

Cell Phone and Computer Use

Do you currently own a cell phone?

- Yes No, but I share or have access to a cell phone No

Is the cell phone that you own or use a smartphone?

(A mobile phone that offers functions that are normally found on a computer. Examples: iPhone, Android, Blackberry, Nexus One, Sidekick, treo, Palm.)

- Yes No

How often do you send or receive text messages on a cell phone?

- Never or hardly ever
 A few times a month
 A few times a week
 A couple of times a day
 Many times a day

Previous

Next

Finish Later

Cell Phone and Computer Use

How often do you access the internet from your home?

Never Less than once a week A few times a week Most days of the week Everyday

What type of device(s) do you use to access the internet? (*Check ALL that apply*)

- A computer in my home A computer where I work
 A public computer (at library, café etc.) A mobile phone
 Other (iPod, family/friend's computer etc.)

Please list:

Do you receive e-mails, text messages or other information that relates to being a new mother from the following websites, phone applications or text messaging systems?

Please check ALL that apply:

- Americanpregnancy.org Babycenter.com
 Babyfit.com iPregnancy
 La Leche League (LLLUSA.org) Pampers.com
 Parenting.com Parents.com
 Pregnancy.org Text4Baby
 TheBump.com WebMD.com
 Whattoexpect.com Any other websites or phone applications related to being a new mom
 None

Please list:

Previous

Next

Finish Later

Your Eating Patterns

This section asks about the way you are eating now.

I feel my eating habits right now are

- Very healthy
- Need some improvement
- Unhealthy

How has the amount of food you eat now changed compared to when you were pregnant?

Eat a lot more food Eat a little more food About the same Eat a little less food Eat a lot less food

How would you describe your appetite now, compared to when you were pregnant?

A lot more hungry A little more hungry About the same A little less hungry A lot less hungry

How many servings of fruits and vegetables (not including juice) do you eat per day?
(serving=1/2 cup or 1 medium piece)

Less than one a day One or two a day Three or four a day Five a day or more

How often have you been taking a vitamin or mineral supplement since your baby was born?

Never Once a week or less 2-3 times a week 4-6 times a week Everyday

Previous

Next

Finish Later

Sugar-Sweetened Beverage Consumption

Over the past 30 days, how often did you drink soda or pop?

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

How often were these sodas or pop diet or sugar-free?

- Almost never or never
- About 1/4 of the time
- About 1/2 the time
- About 3/4 of the time
- Almost always or always

[Previous](#)

[Next](#)

[Finish Later](#)

Sugar-Sweetened Beverage Consumption

Over the past 30 days, how often did you drink fruit drinks? Please do not include 100% juice beverages like orange juice, but do include drinks such as cranberry cocktail, Hi-C, lemonade, or Kool-Aid, diet or regular.

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

How often were your fruit drinks diet or sugar-free drinks?

- Almost never or never
- About 1/4 of the time
- About 1/2 of the time
- About 3/4 of the time
- Almost always or always

Previous

Next

Finish Later

Sugar-Sweetened Beverage Consumption

Over the past 30 days, how often did you drink sports drinks (such as Propel, PowerAde, or Gatorade)?

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

Over the past 30 days, how often did you drink energy drinks (such as Red Bull or Jolt)?

- NEVER
- 1 time per month or less
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2-3 times per day
- 4-5 times per day
- 6 or more times per day

Previous

Next

Finish Later

Eating Away from Home

Over the past 30 days, how many times did you buy food at a fast food restaurant, such as McDonald's, Burger King, Arby's, Wendy's, Taco Bell, Chipotle, KFC, Pizza Hut, Panera, Subway, Quiznos?

- Never or rarely
- 1 time per month
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2 times per day
- 3 or more times per day

Not including the fast food restaurants listed above, in the past 30 days, how many times did you buy food at any other sit down (full service) restaurant and order from a waiter/waitress?

- Never or rarely
- 1 time per month
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2 times per day
- 3 or more times per day

Previous

Next

Finish Later

Eating Away from Home

Over the past 30 days, how many times did you buy food from an all-you-can-eat buffet, such as Golden Corral, CiCi's Pizza, Sweet Tomatoes, Old Country Buffet, Grand Super Buffet, China Buffet, all-you-can-eat café at college or university dining halls?

- Never or rarely
- 1 time per month
- 2-3 times per month
- 1-2 times per week
- 3-4 times per week
- 5-6 times per week
- 1 time per day
- 2 times per day
- 3 or more times per day

Over the past week, how many times did you eat the following meals that were prepared in your home or in the place where you live? (Fill in the number of days for each meal)

Breakfast days per week
Lunch days per week
Dinner days per week

Previous

Next

Finish Later

Daily Meal Patterns

In a *typical week*, how many times do you (count an eating occasion in only one row):

	0 times	1-2 times	3-4 times	5-6 times	7 times
Eat breakfast	<input type="radio"/>				
Eat mid-morning snack	<input type="radio"/>				
Eat lunch	<input type="radio"/>				
Eat mid-afternoon snack	<input type="radio"/>				
Eat dinner	<input type="radio"/>				
Eat evening snack	<input type="radio"/>				
Eat within an hour of bedtime	<input type="radio"/>				

Previous

Next

Finish Later

Meals and Eating

Are you the main person to plan the meals for your household?

Yes No

How many adults and children eat at your home on a regular basis?

of adults (count yourself)

of children

Please rate how confident you are that you can do these things consistently for the next six months

	I know I cannot	I probably cannot	Not sure	I probably can	I know I can
Plan healthy meals daily for you and your family.	<input type="radio"/>				
Plan meals that include baking, grilling, stir-frying, roasting, stewing or steaming foods instead of frying.	<input type="radio"/>				
Plan new meals using leftovers.	<input type="radio"/>				
Plan meals with basic ingredients such as fresh/frozen vegetables, raw meats, whole grains.	<input type="radio"/>				

Please rate how much you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I think planning a healthy meal is easy.	<input type="radio"/>				
I do not like to cook because it takes too much time.	<input type="radio"/>				
Meal planning is frustrating.	<input type="radio"/>				
It is too much work to plan meals.	<input type="radio"/>				
I find planning meals in advance to be tiring.	<input type="radio"/>				
I think planning a healthy meal is something I can do.	<input type="radio"/>				

Previous

Next

Finish Later

Feelings About Eating

The next part includes some statements on how sure you feel about being able to eat in healthy ways.

How much do you want to make changes in your eating habits?

0 1 2 3 4 5 6

Not at All Completely Change My Eating

For the next sections, select the answer which is closest to how you feel about each statement.

How sure are you that you will be able to avoid overeating.

	Very sure	Somewhat sure	Neither sure nor unsure	Somewhat unsure	Very unsure
When you are stressed...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you have cravings...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you are at parties...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you feel your life is out of control...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Feelings About Eating

How sure are you that you will be able to eat a healthy diet.

	Very sure	Somewhat sure	Neither sure nor unsure	Somewhat unsure	Very unsure
When you are busy...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When cooking takes a lot of effort...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When others around you eat unhealthy foods...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you are in a bad mood...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When eating out...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Feelings About Eating

Please choose a response that best expresses how well each statement describes you.

This describes me...	Not at all	Slightly	More or less	Pretty well	Completely
I purposefully hold back at meals to not gain weight ...	<input type="radio"/>				
I tend to eat more when I am anxious, worried, or tense ...	<input type="radio"/>				
I count calories as a conscious means of controlling my weight ...	<input type="radio"/>				
When I feel lonely I console myself by eating ...	<input type="radio"/>				
I tend to eat more food than usual when I have more available places that serve or sell food ...	<input type="radio"/>				
I tend to eat when I am disappointed or feel let down ...	<input type="radio"/>				
I often refuse foods or drinks offered because I am concerned about my weight ...	<input type="radio"/>				
If I see others eating, I have a strong desire to eat too ...	<input type="radio"/>				

Please choose a response that best expresses how well each statement describes you.

This describes me...	Not at all	Slightly	More or less	Pretty well	Completely
Some foods taste so good I eat more even when I am no longer hungry ...	<input type="radio"/>				
When I have eaten too much during the day, I will often eat less than usual on the following day ...	<input type="radio"/>				
I often eat so quickly I don't notice I'm full until I've eaten too much ...	<input type="radio"/>				
If I eat more than usual during a meal, I try to make up for it at another meal ...	<input type="radio"/>				
When I'm offered delicious food, it's hard to resist eating it even if I've just eaten ...	<input type="radio"/>				
I eat more when I'm having relationship problems ...	<input type="radio"/>				
When I'm under a lot of stress, I eat more than I usually do ...	<input type="radio"/>				
When I know I'll be eating a big meal during the day, I try to make up for it by eating less before or after that meal ...	<input type="radio"/>				

Previous

Next

Finish Later

Physical Activity

During the past 30 days, when you are NOT at work, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 1 hour per day	1 to almost 2 hours per day	2 to almost 3 hours per day	3 or more hours per day
Preparing meals (cook, set table, wash dishes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing, bathing, feeding children while you are <u>sitting</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing, bathing, feeding children while you are <u>standing</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Playing with children while you are <u>sitting or standing</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Playing with children while you are <u>walking or running</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carrying children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking care of an older adult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and using a computer or writing, while <u>not</u> at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past 30 days, when you are NOT at work, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 2 hours per day	2 to almost 4 hours per day	4 to almost 6 hours per day	6 or more hours per day
Watching TV or a video	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and reading, talking, or on the phone, while <u>not</u> at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Physical Activity

During the past 30 days, when you are NOT at work, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 1 hour per day	1 to almost 2 hours per day	2 to almost 3 hours per day	3 or more hours per day
Playing with pets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Light cleaning (make beds, laundry, iron, put things away)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping (for food, clothes, or other items)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past 30 days, when you are NOT at work, how much time during the week do you usually spend:

	None	Less than 1/2 hour per week	1/2 to almost 1 hour per week	1 to almost 2 hours per week	2 to almost 3 hours per week	3 or more hours per week
Heavier cleaning (vacuum, mop, sweep, wash windows)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mowing lawn while on a riding mower	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mowing lawn using a walking mower, raking, gardening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Physical Activity

Going Places...

During the past 30 days, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 1 hour per day	1 to almost 2 hours per day	2 to almost 3 hours per day	3 or more hours per day
Walking <u>slowly</u> to go places (such as to the bus, work, visiting) <u>Not</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>quickly</u> to go places (such as to the bus, work, or school) <u>Not</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving or riding in a car or bus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For Fun or Exercise...

During the past 30 days, how much time during the week do you usually spend:

	None	Less than 1/2 hour per week	1/2 to almost 1 hour per week	1 to almost 2 hours per week	2 to almost 3 hours per week	3 or more hours per week
Walking <u>slowly</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking more <u>quickly</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>quickly up hills</u> for fun or exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jogging	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swimming	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dancing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doing other things for fun or exercise? - Other activity 1:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doing other things for fun or exercise? - Other activity 2:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Physical Activity

At Work...

Do you work for wages, as a volunteer, or are you a student?

Yes No

During the past 30 days, how much time during the day do you usually spend:

	None	Less than 1/2 hour per day	1/2 to almost 2 hours per day	2 to almost 4 hours per day	4 to almost 6 hours per day	6 or more hours per day
Sitting at work or in class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing or slowly walking at work while carrying things (heavier than a 1 gallon milk jug)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing or <u>slowly</u> walking at work <u>not</u> carrying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>quickly</u> at work while <u>carrying</u> things (heavier than a 1 gallon milk jug)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>quickly</u> at work <u>not</u> carrying anything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Physical Activity

Please tell us about your physical activity. It is very important that you tell us about yourself honestly. There are no right or wrong answers. We just want to know about the things you have been doing in the last month.

How often did you do physical activity that makes your heart and breathing rate moderately increase?

Often (everyday) Sometimes (every other day) Rarely (once a week) Hardly ever Never

You may click anywhere on the line that represents where you fall between the two ends of the scale.

How likely is it that you will engage in 30 minutes of moderate-intensity physical activity on 5 or more days per week for the next 6 months?

Likely Unlikely

How important is it to you to engage in 30 minutes of moderate-intensity physical activity for 5 or more days per week for the next 6 months?

Very important Important Neither important or unimportant Unimportant Very unimportant

Previous

Next

Finish Later

Physical Activity

How sure are you that you will be able to complete 30 minutes of moderate-intensity physical activity on 5 or more days per week for the next 6 months?

Very sure

Somewhat sure

Neither sure or unsure

Somewhat unsure

Very unsure

How sure are you that you will be able to be physically active when:

	Very sure	Somewhat sure	Neither sure nor unsure	Somewhat unsure	Very unsure
You are tired ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You are in a bad mood ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You don't feel you have the time...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You are on vacation ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is raining or snowing ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Physical Activity

Was there anything about the past week that made exercising especially different for you in terms of extended illness, injury, or vacation?

- Yes No

Previous

Next

Finish Later

Physical Activity

Please complete the following questions about this past week.

First, we are interested in the number of flights of stairs you climbed on average EACH DAY in this week. We only want to know the number of flights you climb going UP - not down.

When answering this question, One Flight of Stairs = 10 steps if you know the number of steps.

Flights per day _____

We want to know how much time you spent this past week brisk walking for exercise or transportation. We are interested in bouts of walking that were at least 10 continuous minutes in duration. This would include walking outside, at an indoor facility, or on a treadmill.

How many days this week did you walk briskly for the purpose of exercise or transportation for at least 10 continuous minutes outside, at an indoor facility, or on a treadmill? _____ Days in the past week

On these days in which you walked briskly at least 10 continuous minutes, on average, how many minutes per day did you walk briskly? _____ Minutes per day

Previous

Next

Finish Later

Physical Activity

Please complete the following questions about this past week.

Were there any other sport, fitness, or recreational activities in which you participated? We are interested only in time that you were physically active while performing the activity. Please add as many activities as are applicable below.

Please enter only one activity per line. Use the "Add Another Activity" button to add additional activities.

Sport, Fitness, or Recreation	Days per Week	Average Time per Day
		Minutes per Day

Add Another Activity

Previous

Next

Finish Later

Physical Activity

Please complete the following questions about this past week.

Would you say that during the past week (the week you are thinking about in this survey) you were:

- Less active than usual
- More active than usual
- About as active as usual

In general, at least once per week, do you engage in regular activity similar to brisk walking, jogging, bicycling, etc. long enough to work up a sweat, get your heart thumping, or get out of breath?

- Yes
- No

Please indicate the number of days per week: _____

Previous

Next

Finish Later

Activities While You Sit: Weekday

On a typical **WEEKDAY**, how much time do you spend (from when you wake up until you go to bed) doing the following? Please check one answer per question.

	None	15 min. or less	30 min.	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours or more
Sitting while watching television (including videos on VCR/DVD).	<input type="radio"/>								
Sitting at work/school doing computer work (email, word or data processing, web-based applications, etc.).	<input type="radio"/>								
Sitting while using the computer for non-work/school activities or playing video games.	<input type="radio"/>								
Sitting at work/school doing non-computer office/school work or paperwork.	<input type="radio"/>								
Sitting while doing non-computer office work or paperwork <u>not</u> related to your job/school (paying bills, etc).	<input type="radio"/>								
Sitting listening to music, reading a book or magazine, or doing arts and crafts.	<input type="radio"/>								
Sitting and talking on the phone or texting.	<input type="radio"/>								
Sitting in a car, bus, train or other mode of transportation	<input type="radio"/>								

Previous

Next

Finish Later

Activities While You Sit: Weekend Day

On a typical **WEEKEND DAY**, how much time do you spend (from when you wake up until you go to bed) doing the following? Please check one answer per question.

	None	15 min. or less	30 min.	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours or more
Sitting while watching television (including videos on VCR/DVD).	<input type="radio"/>								
Sitting at work/school doing computer work (email, word or data processing, web-based applications, etc.).	<input type="radio"/>								
Sitting while using the computer for non-work/school activities or playing video games.	<input type="radio"/>								
Sitting at work/school doing non-computer office/non-school work or paperwork.	<input type="radio"/>								
Sitting while doing non-computer office work or paperwork <u>not</u> related to your job/school (paying bills, etc).	<input type="radio"/>								
Sitting listening to music, reading a book or magazine, or doing arts and crafts.	<input type="radio"/>								
Sitting and talking on the phone or texting.	<input type="radio"/>								
Sitting in a car, bus, train or other mode of transportation	<input type="radio"/>								

Previous

Next

Finish Later

Weight Management Practices

How often do you weigh yourself?

- Never
- Once a year or less
- Every couple of months
- About once a month
- About once a week
- About once a day
- More than once a day

Do you have access to a bathroom scale at home?

- Yes
- No

Previous

Next

Finish Later

Your Feelings about Weight Control

The next set of statements asks about your feelings about weight and weight control. *(Please select the answer which is closest to how you feel about each statement.)*

How important is it to you to lose the weight you gained during this most recent pregnancy?

Very important Important Neither important or unimportant Unimportant Very unimportant

How sure are you that you will be able to lose the weight you gained during your most recent pregnancy?

Very sure Sure Neither sure nor unsure Unsure Very Unsure

The next set of statements asks about your feelings about weight and weight control. *(Please select the answer which is closest to how you feel about each statement.)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The best way for me to lose weight after pregnancy is to eat the right amount of healthy food.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The best way for me to lose weight after pregnancy is to be physically active on most days of the week.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The best way for me to lose weight after pregnancy is to breastfeed exclusively for up to six months.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Your Feelings about Weight Control

The next set of statements asks for your perceptions about how others feel about your weight and weight control.
(Please select the answer which is closest to how you feel about each statement.)

	Very important	Important	Neither important or unimportant	Unimportant	Very unimportant	Not Applicable
How important is it to your spouse/significant other that you lose your pregnancy weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is it to your family members that you lose your pregnancy weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is it to your friends that you lose your pregnancy weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Your Feelings about Weight Control

The next set of statements asks for your perceptions of how others feel about your weight control efforts. *(Please select the answer which is closest to how you feel about each statement.)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not applicable
My spouse/significant other supports my efforts to lose my pregnancy weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My spouse/significant other supports my efforts to eat a healthy diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My spouse or significant other eats the same meals as me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My spouse/significant other joins in my physical activities to lose weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family members support my efforts to lose my pregnancy weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family members support my efforts to eat a healthy diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family members join in my physical activities to lose weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends support my efforts to lose my pregnancy weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends support my efforts to eat a healthy diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My friends join in my physical activities to lose weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Your Weight Changes

Please tell us about your weight changes during your pregnancy and since your baby was born.

How much weight did you gain during your pregnancy? _____ pounds

How much do you weigh now without clothes or shoes?

_____ pounds

When was this weight measured?

--Month-- --Day-- --Year--

Since your baby was about one month old has your weight:

- Increased
- Stayed The Same
- Decreased

How much of the weight that you gained during your pregnancy do you still have on your body now?

- None – I Weigh Less Than Before I Got Pregnant
- Between 0-5 Pounds
- Between 6-10 Pounds
- Between 11-20 Pounds
- More Than 20 Pounds

Previous

Next

Finish Later

Your Weight Changes

Would you say your present weight is:

- Too Low
- About Right
- Too High

How satisfied are you with your weight now?

- Very satisfied Somewhat satisfied Not very satisfied Not at all satisfied

Since your baby was about one month old, have you done anything special to lose weight or control your weight?

- Yes
- No

If you did something special to lose weight or control your weight, which of the following things did you do? (check all that apply)

- Ate less food
- Ate different kinds of food (e.g. low-cal, low-fat, etc.)
- Got more exercise
- Breastfed my baby
- Other - please specify

Which of the things that you selected on the above list was the most successful method in helping you lose weight or control your weight?

- Nothing worked
- Ate less food
- Ate different kinds of food (e.g. low-cal, low-fat, etc.)
- Got more exercise
- Breastfed my baby
- Other - please specify

If you haven't done something special to lose weight or control your weight, what is the reason?

- It just came off by itself
- I can't think about losing weight right now
- I weighed too little before I was pregnant, so I don't want to lose weight now

Previous

Next

Finish Later

Health (Mood)

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
During the <i>past week</i>:				
I was bothered by things that usually don't bother me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had trouble keeping my mind on what I was doing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that everything I did was an effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt fearful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt hopeful about the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt lonely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not "get going".	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Health (Mood)

Please tell us about your health since your baby was born.

How would you describe your health since your baby was born?

Excellent

Good

Fair

Poor

As you have recently had a baby, we would like to know how you are feeling. Please check the response that comes closest to how you have felt in **THE PAST 7 DAYS**, not just how you feel today.

I have blamed myself unnecessarily when things went wrong.

- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

I have felt scared or panicky for no very good reason.

- Yes, quite a bit
- Yes, sometimes
- No, not much
- No, not at all

I have been anxious or worried for no good reason.

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

Previous

Next

Finish Later

Health (Mood)

As you have recently had a baby, we would like to know how you are feeling. Please check the response that comes closest to how you have felt in **THE PAST 7 DAYS**, not just how you feel today.

I have been able to laugh and see the funny side of things.

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

I have been so unhappy that I have had difficulty sleeping.

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

I have been so unhappy that I have been crying.

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

I have looked forward with enjoyment to things.

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

Things have been getting on top of me.

- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

I have felt sad or miserable.

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

The thought of harming myself has occurred to me.

- Yes, quite often
- Sometimes
- Hardly ever
- Never

Previous

Next

Finish Later

Health (Mood)

Since your baby was born, have you felt depressed or had the "baby blues"?

- Yes No

Are you taking medication or seeing a health professional because you are feeling depressed?

- Yes No

Previous

Next

Finish Later

Smoking

Did you smoke right before your last (most recent) pregnancy?

- Yes No

Which best describes your smoking behavior during your most recent pregnancy?

- Quit for pregnancy
 Cut down for pregnancy
 Smoked during pregnancy

Previous

Next

Finish Later

Smoking

Do you currently use chewing tobacco, snuff, snus, pipes, cigars or any other tobacco product other than cigarettes?

Yes No

Have you smoked at least 100 cigarettes in your entire life? NOTE: 5 packs = 100 cigarettes

Yes No

Previous

Next

Finish Later

Smoking

Do you now smoke cigarettes every day, some days, or not at all?

- Every day Some days Not at all

On average, how many cigarettes do you smoke each day?

- I did not smoke cigarettes during the past 30 days
- 1 cigarette or less per day
- 2 to 5 cigarettes per day
- 6 to 10 cigarettes per day
- 11 to 20 cigarettes per day
- More than 20 cigarettes per day

Previous

Next

Finish Later

Smoking

During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

- Yes No

How long has it been since you last smoked cigarettes regularly?

- Within the past month (*less than 1 month ago*)
- Within the past 3 months (*1 month but less than 3 months ago*)
- Within the past 6 months (*3 months but less than 6 months ago*)
- Within the past year (*6 months but less than 1 year ago*)
- Within the past 5 years (*1 year but less than 5 years ago*)
- Within the past 10 years (*5 years but less than 10 years ago*)
- 10 years or more

Previous

Next

Finish Later

Alcohol

During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? (One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.)

Yes No

Previous

Next

Finish Later

Alcohol

During the past past 30 days, how many days did you have at least one drink of any alcoholic beverage? -- Select --

During the past 30 days, on the days when you drank, about how many drinks did you drink on average?

NOTE: A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks. _____ drinks per day

Considering all types of alcoholic beverages, how many times during the past 30 days did you have 4 or more drinks?

Number of times

No times

Previous

Next

Finish Later

Sleep

In the past 24 hours, what is the longest stretch of time that you have slept without waking up?

hours (answer to the nearest half hour)

In the past 24 hours, how many hours did you sleep in total?

hours (answer to the nearest half hour)

Please rate your general level of tiredness during the past week.

You may click anywhere on the line that represents where you fall between the two ends of the scale.

Not at all
tired

The most
tired I
could be

Previous

Next

Finish Later

Sleep

During the past 30 days, for about how many days have you felt you did not get enough rest or sleep? Please fill in your estimate of the number of days. days

In the past week, how many days have you had trouble staying awake while driving, eating meals, in class or engaging in social activity? Please check the appropriate response.

- 0-2 days/week 3-5 days/week 6-7 days/week

Previous

Next

Finish Later

Family Planning

What kind of birth control are you or your husband or partner using now? (Check all that apply)

- Not using any kind of birth control
- Shot once a month (Lunelle)
- Not having sex (abstinence)
- Shot once every 3 months (Depo-Provera)
- Tubes tied or closed (female sterilization)
- Contraceptive patch (OrthoEvra)
- Vasectomy (male sterilization)
- Diaphragm, cervical cap, or sponge
- Mini-pill
- Pill
- Cervical ring (NuvaRing or others)
- Hormonal IUD (Mirena)
- Non-hormonal IUD (Paragard)
- Implant (Implanon)
- Condoms
- Rhythm method or natural family planning
- Withdrawal (pulling out)

Previous

Next

Finish Later

Stress in your life

In the last month...	Never	Almost never	Sometimes	Fairly often	Very often
How often have you been upset because of something that happened unexpectedly?	<input type="radio"/>				
How often have you felt that you were unable to control the important things in your life?	<input type="radio"/>				
How often have you felt nervous and "stressed"?	<input type="radio"/>				
How often have you felt confident about your ability to handle your personal problems?	<input type="radio"/>				
How often have you felt that things were going your way?	<input type="radio"/>				
How often have you found that you could not cope with all the things that you had to do?	<input type="radio"/>				
How often have you been able to control irritations in your life?	<input type="radio"/>				
How often have you felt that you were on top of things?	<input type="radio"/>				
How often have you been angered because of things that were outside of your control?	<input type="radio"/>				
How often have you felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>				

Previous

Next

Finish Later

Your Baby's Health and Nutrition

Please tell us about your baby's health and how you have been feeding your baby over the past six months.

Has your baby had colic (cries all the time), jaundice, surgery or any other illnesses or hospitalizations since being born?

Yes No

What illnesses?

If hospitalized, for how many days?

days

[Previous](#)

[Next](#)

[Finish Later](#)

Your Baby's Health and Nutrition

Are you breastfeeding your baby now?

Yes No

How many times in 24 hours?

_____ times

In addition to your breast milk, are you giving your baby any infant formula or milk other than breast milk now?

Yes No

How often are you giving your baby formula or milk other than breast milk?

_____ Times Per Day

OR

_____ Per Week

How many ounces of formula or milk, other than breast milk do you give your baby at one time?

_____ ounces

How old was your baby when you started giving infant formula or milk other than breast milk?

_____ weeks

Previous

Next

Finish Later

Your Baby's Health and Nutrition

Are you giving your baby any baby food or strained mashed table foods?

- Yes No

How much baby food or mashed table food do you give your baby per day?

- Two tablespoons or less
 Between two and four tablespoons
 Between four and six tablespoons
 Between six and eight tablespoons
 Eight tablespoons or more

How old was your baby when you started giving solid foods?

weeks

[Previous](#)

[Next](#)

[Finish Later](#)

Your Baby's Health and Nutrition

Did you ever breastfeed your baby?

Yes No

How old was your baby when you started giving infant formula or milk other than breast milk?

weeks

How old was your baby when you stopped breastfeeding?

weeks

Did you breastfeed for as long as you wanted to?

Yes No

Previous

Next

Finish Later

Your Baby's Health and Nutrition

Did any of the following people *help you* to continue to breastfeed or breastfeed for as long as you wanted? (Mark "does not apply" if you do not have the person listed, such as "employer" if you do not work for pay.)

	Yes	No	Does not apply/ don't know
The baby's father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mother-in-law	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Another family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A doctor or other health professional, including a lactation consultant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your employer or supervisor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A breastfeeding support group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The eMomsRoc community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Supportive Relationships

Now we would like to ask you about support from family and friends.

Please read each statement carefully and click on the point of the line below that is closest to your situation.

I have people who care what happens to me

As much
as I would
like

Much less
than I
would like

I have love and affection

As much
as I would
like

Much less
than I
would like

I have chances to talk to someone about problems at work or with my housework

As much
as I would
like

Much less
than I
would like

I have chances to talk to someone I trust about my personal and family problems

As much
as I would
like

Much less
than I
would like

I have chances to talk about money matters

As much
as I would
like

Much less
than I
would like

Previous

Next

Finish Later

Supportive Relationships

Now we would like to ask you about support from family and friends.

Please read each statement carefully and click on the point of the line below that is closest to your situation.

I have invitations to go out and do things with other people

As much
as I would
like

Much less
than I
would like

I have useful advice about important things I like

As much
as I would
like

Much less
than I
would like

I have help when I'm sick in bed

As much
as I would
like

Much less
than I
would like

I have help around the house or with child care

As much
as I would
like

Much less
than I
would like

I have people who help me when I can't make ends meet

As much
as I would
like

Much less
than I
would like

Previous

Next

Finish Later

Supportive Relationships

How supportive has the baby's father been?

- Very supportive
- Somewhat supportive
- Not as supportive as I would have liked
- Not at all supportive
- Father not involved

Previous

Next

Finish Later

Connecting with Others Online

I connected with other people on the eMomsRoc website on the following topics (check all that apply)

- Being a mom
- Nutrition
- Physical activity
- Weight
- Infant feeding
- Other - please specify: _____

For the next set of questions, please tell us whether you agree or disagree.

	Disagree a lot	Disagree a little	Agree a little	Agree a lot
I never posted messages on the eMomsRoc web site.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt comfortable sharing private or personal thoughts with other members of eMomsRoc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
By giving advice to other members of eMomsRoc, my own health efforts were reinforced.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being anonymous made it easier to share personal information with other participants in eMomsRoc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I got advice and support on eMomsRoc that I could not find anywhere else.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It was comforting to know that I wasn't alone in being a mom.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The fact that eMomsRoc is available whenever I need it, night or day, was important to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt supported and encouraged by other eMomsRoc members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Advice and support from people in different stages of postpartum was helpful to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received negative or critical comments from other eMomsRoc members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received some bad information or advice from someone on eMomsRoc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Previous

Next

Finish Later

Your Life Situation

Please tell us about your life situation.

Do you think you will have another baby in the next year or two?

- Yes
- Probably
- Not Sure
- No

Are you pregnant now?

- Yes
- No

What was the date of your last menstrual period?

--Month-- --Day-- --Year--

When is your baby due to be born?

--Month-- --Day-- --Year--

Previous

Next

Finish Later

Your Life Situation

Please tell us about your life situation.

Do you have a job for pay now?

Yes No

How old was your baby when you returned to work?

weeks
OR
 months

How happy are you with your job?

Very happy

Somewhat happy

Not very happy

Not at all happy

How many hours per week do you work?

hours per week

Previous

Next

Finish Later

Dealing with Life Situations

Please rate how much you agree or disagree with the following statements:

	Strongly agree	Agree	Somewhat agree	Somewhat disagree	Disagree	Strongly disagree
I am usually able to think up creative and effective alternatives to solve a problem.	<input type="radio"/>					
I have the ability to solve most problems even though initially no solution is immediately apparent.	<input type="radio"/>					
Many problems I face are too complex for me to solve.	<input type="radio"/>					
I make decisions and am happy with them later.	<input type="radio"/>					
When I make plans to solve a problem, I am almost certain that I can make them work.	<input type="radio"/>					
Given enough time and effort, I believe I can solve most problems that confront me.	<input type="radio"/>					
When faced with a novel situation I have confidence that I can handle problems that may arise.	<input type="radio"/>					
I trust my ability to solve new and difficult problems.	<input type="radio"/>					
After making a decision, the outcome I expected usually matches the actual outcomes.	<input type="radio"/>					
When confronted with a problem, I am unsure of whether I can handle this situation.	<input type="radio"/>					
When I become aware of a problem, one of the first things I do is to try to find out exactly what the problem is.	<input type="radio"/>					

Previous

Next

Finish Later

Your Neighborhood

Next we have a few questions about your neighborhood.

What is the main type of housing in your neighborhood (where you currently reside most days of the week)?

- Dormitory or residence hall
- Detached single-family housing
- Townhouses, row houses, apartments, or condos of 2-3 stories
- Mix of single-family residences and townhouses, row houses, apartments or condos
- Apartments or condos of 4-12 stories
- Apartments or condos of more than 12 stories
- Don't know/Not sure

[Previous](#)

[Next](#)

[Finish Later](#)

Your Neighborhood

The fresh fruits and vegetables in my neighborhood are of high quality.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

A large selection of fresh fruits and vegetables is available in my neighborhood.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

A large selection of low-fat products such as low-fat milk and lean meats is available in my neighborhood.

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

Previous

Next

Finish Later

Your Neighborhood

Do you or other members of your household do any vegetable gardening?

Yes No

Do you or other members of your household buy food from a farmers market or farm stand?

Yes No

Do you know of a food pantry, soup kitchen, church or other organization that gives out food that you could go to if you needed to?

Yes No

Have you gotten food from a food pantry, soup kitchen or other organization during the past year?

Yes No

[Previous](#)

[Next](#)

[Finish Later](#)

Neighborhood environment

The next items are statements about your neighborhood related to walking and bicycling.

	Strongly disagree	Disagree	Agree	Strongly agree	Don't Know
Many shops, stores, markets or other places to buy things I need are within easy walking distance of my home.	<input type="radio"/>				
It is within a 10-15 minute walk to a transit stop (such as bus, train, trolley, or tram) from my home.	<input type="radio"/>				
There are sidewalks on most of the streets in my neighborhood.	<input type="radio"/>				
There are facilities to bicycle in or near my neighborhood, such as special lanes, separate paths or trails, shared use paths for cycles and pedestrians.	<input type="radio"/>				
My neighborhood has several free or low cost recreation facilities, such as parks, walking trails, bike paths, recreation centers, playgrounds, public swimming pools, etc.	<input type="radio"/>				
The crime rate in my neighborhood makes it unsafe to go on walks at night.	<input type="radio"/>				

Previous

Next

Finish Later

Neighborhood environment

How many motor vehicles in working order (e.g., cars, trucks, motorcycles) are there at your household?

Motor Vehicles

Don't know / not sure

Previous

Next

Finish Later

Household Characteristics

What is the highest grade in school you have finished?

- Did not finish elementary school
- Finished middle school (8th grade)
- Finished some high school
- High school graduate or G.E.D.
- Vocational or training school after high school
- Some College or Associate degree
- College graduate or Baccalaureate Degree
- Masters or Doctoral Degree (PhD, MD, JD, etc)

How many children under the age of 18 live in your home?

How many adults (age 18 or older) live in your home? (count yourself)

Previous

Next

Finish Later

Household Characteristics

Which of these categories best describe your income (not the income of your household, but your own income) for the past 12 months? This should include income (before taxes) from all sources, wages, veteran's benefits, help from relatives, rent from properties and so on.

- Less than \$5,000
- \$5,000 through \$11,999
- \$12,000 through \$15,999
- \$16,000 through \$24,999
- \$25,000 through \$34,999
- \$35,000 through \$49,999
- \$50,000 through \$74,999
- \$75,000 through \$99,999
- \$100,000 and greater
- Don't know

What is your current relationship status?

- Single or casually dating
- In a committed relationship or engaged
- Living in a marriage-like relationship
- Presently married
- Separated
- Divorced
- Widowed

[Previous](#)

[Next](#)

[Finish Later](#)

Your household

Please select the practice where you currently receive Ob/Gyn care

-- Select --

If your current practice for Ob/Gyn care is not in the above drop down menu, please specify:

Please select you baby's pediatric practice from the list below:

-- Select --

If your pediatrician is not in the above drop down menu, please specify:

Please use the following space to give us any comments you have about the questionnaire

Previous

Submit Survey

Finish Later