiety Scale (E, S)

17. Do you have any additional thoughts you would like to share with us about your current feelings of social connectedness? If so, please provide them in the box below. (E, S)_____

18. UCLA Loneliness Scale (E, S)

19. Do you have any additional thoughts you would like to share with us about your current feelings of social connectedness? If so, please provide them in the box below. (E, S)

20. Since becoming pregnant have you received any of the following services or information? Please check all that apply. (E, S)

	Yes	No
A class or classes to prepare for childbirth or parenting	□	□
A home visit to prepare for the new baby	□	□
Information, education, or support on infant feeding, lactation, donor human milk	□	□
Counseling for personal or family problems or for stress, depression, anxiety or any mental illness	□	□
Help from a social worker in the community, in a clinic or in the hospital	□	□
Help with stopping smoking	□	□
Help with an alcohol or drug problem	□	□
Help to reduce violence in my home	□	□
Reduce violence in health care, in society, at work, in my community	□	□
Mental health support for my worry, fear, anxiety, frustration, anger, stress, or sadness	□	□
Help from a lawyer or Legal Aid	□	□
Financial help (money)	□	□
Housing assistance (money or placement)	□	□
Food assistance (food or money from a food bank, shelter, WIC or food stamps)	□	□
Help or assistance from my church	□	□
Help from the Black Infant Health Program or other similar state or local program	□	□
Doula support to help me through my pregnancy and to prepare for birth of my baby	□	□

21. Interpersonal Support Evaluation List (E, S)

22. Do you have any additional thoughts you would like to share with us about your current feelings about interpersonal support from family or friends? (E, S) _____

23. The Brief Resilience Scale (E, S)

24. The Connor-Davidson 10-item Resilience Scale (CD-RISC-10) (E, S)

25. Do you have any additional thoughts you would like to share with us about your current feelings about how you deal with hard times, stressful events, and set-backs? (E, S) _____

<u>Section #7</u>

1. Have you had and SARS-COV-2/ or COVID-19 testing since the start of the pandemic? (E, S)

□ Yes

□ No

How many tests have you had? (E, S) _____

What were the dates of the tests (please approximate if you don't know the exact date) (provide up to 10)? (E, S)

Test #1 MMYYYY

Test #2 MMYYYY

Test #3 MMYYYY

What type of test(s) have you had? (check all that apply) (E, S)

□ Testing using a nasal swab for the actual virus

□ Antibody testing using a blood test

□ I had testing but not sure what type of testing

What was (were) the result of your testing (check all that apply) (E, S)

□ Positive

□ Negative

□ Not sure

Did you have symptoms? (E, S)

□ Yes

□ No

When did you symptoms begin (if you don't remember the exact date, please approximate)? (E, S) MMYYYY

Please check any of the following symptoms you experienced: (E, S)

	Yes	No	Start date	End date
Fever >100.4F (38C)c	□	□		
Subjective fever (felt feverish)	□	□		
Chills	□	□		
Repeated shaking with chills	□	□		
Muscle aches (myalgia)	□	□		
Runny nose (rhinorrhea)	□	□		
Sore throat	□	□		
Cough (new onset or worsening of chronic cough)	□	□		
Shortness of breath (dyspnea)	□	□		
Nausea or vomiting	□	□		
Headache	□	□		
Ageusia (loss of taste)	□	□		
Anosia (loss of smell)	□	□		
Abdominal pain	□	□		
Diarrhea (≥3 loose/looser than normal stools/24hr period)	□	□		
Pneumonia	□	□		
Acute respiratory distress syndrome	□	□		
Neurological symptoms, What type of neurologic symptoms did you experience? _____	□	□		
Other, What type of other symptoms did you experience? _____	□	□		

Did you have an abnormal chest X-ray? (E, S)
□ Yes
□ No
□ Unknown

Were you hospitalized? (E, S)
□ Yes
□ No, What other medical care did you receive related to your infection? _____

What day were you admitted to the hospital (if you don't remember, please approximate) (E, S)
MMDDYY

What day were you discharged from the hospital (if you don't remember, please approximate) (E, S) MMDDYY

Were you admitted to an intensive care unit (ICU)? (E, S)
□ Yes
□ No
□ Unknown

Did you receive mechanical ventilation/intubation? (E, S)
□ Yes, How many days you were on mechanical ventilation/intubation? ___
□ No
□ Unknown

Do you have any additional thoughts you would like to share with us about your experience with testing positive for SARS-COV-2/COVID-19 and about your related illness and treatment? (E, S)
_____

2. Has anyone in your immediate family/ person living in your household been diagnosed with SARS-COV-2 or COVID-19 since the start of the pandemic? (E, S)
□ Yes
□ No

What relationship to you is this person? (E, S)
*If more than one person was diagnosed you will be able to enter other records after this current record.
□ Spouse/ partner
□ Child
□ Parent
□ Other, Please describe the relationship with the other person: ____

What was the approximate date of first their positive test (E, S) MMDDYYYY

Did he/she have symptoms? (E, S)

□ Yes
□ No

When did the symptoms begin (if you don't remember the exact date, please approximate)? (E, S) MMYYYY

Please check any of the following symptoms that this person experienced: (E, S)

	Yes	No	Start date	End date
Fever >100.4F (38C)c	□	□		
Subjective fever (felt feverish)	□	□		
Chills	□	□		
Repeated shaking with chills	□	□		
Muscle aches (myalgia)	□	□		
Runny nose (rhinorrhea)	□	□		
Sore throat	□	□		
Cough (new onset or worsening of chronic cough)	□	□		
Shortness of breath (dyspnea)	□	□		
Nausea or vomiting	□	□		
Headache	□	□		
Ageusia (loss of taste)	□	□		
Anosia (loss of smell)	□	□		
Abdominal pain	□	□		
Diarrhea (≥3 loose/looser than normal stools/24hr period)	□	□		
Pneumonia	□	□		
Acute respiratory distress syndrome	□	□		
Neurological symptoms, What type of neurologic symptoms did they experience? ___	□	□		
Other, What type of other symptoms did they experience? ____	□	□		

Did this person receive an abnormal chest X-ray? (E, S)
□ Yes
□ No
□ Unknown

Did the person die as a result of this illness? (E, S)
□ Yes, What day did they die (if you don't remember, please approximate) MMDDYY
□ No

Was he/she hospitalized? (E, S)
□ Yes
□ No, What other medical care did they receive related to their infection? _____
□ Unknown

What day were they admitted to the hospital (if you don't remember, please approximate) (E, S) MMDDYY

What day were they discharged from the hospital (if you don't remember, please approximate. If they are still hospitalized, leave blank) (E, S) MMDDYY

If you had more than 3 family members diagnosed with SARS-COV-2/COVID-19, please list your relationship, the month and date of first illness (or indicate that they had no symptoms), whether they were hospitalized, and outcome of other family members diagnosed. (E, S) _____

Do you have any additional thoughts you would like to share with us about your experience with an immediate family member or person living in your household testing positive for SARS-COV-2/COVID-19 and about their related illness and treatment? If so, please provide them in the box below. (E, S) _____

2a. If not tested or had a negative SARS-COV-2 or COVID-19 test, have you experienced any of the following symptoms or been diagnosed with any of the following since becoming pregnant? (E, S)

	Yes	No	Start date	End date
Fever >100.4F (38C)c	□	□		
Subjective fever (felt feverish)	□	□		
Chills	□	□		
Repeated shaking with chills	□	□		
Muscle aches (myalgia)	□	□		
Runny nose (rhinorrhea)	□	□		
Sore throat	□	□		
Cough (new onset or worsening of chronic cough)	□	□		
Shortness of breath (dyspnea)	□	□		
Nausea or vomiting	□	□		
Headache	□	□		
Ageusia (loss of taste)	□	□		
Anosia (loss of smell)	□	□		
Abdominal pain	□	□		
Diarrhea (≥3 loose/looser than normal stools/24hr period)	□	□		
Pneumonia	□	□		
Acute respiratory distress syndrome	□	□		
Influenza (flu)	□	□		
Other symptom(s), What type of other symptoms did they experience?_____	□	□		

3. Since the COVID-19 outbreak, have you reduced the frequency in which you receive in-person prenatal care? (E, S)

□ Yes, completely stopped in-person care

□ Yes, reduced in-person care but still have some in-person appointments

□ No

4. Since the COVID-19 outbreak, have you used a video visit to talk to a healthcare provider? (E, S)

□ Yes

□ No

5. Since the COVID-19 outbreak have you used a phone visit to talk to a healthcare provider? (E, S)

□ Yes

□ No

6. Please indicate the extent to which you agree or disagree with the following statements as they relate to your prenatal care and the COVID-19 pandemic. (E, S)

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I prefer video visits with my prenatal care provider when possible.	□	□	□	□	□
I prefer phone visits with my prenatal care provider when possible.	□	□	□	□	□
I prefer in-person visits with my prenatal care provider when possible.	□	□	□	□	□
After the COVID-19 pandemic is over, I think it would be useful for more prenatal care visits to be done by video or by phone rather than in person.	□	□	□	□	□
After the COVID-19 pandemic is over, I think it would be useful for most prenatal visits to go back to being in person.	□	□	□	□	□
I feel like my prenatal care has been better than it would have been before the COVID-19 pandemic.	□	□	□	□	□

7-10. Michigan COVID-19 Pregnancy. (E, S)

11. In the space below, can you tell us more about how your birth plans been affected? How have your desires and plans for birth changed, and how have they remained the same? (E, S) _____

12. Please rate each of the following statements as they relate to how you currently feel about COVID-19. (E, S)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Because of COVID-19, I am worried about not having a support person with me during labor and delivery if I give birth in the hospital.	□	□	□	□	□
Because of COVID-19, I am worried about being be treated or viewed unfairly by hospital staff during labor and delivery because of my race or ethnic group.	□	□	□	□	□
Because of COVID-19, I have felt increased stress about food running out or being unavailable.	□	□	□	□	□
Because of COVID-19, I have felt increased stress about losing a job or decrease in family income.	□	□	□	□	□
Over the past few weeks, I have felt increased stress about myself, my baby, or someone in my family getting infected with COVID-19	□	□	□	□	□

13. Thinking back on the last week, have you experienced any of the following? (E, S)

	Yes	No	Start date	End date
Fever >100.4F (38C)c	□	□		
Subjective fever (felt feverish)	□	□		
Chills	□	□		
Repeated shaking with chills	□	□		

Muscle aches (myalgia)	□	□		
Runny nose (rhinorrhea)	□	□		
Sore throat	□	□		
Cough (new onset or worsening of chronic cough)	□	□		
Shortness of breath (dyspnea)	□	□		
Nausea or vomiting	□	□		
Headache	□	□		
Ageusia (loss of taste)	□	□		
Anosia (loss of smell)	□	□		
Abdominal pain	□	□		
Diarrhea (≥3 loose/looser than normal stools/24hr period)	□	□		

Did you seek medical care (by visit or call) for these symptoms? (E, S)

□ Yes

What did your provider recommend (including over the counter or prescription medications)?

_____

□ No

Why didn't you receive medical care? _____

14. Thinking back on the last week, have anyone living with you experienced any of the following? (E, S)

	Yes	No	Start date	End date
Fever >100.4F (38C)c	□	□		
Subjective fever (felt feverish)	□	□		
Chills	□	□		
Repeated shaking with chills	□	□		
Muscle aches (myalgia)	□	□		
Runny nose (rhinorrhea)	□	□		
Sore throat	□	□		
Cough (new onset or worsening of chronic cough)	□	□		
Shortness of breath (dyspnea)	□	□		
Nausea or vomiting	□	□		
Headache	□	□		
Ageusia (loss of taste)	□	□		
Anosia (loss of smell)	□	□		
Abdominal pain	□	□		
Diarrhea (≥3 loose/looser than normal stools/24hr period)	□	□		

Did he/she seek medical care (by visit or call) for these symptoms? (E, S)

□ Yes

What did his/her provider recommend (including over the counter or prescription medications)?

_____

□ No

Why didn't they receive medical care? _____

15. Are you currently sheltering at home/not working in the community? (E, S)

□ Yes

□ No

16. Are the other people in your household currently sheltering at home/not working in the community? (E, S)

□ Yes
□ No
□ Not relevant, I live alone

17. When you are out in the community or at work, how often do you wear a face mask? (E, S)

□ Never
□ Sometimes
□ Most of the time
□ Always
□ Not relevant, I don't go out in the community

When you are out in the community or at work, do you try and stay 6-feet away from people? (E, S)

□ Never
□ Sometimes
□ Most of the time
□ Always

18. Over the past week, on average how many other people have you been in contact with at less than 6-feet (do not include people you live with)? (E, S) _____

19. Have you or any members of your immediate or extended group of family or friends experienced any of the following as result of the COVID-19 pandemic? (E, S)

	Yes, Me	Yes, friends or family who live with me	Yes, family that does not live with me	Yes, friends who do not live with me	No
Job loss	□	□	□	□	□
Reduced hours at work	□	□	□	□	□
Inability to pay rent or mortgage	□	□	□	□	□
Eviction	□	□	□	□	□
Homelessness	□	□	□	□	□
Lack of available food	□	□	□	□	□
Lack of fresh food	□	□	□	□	□
Lack of sleep	□	□	□	□	□
Lack of sanitation products	□	□	□	□	□
Inability to wash/clean my hands or body regularly	□	□	□	□	□
Lack of available medicine	□	□	□	□	□
COVID-19 infection	□	□	□	□	□
COVID-19-related death	□	□	□	□	□

20. In the past month, how would you say your total household income has changed as a result of COVID-19? Would you say it's (E, S)

□ A lot less
□ Slightly less
□ Roughly the same
□ Slightly more
□ A lot more

21. Do you have any additional thoughts you would like to share with us about your current feelings about being pregnant at the time of the COVID19 pandemic? If so, please provide them in the box below. (E, S)

_____

22. We would like to ask you a few last some questions about how the epidemic might affect the choices you make. Suppose you bought a ticket before the epidemic to attend a live concert scheduled two weeks from now. The Governor lifts the ban on such concerts next week. Would you go to the concert? (E)

□ Yes
□ No

Suppose you get to the concert and discover the performance is worse than you expected. Would you leave? (E)

□ Yes
□ No

23. If ticket cost $200 would you go to the concert? (E)

□ Yes
□ No

Please provide us any input you may have about your experience with completing this survey in the box below. (E, S)_____