Supplemental Table 2. Postnatal survey (P = 6 – 8 week survey, B = 6 month, 12 month, and 18 month survey)

Section #1

1. When was your baby born? (P) MMDDYYYY

2. Is your baby alive now? (P, B)
□ Yes
□ No

2a. We are very sorry for your loss. On what day did your baby pass away? (P, B) MMDDYYY

2b. Are you aware of the reason for your baby's death? (P, B)
□ Yes
□ No
□ Decline to state

2c. Please describe the reason for your baby's death: (P, B) _____

2d. Are you aware of any complications with your pregnancy or any illness that may have contributed to your baby passing away? (P, B)
□ Yes
□ No
□ Decline to state

2e. Please describe the complications with your pregnancy or any illness that may have contributed to your baby passing away: (P, B) _____

3. How much did your baby weigh when born? (P) ____

4. How long was your baby when born? (P) _____

5. What was the circumference of your baby's head when s/he was born? (P) _____

6. Please verify what your due date was: (P) MMDDYYYY

7. Where did you give birth? (P)
□ In a hospital
□ In a birth center outside a hospital
□ At home
□ Other, Please describe: _____

8. After your baby was delivered, how long did s/he stay in the hospital or at the birth center? (P)
□ My baby was never 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 is still in the hospital

9. Do you feel/trust your baby is healthy? (P, B)
□ Yes
□ No

10. Do you think your baby is well or thriving and growing appropriately? (P, B)
□ Yes
□ No

11. I worry a lot about my baby. (P, B)
□ True, Please describe why you worry a lot about your baby: _____
□ False

12. Did your baby experience any of the following after birth or has s/he been diagnosed with any of the following conditions since birth? (After 6 – 8 week survey, this is phrased "since the last survey you completed") (P, B)

	Yes	No	Check if your baby was in the hospital when he/she this happened?	Check if your baby had to be admitted to the hospital because of the condition?	Start date	End date
Difficulty breathing, If yes, did he or s/he receive supplementary oxygen to help him/her breathe?_____	□	□	□	□		
Difficulties with digestion and processing food	□	□	□	□		
Seizure(s)	□	□	□	□		
Problems with sight	□	□	□	□		
Problems with hearing	□	□	□	□		
A physical abnormality (for example a heart or limb abnormality) Please describe: _____	□	□	□	□		
A chromosomal abnormality (for example Down syndrome) Please describe: _____	□	□	□	□		

Jaundice (too much bilirubin in his/her blood – often identified initially by yellowish skin color), If yes, did your baby receive light therapy for the jaundice? _____	□	□	□	□		
Vomiting	□	□	□	□		
Diarrhea	□	□	□	□		
Extreme lethargy or unresponsiveness	□	□	□	□		
Not able or willing to nurse or take a bottle	□	□	□	□		
Fever (at or above 38 degrees Celsius or 100.4 degrees Fahrenheit)	□	□	□	□		
Infection, Please describe: _____	□	□	□	□		
Other Medical Condition(s), Please describe: _____	□	□	□	□		

13. Has your baby received any prescription or over the counter medicines since being born? (After 6 – 8 week survey, this is phrased "since the last survey you completed") (P, B)

□ Yes

□ No

(provide for up to 5 medications)

What is the name of medication #1?

Why did he/she take medication #1?

What are the approximate dates of use of medication #1 (if currently taking, do not enter end date)?

Start: MMDDYYYY End: MMDDYYYY

14. Was your baby admitted to the neonatal intensive care unit (NICU) after birth? (P)

□ Yes

□ No

14a. Is your baby still receiving care in the NICU? (P)

□ Yes

□ No

What was the approximate date your baby was discharged from the NICU: MMDDYYYY

14b. Please rate your level of satisfaction with your NICU experience (P)

□ Very satisfied

□ Somewhat satisfied

□ Neutral

□ Somewhat dissatisfied

□ Very dissatisfied

14c. Modified Neonatal Satisfaction Survey (NSS-8)

14d. Is there any additional information you would like to share with us about your experiences with your baby while in the NICU? (P) _____

Section #2

For 6 – 8 weeks survey, Ages and Stages Questionnaire for 2 months

For 6 month survey, Ages and Stages Questionnaire for 6 months

For 12 month survey, Ages and Stages Questionnaire for 12 months

For 18 month survey, Ages and Stages Questionnaire for 18 months

Section #3

1. Overall how happy/satisfied are you with your labor and delivery experience? (P)
□ Not at all happy/not at all satisfied
□ Somewhat happy/satisfied
□ Neutral/no opinion
□ Somewhat happy/satisfied
□ Satisfied

2. In the space below, please describe why you answered the way you did in #1. (P) _____

3. Before you went to the hospital or birth center to have your baby (or before you had a home birth), did you go to the clinic, hospital or birth center because you thought you were going into labor? (P)
□ Yes
□ No

3a. What specifically was the reason you thought you were going into labor? (P) (check all that apply)
□ I felt contractions or something that felt like contractions
□ Strong pressure on my cervix/vagina
□ Clear fluid/ water-like discharge
□ Other, What other reason did you think you were going into labor?

3b. How did this visit resolve (P) (check all that apply)
□ I was told to go home, this was not "real" labor
□ I was given medications to stop contractions
□ I had a procedure done that they felt would help keep me from delivering
□ I was admitted to the hospital for monitoring and then discharged
□ Other, How else did this visit resolve? _____

3c. How many days after this visit or discharge did you have your baby? (P) ____ days

3d. Do you have any additional thoughts you would like to share with us about the experience? If so, please provide them in the box below. (P)_____

4. Before you went to the hospital or birth center to have your baby (or before you had a home birth), did you go to the clinic, hospital or birth center because you were worried about the baby and how s/he was doing? (P)

□ Yes
□ No

4a. Did you seek help or health care advice from a doula, midwife, or nurse before going to the hospital or birth center? (P)

□ Yes
□ No

4b. What specifically was the reason you were worried about your baby? (P) (check all that apply)

□ Increased baby kicking
□ Decreased baby kicking
□ Couldn't hear heartrate
□ Other, Please describe: _____

4c. How did this worry resolve (P) (check all that apply)

□ They did an ultrasound and said the baby was fine
□ They listened to the baby heart and said everything was fine
□ I was admitted to the hospital for baby monitoring and then discharged
□ Other, Please describe: _____

4d. How many days after this visit or discharge did you have your baby? (P) ____ days

4e. Do you have any additional thoughts you would like to share with us about the experience? If so, please provide them in the box below. (P)

<u>From CDC PRAMS version 8 standard and core questions (#5-7 (excluding 6d)</u>

5. How did the doctor, nurse, or other health care worker who provided your prenatal care suggest you deliver your new baby? Check one answer. (P)

□ He or she suggested I deliver my baby vaginally (naturally)
□ He or she suggested I have a cesarean delivery (c-section)
□ He or she didn't suggest how I deliver my baby

6. How was your new baby delivered? (P)

□ Vaginally
□ Cesarean delivery (c-section)

6a. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)? Please check one answer. (P)

□ My health care provider recommended a cesarean delivery before I went into labor
□ My health care provider recommended a cesarean delivery while I was in labor
□ I asked for the cesarean delivery

6b. What was the reason that your new baby was born by cesarean delivery (c-section)? Check all that apply. (P)

□ 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 pre-eclampsia, 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, what other reason was your new baby born by cesarean delivery (c-section)?
_____

6c. Did you plan or schedule a cesarean delivery (c-section) at least one week before your new baby was born? (P)

□ Yes
□ No

6d. Regarding the decision for you to have a cesarean delivery (c-section) did you (check all that apply): (P)

□ Agree with the recommendation to have a cesarean delivery
□ Have an opportunity to ask questions for more information
□ Understand the risks and benefits of the surgery
□ Feel you could speak up and against the recommendation without fear of retaliation or abuse from the health care provider or hospital

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

□ Yes
□ No

7a. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)? Check all that apply. (P)

□ 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 pre-eclampsia)
□ I wanted to schedule my delivery
□ I wanted to give birth with a specific health care provider
□ Other, What other reason was your labor was induced? _____

8. Where did you deliver your baby? (P)

□ Hospital/birth center, What is the name of the hospital/birth center?_____
□ Home
□ Other, What other location did you deliver your baby?_____

9. What health care providers was present at your delivery (check all that apply)? (P)

□ Doctor
□ Midwife
□ Doula
□ Nurse

10. Did the clinician use forceps or a vacuum to assist in the birth? (P)

□ No
□ Yes, forceps
□ Yes, vacuum
□ Yes, both forceps and vacuum

11. Do you have any additional thoughts you would like to share with us about your labor and delivery experience? If so, please provide them in the box below. (P)

Section #4

1. Were you offered consultation or support from a lactation (breastfeeding) education expert during (check all that apply): (P)

□ Pregnancy
□ Labor
□ Within 72 hours (3 days) of your birth
□ During 1 to 2 weeks after birth

2. Overall how happy/satisfied were you with your breastfeeding experience to date? (P, B)

□ Does not apply, not breastfeeding
□ Not at all happy/not at all satisfied

□ Somewhat happy/satisfied
□ Neutral/no opinion
□ Somewhat happy/satisfied
□ Satisfied

Modified from CDC PRAMS version 8 standard and core questions (questions 2a – 2c)

2a. What are your reasons for deciding not to breastfeed? Check all that apply. (P, B)

□ I have been sick or on medicine
□ I have other children to take care of
□ I have too many household duties
□ I didn't like breastfeeding
□ I tried but it was too hard
□ I don't want to
□ I went back to work
□ I went back to school
□ I met my breastfeeding goals
□ Other, for what other reason did you decide not to breastfeed? _____

2b. Did anyone suggest that you not breastfeed your new baby? Check all that apply (P, B)

□ No
□ My husband or partner
□ My mother, father, or in-laws
□ Other family member or relative
□ My friends
□ My baby's doctor, nurse, or other health care worker
□ My doctor, nurse, or other health care worker
□ Other, Who else suggested that you don't breastfeed? _____

2c. This question asks about things that may have happened at the hospital where your new baby was born related to breastfeeding. For each item, check No if it did not happen or Yes if it did. (P, B)

	Yes	No
Hospital staff gave me information about breastfeeding	□	□
My baby stayed in the same room with me at the hospital	□	□
I breastfed my baby in the hospital	□	□
Hospital staff helped me learn how to breastfeed	□	□
I breastfed in the first hour after my baby was born	□	□
My baby was placed in skin-to-skin contact within the first hour of life	□	□
My baby was fed only breast milk at the hospital	□	□
Hospital staff told me to breastfeed whenever my baby wanted	□	□
The hospital gave me a breast pump to use	□	□

The hospital gave me a gift pack with formula	□	□
The hospital gave me a telephone number to call for help with breastfeeding	□	□
Hospital staff gave my baby a pacifier	□	□

3. What statement best describes how much breastmilk and formula your baby currently drinks? (select one). (P, B)

□ Breastmilk only
□ Formula only, Please describe the reason you baby uses formula: _____
□ Breastmilk and formula, Please describe the reason you baby uses formula: _____

3a. Do you use any donor breastmilk? (P, B)
□ Yes, Please describe the reason you baby uses donor breastmilk: _____
□ No

3b. How long has he/she been donor breastmilk or formula? (P, B)
□ Since birth
□ 1 to 2 weeks
□ 3 to 4 weeks
□ More than 4 weeks

3c. How long do you hope to breastfeed? (P, B)
□ Until my baby is 3 months
□ Until my baby is 4-6 months
□ Until my baby is 7-12 months
□ Until my baby is more than 12 months
□ Not sure

4. Do you have any additional thoughts you would like to share with us about feeding your baby? If so, please provide them in the box below. (P, B)_____

<u>Section #5</u>

1. Overall how happy/satisfied are you with the prenatal care you received? (P)
□ Not at all happy/not at all satisfied
□ Somewhat happy/satisfied
□ Neutral/no opinion
□ Somewhat happy/satisfied
□ Satisfied
□ Does not apply, no prenatal care

1a. How likely are you to refer your prenatal care provider to your close friends, coworker, or family member? (P)
□ Not at all likely
□ Somewhat unlikely

□ Neutral/no opinion
□ Somewhat likely
□ Very likely

1b. How many prenatal care appointments did you attend while pregnant (including your first appointment)? (P) ___

2. What kind of places did you live in during your pregnancy (check all that apply)? (P)
□ 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_____
□ Decline to state

3. Overall, which one of the following best describes how well you are managing financially these days: (this is in the next section after the 6-8 week survey) (P, B)
□ Living comfortably
□ Doing okay
□ Just getting by
□ Finding it difficult to get by

4. 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? (this is in the next section after the 6-8 week survey) (P, B)
□ Much better off
□ Somewhat better off
□ About the same
□ Somewhat worse off
□ Much worse off

5. 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? (this is in the next section after the 6-8 week survey) (P, B)
□ Under $50
□ $50-$99
□ $100 to $199
□ $200 to $299
□ $300 to $399

□ Over $400

6. While pregnant, how many hours did you work a week at your job or jobs? (P, B)
□ None
□ < 20 hours
□ 20-40 hours
□ More than 40 hours

6a. During your pregnancy did you regularly have to do any of the following as a requirement of your job (check all that apply)? (P, B)
□ 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

6b. When did you stop working in anticipation of your delivery? (P, B)
□ Worked until I went into labor
□ Less than 1 week before
□ 1 week to one month before
□ Greater than 1 month before

6c. When did you return to work after delivery? (P, B)
□ I have not yet returned to work
□ < 6-weeks
□ 6-weeks to 3 months
□ Greater than 3 months
□ Not planning on working
□ Unknown

6d. Do you have any additional thoughts you would like to share with us about your employment situation while pregnant or since delivering. If so, please provide them in the box below. (P, B)

7. During your pregnancy, would you say that your health is generally: (this is in the next section after the 6-8 week survey) (P, B)
□ Excellent
□ Very Good
□ Good
□ Fair
□ Poor

8. Please describe why you feel this way: (P, B) _____ (this is in the next section after the 6-8 week survey)

9. What was your weight at the end of your pregnancy: (P) ____ pounds

10. During the last four weeks of your pregnancy, on average, how many days a week did you exercise for at least twenty-minutes (hard enough to cause heavy breathing)? (P)____ days per week

11. During the last four weeks of your pregnancy, on average how many nights a week do you get at least 7-hours of sleep? **(P)** ____nights per week

12. Were any of the following newly diagnosed WHILE pregnant? (P)

	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)	☐	☐

13. While pregnant did you take any prescription medication? (P)

□ Yes

□ No

How many prescription medications do you currently take?

Provide the below for up to 5 medications.

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: _____

14. While pregnant did you take any over the counter medication? (P)
□ Yes
□ No

15. Did your prenatal provider or anyone else suggest that you take baby aspirin at any time during pregnancy? (P)
□ Yes, What was the reason for the recommendation to take baby aspirin? _____
□ No

How often did you take baby aspirin? (P)
□ Daily
□ Sometimes but not daily

When did you begin taking aspirin? (P)
□ 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

15a. What type of over the counter medications did you take during pregnancy? (P)

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

16. While pregnant, did you take or use any of the following*? (P)
**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	□ 1

			□ Weekly □ Monthly □ Less than once a month	□ 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

16. Did any other person in your home use tobacco while you were pregnant? (P)
□ Yes
□ No

17. Did any other person in your home smoke marijuana (e.g. pot, weed) while you were pregnant? (P)
□ Yes
□ No

18. Did any other person in your home use other forms of marijuana (e.g. THC, CBD, edibles. Please do not include lotions, creams, or gels) while you were pregnant? (P)
□ Yes
□ No

19. Did any other person in your home use street drugs (e.g. cocaine, methamphetamine, heroin, unprescribed pain killers, other) while you were pregnant? (P)
□ Yes, What type of street drug was used in your home? _____
□ No

20. Did you receive progesterone shots or any other treatments to prevent preterm labor? (P)
□ Yes
□ No

Have you been receiving (check all that apply):
□ Progesterone shots
□ Other treatment(s) to prevent preterm labor, What type of other treatment have you received to prevent preterm labor? _____

21. Did you receive any of the following services or information? Please check all that apply. (P)

	Yes	No
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	□	□

22. Do you have any additional thoughts you would like to share with us about your health while pregnant? If so, please provide them in the box below. (P)

Section #6

1. Here are a few things that might happen to some people or their partners during pregnancy or shortly after delivery. Did any of these things happen to you while pregnant or since giving birth? (P)
□ I got separated or divorced from my partner
□ My partner or I was 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
□ I was homeless
□ I often did not have enough food to have three meals a day
□ I did not have the medicine I needed because it cost too much
□ None of the above

2. During pregnancy how satisfied were you with the support given to you by the baby's father? (P)
□ Not at all satisfied
□ Somewhat dissatisfied
□ Somewhat satisfied
□ Very satisfied
□ Does not apply/ decline to state

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

4. Currently, how many times a week are you able to do at least one of the things listed in #3? (P, B)
□ More than 5 times a week
□ 2 to 4 times a week
□ 1 time a week
□ Less than1 time a week

5. 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? If so, please provide them in the box below. (P, B)

6. Generalized Anxiety Disorder 7-item (GAD-7) scale (P, B)

6a. 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? (P, B)

7. <u>Perceived Stress Scale 4 (PSS-4)</u> (P, B)

8. 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? (P, B)____

9 – 18. Edinburgh Postnatal Depression Scale (P, B)

19. Since having your baby have you received any of the following services or information? Please check all that apply. (After 6 – 8 week survey, this is phrased "since the last survey you completed") (P, B)

	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	□	□

20. <u>Interpersonal Support Evaluation List</u> (P, B)*Please answer these questions in the context of there NOT being any stay at home or social distancing orders in place related to COVID-19.*

21. Do you have any additional thoughts you would like to share with us about your current feelings about interpersonal support from family or friends? If so, please provide them in the box below. (P, B)

<u>Section #7</u>

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

□ Yes

□ No

How many tests have you had? (P, B)

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

Test #1 MMYYYY

Test #2 MMYYYY

Test #3 MMYYYY

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

□ 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) (P, B)

□ Positive

□ Negative

□ Not sure

Did you have symptoms? (P, B)

□ Yes

□ No

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

Please check any of the following symptoms you experienced: (P, B)

	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? (P, B)
□ Yes
□ No
□ Unknown

Were you hospitalized? (P, B)
□ 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) (P, B)
MMDDYY

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

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

Did you receive mechanical ventilation/intubation? (P, B)
□ 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? (P, B)
_____

2. Has your baby been diagnosed with SARS-COV-2/ or COVID-19? (P, B)
□ Yes
□ No

If yes, approximate date(s) of first positive test (P, B) MMYYYY

If yes, do you know what type of test he/she had? (check all that apply) (P, B)
□ Yes, testing using a nasal swab for the actual virus
□ Yes, antibody testing using a blood test
□ He/she had testing but not sure what type of testing

Did he/she have symptoms? (P, B)
□ Yes
□ No

When did the symptoms begin (if you don't remember the exact date, please approximate)? (P, B)

MMYYYY

When did the symptoms end (if you don't remember the exact date, please approximate)? (P, B) MMYYYY

Please check any of the following symptoms that your baby experienced: (P, B)

	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	□	□		
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 your baby receive an abnormal chest X-ray? (P, B)

□ Yes

□ No

□ Unknown

Was he/she for this illness hospitalized? (P, B)

□ Yes

□ No

□ Unknown

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

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

Was your baby admitted to an intensive care unit (ICU)? (P, B)

□ Yes

□ No

□ Unknown

Did your baby receive mechanical ventilation/intubation? (P, B)

□ Yes, How many days was your baby on mechanical ventilation/intubation? ___

□ No

□ Unknown

What other medical care did your baby receive related to his/her infection? Please describe in the box below. (P, B)

Do you have any additional thoughts you would like to share with us about your experience with your baby testing positive for SARS-COV-2/COVID-19 and about their related illness and treatment? If so, please provide them in the box below. (P, B)

3. 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? (P, B)

□ Yes

□ No

What relationship to you is this person? **(P, B)**

*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 (P, B) MMDDYYYY

Did he/she have symptoms? (P, B)

□ Yes

□ No

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

Please check any of the following symptoms that this person experienced: (P, B)

	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? (P, B)

□ Yes

□ No

□ Unknown

Did the person die as a result of this illness? (P, B)

□ Yes, What day did they die (if you don't remember, please approximate) MMDDYY

□ No

Was he/she hospitalized? (P, B)

□ 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) (P, B) MMDDYY

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

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. (P, B) _____

3a. 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? (P, B)

	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?_____	□	□		

4. Since the COVID-19 outbreak, has the frequency in which you receive in-person pediatric care been reduced? (P, B)

□ Yes, completely stopped in-person care

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

□ No

5. Since the COVID-19 outbreak have you talked to a healthcare provider about your child by video conference? (P, B)

□ Yes

□ No

6. Since the COVID-19 outbreak have you talked to a healthcare provider about your child by phone? (P, B)

□ Yes

□ No

7. Please indicate the extent to which you agree or disagree with the following statements as they relate to pediatric care and the COVID-19 pandemic. (P, B)

	Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
I prefer video visits with infant's provider when possible.	□	□	□	□	□
I prefer phone visits with my infant's care provider when possible.	□	□	□	□	□
I prefer in-person visits with my infant's pediatric care provider when possible.	□	□	□	□	□
After the COVID-19 pandemic is over, I think it would be useful for more pediatric 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 pediatric visits to go back to being in person.	□	□	□	□	□

I feel like my infant's pediatric care has been better than it would have been before the COVID-19 pandemic	□	□	□	□	□

Modified from Michigan COVID-19 Pregnancy (question 8)

8. Now we would like you to think about your level of anxiety about having a baby during the COVID-19 pandemic on a scale of 1 to 10, with 1 being not at all anxious, and 10 being extremely anxious. (P, B)

	1 5 10
Anxiety about having a baby during COVID-19 outbreak	

9. In the space below, can you take a minute to explain your answer? What makes you the most anxious? What keeps you from being anxious? (P, B)

10. Thinking back on the last week, have you experienced any of the following? (P, B)

	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? (P, B)

□ Yes

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

_____

□ No

Why didn't you receive medical care? _____

11. Thinking back on the last week, have anyone living with you experienced any of the following? (P, B)

	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? (P, B)

□ Yes

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

_____

□ No

Why didn't they receive medical care? _____

12. Are you currently sheltering at home/not working in the community? (P, B)

□ Yes

□ No

13. Are the other people in your household currently sheltering at home/not working in the community? (P, B)

□ Yes

□ No

□ Not relevant, I live alone

14. When you are out in the community or at work, how often do you wear a face mask? (P, B)

□ Never

□ Sometimes

□ Most of the time

□ Always

□ Not relevant, I don't go out in the community

14a. When you are out in the community or at work, do you try and stay 6-feet away from people? (P, B)

□ Never

□ Sometimes

□ Most of the time

□ Always

15. 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)? (P, B)

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

	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	□	□	□	□	□

17. 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 (P, B)

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

18. Do you have any additional thoughts you would like to share with us about your current feelings about having a baby at the time of the COVID19 pandemic? If so, please provide them in the box below. (P, B)

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