



PRAMS VIII

**Oklahoma Pregnancy
Risk Assessment
Monitoring System**

A survey of the
health of mothers
and babies.

What is PRAMS?

PRAMS is a survey that asks mothers about their health and pregnancy experiences. More than 40 states all across the United States participate in PRAMS.

What does PRAMS do with the information?

- Help doctors and nurses improve health care
- Help mothers learn more about health during pregnancy
- Develop health programs and policies to make better use of resources

How was I chosen for the PRAMS survey?

Your name was randomly picked by computer from the Oklahoma Birth Certificate registry. Only one of 25 new mothers is chosen to be in the survey.

Every mother has a chance to be selected, no matter what her pregnancy was like.

Are my answers kept private?

Yes! No one outside the PRAMS staff will know your name or address. Your survey is separated from your name and coded by a number, so your name and address are not linked to your answers.

We follow very strict rules about privacy and confidentiality.

Are my answers really important?

Yes, very important!

Every mother has unique experiences. PRAMS mothers provide a complete overall picture of the health of mothers and babies in Oklahoma.

No matter what your pregnancy was like, your answers are very important.

By sharing your pregnancy and birth story with us, you can help other mothers and babies in Oklahoma.

What can I do to help?

Please answer the questions in the survey and mail it back in the pre-paid envelope. You will receive thank-you items for your time.

What if I want to know more?

If you have questions or would like to answer over the phone, call toll free 1-800-766-2223 or 271-6761 in Oklahoma City or visit www.health.ok.gov – keyword “PRAMS”

What women who answer the survey say about PRAMS:

“I hope my answers will help other mothers to know they are not alone.”

“If I could do just one thing to save babies, I would do anything it takes!”

“Thank you for asking me for my opinion.”

“Thank you for your efforts to help mothers and babies. And thank you for choosing me.”

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

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

4. During the 3 months before you got pregnant with your new baby, did you have any of the following health conditions? For each one, check **No** if you did not have the condition or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes (not gestational diabetes or diabetes that starts during pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Anemia (poor blood, low iron)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Heart problems | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| h. PCOS (polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> |

5. 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

6. In the 12 months before you got pregnant with your new baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?

- No → **Go to Question 9**
- Yes

7. What type of health care visit did you have in the 12 months before you got pregnant with your new baby?

Check ALL that apply

- Regular checkup at my family doctor's office
- Regular checkup at my OB/GYN's office
- Visit for an illness or chronic condition
- Visit for an injury
- Visit for family planning or birth control
- Visit for depression or anxiety
- Visit to have my teeth cleaned by a dentist or dental hygienist
- Other → Please tell us:

8. During any of your health care visits in the 12 months before you got pregnant, did a doctor, nurse, or other health care worker do any of the following things?

For each item, check **No** if they did not or **Yes** if they did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Talk to me about how I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about your *health insurance coverage before, during, and after your pregnancy with your new baby.*

9. 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 or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid or SoonerCare
- SoonerPlan
- TRICARE or other military health care
- Indian Health Service or tribal
- Other health insurance → Please tell us:

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

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

Check ALL that apply

- I did not go for prenatal care → **Go to Question 11**
- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid or SoonerCare
- TRICARE or other military health care
- Indian Health Service or tribal
- Other health insurance → Please tell us:

- I did not have any health insurance for my *prenatal care*

11. 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 or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid or SoonerCare
- SoonerPlan
- TRICARE or other military health care
- Indian Health Service or tribal
- Other health insurance → Please tell us:

- I do not have health insurance *now*

12. 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

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

- No
- Yes

Go to Question 15

14. 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 having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- No
- Yes

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.)

15. How many weeks or months pregnant were you when you were *sure* you were pregnant? For example, you had a pregnancy test or a doctor, nurse, or other health care worker said you were pregnant.

Weeks OR Months

- I don't remember

16. How many weeks or months pregnant were you when you had your first visit for prenatal care?

Weeks OR Months

- I didn't go for prenatal care

Go to Question 18

Go to Question 17

17. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the things listed below? For each item, check **No** if they did not ask you about it or **Yes** if they did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. If I knew how much weight I should gain during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If I was taking any prescription medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. If I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was using drugs such as marijuana, cocaine, crack, or meth | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I wanted to be tested for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I planned to breastfeed my new baby..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If I planned to use birth control after my baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

18. 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

19. During the 12 months before the delivery of your new baby, did you get a flu shot?

Check ONE answer

- No
 Yes, before my pregnancy
 Yes, during my pregnancy

20. During your most recent pregnancy, did you get a Tdap shot or vaccination?

A Tdap vaccination is a tetanus booster shot that also protects against pertussis (whooping cough).

- No
 Yes
 I don't know

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

- No
 Yes

22. During your most recent pregnancy, 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. Gestational diabetes (diabetes that started during <i>this</i> pregnancy)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that started during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression..... | <input type="checkbox"/> | <input type="checkbox"/> |

23. 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. Vaginal bleeding..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Kidney or bladder (urinary tract) infection (UTI)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Severe nausea, vomiting, or dehydration that sent me to the doctor or hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Problems with the placenta (such as abruptio placentae or placenta previa)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. 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).

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

- No → **Go to Question 28**

Yes ↓

25. In the 3 months before you got pregnant, how many cigarettes did you smoke on an average day? 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

26. 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

27. 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 using other tobacco products around the time of pregnancy.

E-cigarettes (electronic cigarettes) and other electronic nicotine products (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.

A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

28. Have you used any of the following products in the *past 2 years*? For each item, check **No** if you did not use it or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. E-cigarettes or other electronic nicotine products | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hookah | <input type="checkbox"/> | <input type="checkbox"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 29. Otherwise, go to Question 31.

29. During the *3 months before* you got pregnant, on average, how often did you use e-cigarettes or other electronic nicotine products?

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

30. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes or other electronic nicotine products?

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

The next questions are about drinking alcohol around the time of pregnancy.

31. 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 Page 8, Question 34**
- Yes

32. 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
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then → **Go to Page 8, Question 34**

Go to Page 8, Question 33

33. 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

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

34. 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. My husband or partner lost their job
- e. I lost my job even though I wanted to go on working
- f. I was apart from my husband or partner due to military deployment or extended work-related travel
- g. I argued with my husband or partner more than usual
- h. My husband or partner said they didn't want me to be pregnant
- i. I had problems paying the rent, mortgage, or other bills.....
- j. My husband, partner, or I went to jail
- k. Someone very close to me had a problem with drinking or drugs.....
- l. Someone very close to me died.....

35. In the 12 months *before* you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

- | | No | Yes |
|--------------------------------------|--------------------------|--------------------------|
| a. My husband or partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner | <input type="checkbox"/> | <input type="checkbox"/> |

36. During your most *recent* pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

- | | No | Yes |
|--------------------------------------|--------------------------|--------------------------|
| a. My husband or partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

37. When was your new baby born?

<input style="width: 40px; height: 25px; border: 1px solid black;" type="text"/> / <input style="width: 40px; height: 25px; border: 1px solid black;" type="text"/> / <input style="width: 60px; height: 25px; border: 1px solid black; text-align: center;" type="text" value="20"/>
<div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>

38. 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 41**

39. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 11, Question 52**

40. Is your baby living with you now?

- No → **Go to Page 11, Question 52**
- Yes

41. Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources? For each one, check **No** if you did not receive information from this source or **Yes** if you did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. My doctor | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A nurse, midwife, or doula | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A breastfeeding or lactation specialist | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My baby's doctor or health care provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A breastfeeding support group | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A breastfeeding hotline or toll-free number..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Family or friends..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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

No → **Go to Question 47**

Yes

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

No

Yes → **Go to Question 45**

44. How many weeks or months did you breastfeed or feed pumped milk to your baby?

Less than 1 week

Weeks **OR** Months

If your baby was not born in a hospital, go to Question 46.

45. 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.

No Yes

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

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

If your baby is still in the hospital, go to Question 52.

47. 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

48. In the *past 2 weeks*, how often has your new baby slept alone in his or her own crib or bed?

- Always
- Often
- Sometimes
- Rarely
- Never → **Go to Question 50**

49. When your new baby sleeps alone, is his or her crib or bed in the same room where *you* sleep?

- No
- Yes

50. Listed below are some more things about how babies sleep. How did your new baby usually sleep in the past 2 weeks?

For each item, check **No** if your baby did not usually sleep like this or **Yes** if he or she did.

No Yes

- a. In a crib, bassinet, or pack and play...
- b. On a twin or larger mattress or bed...
- c. On a couch, sofa, or armchair.....
- d. In an infant car seat or swing
- e. In a sleeping sack or wearable blanket.....
- f. With a blanket.....
- g. With toys, cushions, or pillows, including nursing pillows
- h. With crib bumper pads (mesh or non-mesh).....

51. Did a doctor, nurse, or other health care worker tell you any of the following things? For each thing, check **No** if they did not tell you or **Yes** if they did.

No Yes

- a. Place my baby on his or her back to sleep
- b. Place my baby to sleep in a crib, bassinet, or pack and play
- c. Place my baby's crib or bed in my room
- d. What things should and should not go in bed with my baby

52. 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 having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

No

Yes →

Go to Page 12, Question 54

53. 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 want to get pregnant
- I am pregnant now
- I had my tubes tied or blocked
- I don't want to use birth control
- I am worried about side effects from birth control
- I am not having sex
- My husband or partner doesn't want to use anything
- I have problems paying for birth control
- Other → Please tell us:

If you or your husband or partner is not doing anything to keep from getting pregnant *now*, go to Question 55.

54. 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 or Essure®)
- Vasectomy (male sterilization)
- Birth control pills
- Condoms
- Shots or injections (Depo-Provera®)
- Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
- Contraceptive implant in the arm (Nexplanon® or Implanon®)
- Natural family planning (including rhythm method)
- Withdrawal (pulling out)
- Not having sex (abstinence)
- Other _____ → Please tell us:

55. 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 → **Go to Question 57**
- Yes

56. During your postpartum checkup, did a doctor, nurse, or other health care worker do any of the following things?

For each item, check **No** if they did not do it or **Yes** if they did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about healthy eating, exercise, and losing weight gained during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about how long to wait before getting pregnant again | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about birth control methods I can use after giving birth.. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®).. | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Ask me if I was smoking cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if I was feeling down or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Test me for diabetes | <input type="checkbox"/> | <input type="checkbox"/> |

57. *Since your new baby was born, have you had any medical problems that caused you to go to the hospital and stay overnight?*

No → **Go to Question 59**

Yes
↓

58. *What kind of medical problem caused you to go into the hospital?*

Check ALL that apply

- Vaginal bleeding
 Fever or infection
 High blood pressure (hypertension)
 Other → Please tell us:

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

- Always
 Often
 Sometimes
 Rarely
 Never

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

- Always
 Often
 Sometimes
 Rarely
 Never

OTHER EXPERIENCES

The next questions are on a variety of topics.

61. *During your most recent pregnancy, did you take or use any of the following pain relievers for any reason?* For each item, check **No** if you did not use it or **Yes** if you did.

No Yes

- a. Over-the-counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve®
- b. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine

If your baby is not alive, is not living with you, or is still in the hospital, go to Page 14, Question 65.

62. *Since you delivered your new baby, would you have the kinds of help listed below if you needed them?* For each one, check **No** if you would not have it or **Yes** if you would.

No Yes

- a. Someone to loan me \$50.....
- b. Someone to help me if I were sick and needed to be in bed.....
- c. Someone to talk with about my problems.....
- d. Someone to take care of my baby.....
- e. Someone to help me if I were tired and feeling frustrated with my new baby.....

63. Do you have someone you think of as your baby's personal doctor or nurse?

A personal doctor or nurse is a health professional who knows your baby well and is familiar with your baby's health history. (This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant.)

 No

 Yes → **Go to Question 65**
 Yes
64. Can you contact your baby's personal doctor or nurse 24-hours a day, seven days a week?

Please include after-hours paging service or other ways to reach your health care provider after hours.

 No

 Yes
65. When your *first* child was born, how old were you?

Years old

The last questions are about the time during the 12 months before your new baby was born.**66. 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 \$16,000
- \$16,001 to \$20,000
- \$20,001 to \$24,000
- \$24,001 to \$28,000
- \$28,001 to \$32,000
- \$32,001 to \$40,000
- \$40,001 to \$48,000
- \$48,001 to \$57,000
- \$57,001 to \$60,000
- \$60,001 to \$73,000
- \$73,001 to \$85,000
- \$85,001 or more

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

People

68. What is today's date?
 / / 20

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 Oklahoma.

Thanks for answering our questions!

Your answers will help us work to keep mothers and babies in Oklahoma healthy.



Preparing
for a
Lifetime

It's Everyone's Responsibility

Oklahoma State Department of Health
OPRAMS/MCH - 0311
1000 NE 10TH Street
Oklahoma City, OK 73117-1207



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