# **Maternal Health Survey – substance use disorder.**

Thank you for your time, please fill out the survey below on Maternal Health. Your participation will allow us to know you better and contribute to potential future treatment decisions. Feel free to contact Dr. Aize Cao at [acao@mmc.edu](mailto:acao@mmc.edu) if you have any concerns or questions. Thank you!

1. Enter Date: MM-DD-YYYY
2. Please enter your date of birth: MM-DD-YYYY
3. Currently City and State Address?

**Patient Demographics**

1. Are you Hispanic or Not Hispanic?
   1. Yes
   2. No
2. Please select your primary race:
   1. White
   2. Black or African American
   3. Asian
   4. Native Hawaiian or Pacific Islander
   5. Alaska Native
   6. American Indian
   7. Other

If Other, please specify:

1. What is your primary language?
   1. English
   2. Spanish
   3. Chinese
   4. German
   5. French
   6. Other

If other, please specify:

1. What is your marital status?
   1. Single
   2. Married
   3. Divorced
   4. Separated
   5. Widow
2. Please select your primary religion:
   1. Christian
   2. Jewish
   3. Muslim
   4. Hindu
   5. Buddhism
   6. I am not religious.
   7. Other

If Other, please specify.

**Education, Employment, and Income**

9.What is the highest level of education you received?

* 1. Never Attended
  2. Elementary School
  3. Middle School
  4. High School
  5. College
  6. Graduate

10.Are you currently employed?

* 1. Employed, Full time.
  2. Employed, Part time.
  3. Unemployed
  4. Retired

1. What is your current total annual income?
   1. No income
   2. Less than $30K
   3. $31K - $60K
   4. $61K - $90K
   5. Greater than $90K
2. Have you enough money to meet your needs?
   1. Not at all
   2. A little
   3. Moderately
   4. Mostly
   5. Completely

**Living Conditions**

13.In the past 30 days, where have you been living most of the time?

* 1. Secured home.
  2. Transitional house
  3. Homelessness
  4. Living with friends
  5. Living with family members
  6. Jail
  7. Other

If Other, please specify.

14.What is your living situation today?

* 1. I do not have a stable place to live.
  2. I have a stable place to live.
  3. I have a place to live today, but I am worried about losing it in the future.

15.Do you have problems with any of the following in your current living situation? Choose all that apply:

* 1. Pests such as bugs, ants, or mice
  2. Mold
  3. Lead paint or pipes.
  4. Lack of heat
  5. Oven or stove not working.
  6. Water leaks
  7. None of the above

16.How satisfied are you with the conditions of your living space?

* 1. Very satisfied
  2. Satisfied
  3. Neutral
  4. Dissatisfied
  5. Very Dissatisfied

**Food**

17.Within the past 12 months, were you worried that your food would run out before you got money to buy more?

* 1. Often
  2. Sometimes
  3. Never

18.Do you have problems paying your bills such as food, housing, medical care, and heating?

* 1. Yes
  2. No
  3. Sometimes

**Transportation**

19.In the past 12 months, have you had reliable transportation to afford for daily living?

* 1. Yes
  2. No

20.In the past 12 months, have you had reliable transportation to go for medical appointments?

* 1. Yes
  2. No

**Utility**

21.In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

* 1. Yes
  2. No

**Safety**

22.How often does anyone, including family and friends, physically abuse you?

* 1. Never
  2. Rarely
  3. Sometimes
  4. Fairly Often
  5. Frequently

23.How often does anyone, including family and friends, mentally, emotionally, or verbally abuse you?

* 1. Never
  2. Rarely
  3. Sometimes
  4. Fairly Often
  5. Frequently

**Health Status & Health Coverage**

24.Do you identify as someone considered to have a disability in any way?

* 1. Yes
  2. No

25.Do you have any pre-existing medical conditions?

* 1. Yes
  2. No

If yes, please specify.

26.What kind of health insurance do you have now?

* 1. Private health insurance (paid for by me, someone else, or through a job)
  2. Medicaid (Site Medicaid name)
  3. Site-specific option (Other government plan or program such as SCHIP/CHIP)
  4. Site-specific option (TRICARE or other military health care)
  5. I do not have any health insurance now.

If yes, please specify below:

27.Have you been denied healthcare services?

* 1. Yes
  2. No

If yes, please Specify why? (insurance coverage, ethnicity, age)

If yes, please specify how did it impacted your view of the healthcare system?

**Maternal Health**

28.Have you experienced infant mortality?

a. Yes

b. No

If yes, what type of infant mortality and how many infant mortalities?

a. perinatal mortality (miscarriage)

b. Neonatal mortality

c. Post neonatal mortality

29. Has a healthcare provider diagnosed as infertility?

a. Yes

b. No

30.Are you currently pregnant?

* 1. Yes
  2. No

If yes, how many months pregnant are you?

1. Do you have children?
   1. Yes
   2. No

If yes, how many children do you have?

If yes, what age did you deliver your first child?

1. During the month before you got pregnant, what kind of health insurance did you have?
   1. Private health insurance (paid for by me, someone else, or through a job)
   2. Medicaid (Site Medicaid name)
   3. Site-specific option (Other government plan or program such as SCHIP/CHIP)
   4. Site-specific option (TRICARE or other military health care)
   5. I did not have any health insurance during the month before I got pregnant.
2. Did you get prenatal care during your most recent pregnancy?
   1. Yes
   2. No
3. During any of your prenatal care visits, did a healthcare provider do any of the following things? (CHECK YES or NO)

Talk to me about...

a. How much weight I should gain during pregnancy.

b. Doing tests to screen for birth defects or diseases that run in my family.

c. Doing a substance use disorder screening.

d. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)

e. What to do if I feel depressed or anxious during my pregnancy or after my baby is born

Ask me…

f. If I planned to breastfeed my new baby.

g. If I planned to use birth control after my baby was born.

h. If I was taking any prescription medication.

1. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco.
2. If I was drinking alcohol.
3. If someone was hurting me emotionally or psychically
4. If I was using illegal drugs.
5. If I was using marijuana.
6. If I wanted to be evaluated for HIV
7. Have you ever experienced these types of complications while in labor?
   1. Preterm Labor (labor before 37wks)
   2. Premature rapture of the membrane (PROM)
   3. Shoulder Dystocia
   4. Umbilical cord or Placenta problems
8. Did a healthcare provider tell you that you had any of the following health conditions during pregnancy?
   1. Gestational diabetes (diabetes that started during this pregnancy)
   2. b. High Blood pressure (that started during this pregnancy), pre-eclampsia, or eclampsia.
   3. c. Depression
   4. d. Anxiety

37. While getting healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?

* 1. My race, ethnicity, or skin color
  2. My disability status
  3. My immigration status
  4. My age
  5. My weight
  6. My income
  7. My sex or gender
  8. My sexual orientation
  9. My religion
  10. My language or accent
  11. My type or lack of health insurance
  12. My use of substances (alcohol, tobacco, or other drugs)
  13. My involvement with the justice system (jail or prison)

38. have you ever received a postpartum checkup after pregnancy?

1. Yes
2. No

if yes.

39. Have your Health provider discuss the following during the postpartum checkup? (Check Yes or No)

Talk to me about...

a. Healthy eating, exercise, and weight gained during pregnancy.

b. How long to wait before getting pregnant again.

c. Birth control methods

d. Warning signs of medical problems I might be at risk for due to my pregnancy.

e. Regularly checking my blood pressure.

f. What to do if I feel depressed or anxious.

Ask me...

g. If I was smoking cigarettes or using e-cigarettes (“vapes”) or other smokeless tobacco.

h. If someone was hurting me emotionally or physically.

I. Asked to have evaluated me for diabetes.

j. Asked me about substance use disorder or drug screening.

**Substance Use Disorder**

40. During your pregnancy have you consumed the following substance?

a. cigarettes, e-cigarettes, and other tobacco products.

b. Alcoholic

b. cocaine

c. Marijuana

d. opioids or prescriptions drugs

e. Meth or other stimulants

41.During your pregnancy, how often did you continue to consume substances? For each one, check No or Yes

* 1. The first 3 months of pregnancy (first trimester)? This includes the time before knowing you were pregnant.
  2. The second 3 months of pregnancy (second trimester)?
  3. The last 3 months of pregnancy (third trimester)?

42. During your most recent pregnancy, did you feel you needed any of the following services? For each one, check No or Yes.

a. Check in a substance Rehab facility.

b. Join a substance support group.

c. Prescribe Methadone, buprenorphine, or naltrexone.

d. Prescribe Buspirone or Cognitive behavioral therapy,

**Maternal Health Demographics**

43. Did any of the following things happen during the 12 months before pregnancy? (check yes or no)

* 1. I Became separated or divorced.
  2. I was evicted or forced to move.
  3. I didn’t have a regular place to sleep.
  4. I was homeless or had to sleep outside, in a car, or in a shelter.
  5. My spouse, partner, or I lost a job.
  6. My spouse, partner, or I had a cut in work hours or pay.
  7. I had problems paying the rent, mortgage, or other bills.
  8. My spouse or partner went to jail/prison.
     1. I went to jail/prison.
  9. Someone close to me had a problem with drinking or drugs.
  10. Someone close to me was extremely sick or died.
  11. endures physical harm from others.

44.During the 12 months before pregnancy, did lack of transportation keep you from any of the following?

* 1. Going to medical appointments
  2. Going to non-medical appointments, meetings, or work.
  3. Doing errands.

45.During pregnancy, did lack of transportation keep you from any of the following?

* 1. Going to medical appointments
  2. Going to non-medical appointments, meetings, or work.

c. Doing errands.

46. Please tell us how often each of the following happened during your Pregnancy.

1. I worried whether my food would run out before I got money to buy more.

1. Often
2. Sometimes
3. Never

2. The food that I bought just didn't last, and I didn’t have money to get more.

1. Often
2. Sometimes
3. Never

47.During your pregnancy, what was your yearly total household income before taxes?

* 1. No income
  2. Less than $30K
  3. $31K - $60K
  4. $61K - $90K
  5. Greater than $90K

48. What are your reasons for not doing anything to keep from getting pregnant now?

1. I want to get pregnant or don’t mind if I do.
2. I had my tubes tied or blocked.
3. My spouse or partner had a vasectomy.
4. I don’t want to use birth control.
5. I’m worried about side effects from birth control.
6. My spouse or partner doesn’t want to use condoms.
7. My spouse or partner doesn't want me to use birth control.
8. We are same-sex spouses/partners.
9. I have problems getting birth control I want.
10. I have a substance use disorder.
11. I’m not having sex.