Baseline Pregnancy Characteristics

COVID-19 Pregnancy Registry | Biomedical Recommended Measures

The recommendations herein were largely adapted from the Maternal Fetal Medicine Unit (GRAVID) COVID-19 and Delivery Case Report Forms with additional input from the Study of Pregnancy and Neonatal Health (SPAN) and other ongoing or planned studies.

A subset of measures included here are designated as "Tier 2." Those without this designation-i.e., "Tier 1" measures-are recommended for all studies that may include women of reproductive age and pregnant women. Tier 2 measures are suggested additional measures for studies focused exclusively on COVID-19 in pregnancy and/or for any study interested in taking a "deeper dive" in certain domains.

Estimated Due Date

_____
(MMDDYYYY)

Date of Delivery / End of Pregnancy

_____
(MMDDYYYY)

Maternal Height and Weight

Height in meters

_____
(m)

Weight in kilograms

_____
(kg)

Pregnancy History (Tier 2)

Mark the number of previous pregnancies for which the patient has experienced the following outcomes:

Live Birth

◯ 0
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5 or more

Miscarriage [< 20 weeks]

◯ 0
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5 or more

Stillbirth [20+ weeks]

◯ 0
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5 or more

Preterm delivery (< 37 weeks)	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more
Was the preterm delivery spontaneous?	◯ Yes ◯ No
If no, select indication for indicated preterm birth:	◯ COVID-19 ◯ Maternal indication ◯ Fetal indication ◯ Other
Was the second preterm delivery spontaneous?	◯ Yes ◯ No
If no, select indication for indicated preterm birth:	◯ COVID-19 ◯ Maternal indication ◯ Fetal indication ◯ Other
Was the third preterm delivery spontaneous?	◯ Yes ◯ No
If no, select indication for indicated preterm birth:	◯ COVID-19 ◯ Maternal indication ◯ Fetal indication ◯ Other
Was the fourth preterm delivery spontaneous?	◯ Yes ◯ No
If no, select indication for indicated preterm birth:	◯ COVID-19 ◯ Maternal indication ◯ Fetal indication ◯ Other
Was the fifth preterm delivery spontaneous?	◯ Yes ◯ No
If no, select indication for indicated preterm birth:	◯ COVID-19 ◯ Maternal indication ◯ Fetal indication ◯ Other

Mark Yes/No/Unknown for each of the following pregnancy / obstetric complications during previous pregnancies:

	Yes	No	Unknown
Gestational hypertension	◯	◯	◯
Preeclampsia	◯	◯	◯
Gestational diabetes	◯	◯	◯
Prior cesarean	◯	◯	◯

Pre-pregnancy conditions (Tier 2)

Mark Yes/No/Unknown to denote if the patient has any of the following pre-pregnancy conditions for the current pregnancy:

	Yes	No	Unknown
Pregestational diabetes	◯	◯	◯

Hypertension	◯	◯	◯
Pulmonary disease	◯	◯	◯
Immune suppression	◯	◯	◯
HIV	◯	◯	◯
VTE/PE	◯	◯	◯
Mood Disorder (Depression / MDD, Bipolar Disorder)	◯	◯	◯
Anxiety / Panic Disorder	◯	◯	◯
PTSD	◯	◯	◯

COVID-19 vaccination history (Tier 2)

Have [you/the participant] received a vaccination for COVID-19? ◯ Yes ◯ No

Have [you/the participant] completed the vaccination for COVID-19 (dose or doses)?

◯ Yes ◯ No

Enter the name of the vaccine (if known)

- ☐ AstraZeneca's COVID-19 vaccine
- ☐ Janssen's (Johnson & Johnson) COVID-19 vaccine
- ☐ Moderna's COVID-19 vaccine
- ☐ Novavax's COVID-19 vaccine
- ☐ Pfizer's COVID-19 vaccine
- ☐ Other, Specify

Specify Other

_____

On what date did the patient receive the first dose of the vaccine?

_____

On what date did the patient receive the second dose of the vaccine?

_____

[Tier 2] Did [you/the participant] receive a COVID-19 vaccine 90 days after treatment with monoclonal antibodies or 30 days after an active COVID-19 infection?

◯ Yes ◯ No ◯ Unknown ◯ Prefer not to answer

Did you experience any side effects within 2 weeks after the FIRST vaccine dose?

◯ Yes ◯ No ◯ I do not know

What side effect(s) did you experience?
(Select all that apply)

- ☐ Pain where shot was given
- ☐ Fever ≥ 100.4F
- ☐ Fatigue/tiredness
- ☐ Headache
- ☐ Muscle pain in parts of your body beyond where shot was given
- ☐ Immediate, severe allergic reaction (including difficulty breathing and feeling faint, nausea and/or vomiting)
- ☐ Skin rash
- ☐ Facial swelling
- ☐ Other (please describe)

Describe other side effect(s)

Did you experience any side effects within 2 weeks after the SECOND vaccine dose?

◯ Yes ◯ No ◯ I do not know

What side effect(s) did you experience?
(Select all that apply)

- ☐ Pain where shot was given
- ☐ Fever ≥ 100.4F
- ☐ Fatigue/tiredness
- ☐ Headache
- ☐ Muscle pain in parts of your body beyond where shot was given
- ☐ Immediate, severe allergic reaction (including difficulty breathing and feeling faint, nausea and/or vomiting)
- ☐ Skin rash
- ☐ Facial swelling
- ☐ Other (please describe)

Describe other side effect(s)

[Tier 2] Medications taken to treat symptoms post-vaccine
(select all that apply)

- ☐ Ibuprofen
- ☐ Acetaminophen
- ☐ Aspirin
- ☐ Antihistamines
- ☐ Other, specify
- ☐ None

Specify other medication

_____

If not vaccinated, Why? (Select ONE best reason)

◯ The vaccine is not available to me
◯ Doctor did not recommend it
◯ My family did not want me to take it
◯ It was not well tested in ethnically diverse people
◯ It was not well tested among pregnant individuals
◯ I cannot afford the vaccine
◯ I have not had time to get it
◯ I'm at low risk and do not need it
◯ It is riskier to go get the vaccine than staying at home
◯ Worried about side effects
◯ The vaccine's technology hasn't been tested enough
◯ Vaccine was approved too fast
◯ No long-term safety data available
◯ Concerned about vaccine storage
◯ Already had COVID-19
◯ Other, specify

Specify other reason

_____

Do you intend to recieve a coronoavirus (COVID-19) vaccine?

◯ I intend to get it as soon as possible
◯ I intend to wait to see how it affects others in the community before I get it
◯ I do not intend on getting it soon, but might sometime in the future
◯ I do not intend to ever get the vaccine

[Tier 2] Is there anything that might convince you to change your mind about getting vaccinated?

◯ No/Nothing
◯ More research
◯ If it were mandatory/required
◯ Other
◯ Don't know

Flu vaccination history (Tier 2)

Has the patient received a vaccination for influenza during this season/year?

◯ Yes ◯ No ◯ Unknown

If yes, on what date did the patient receive the vaccine?

_____
(MMDDYYYY)

Maternal Covid19 Treatment

Hospitalization

Was the participant hospitalized due to COVID-19 in this pregnancy or while pregnant?
◯ Yes ◯ No

Date admitted
_____
(MMDDYYYY)

What was the indication for the patient's hospitalization?
◯ Admitted due to COVID-19
◯ Admitted for delivery (spontaneous labor, induction, CD)
◯ Admitted for non-COVID / non-labor and delivery

Admitted due to COVID-19

Delivery?
◯ Did not result in delivery
◯ Delivered (include if pregnancy loss)

Labor Type
◯ Spontaneous labor
◯ Induced
◯ No labor

Admitted for delivery (spontaneous labor, induction, CD)

SARS-CoV-2 test performed?
◯ Yes, positive
◯ Yes, negative
◯ Yes, unknown result
◯ No
◯ Unknown

If yes, positive: Was the patient symptomatic?
◯ Yes ◯ No

Admitted for non-COVID / non-labor and delivery

Did the patient test positive for SARS-CoV-2?
◯ Yes ◯ No

Did the admission result in delivery / end of pregnancy?
◯ Yes ◯ No

ICU

Was the Participant in the ICU due to COVID-19?
◯ Yes ◯ No

Date admitted
_____
(MMDDYYYY)

COVID-19 Treatment Medication

Mark Yes/ No/ Unknown to denote if the patient received any of the following COVID-19 treatments.

Please note that these options reflect the available treatments in October 2020. Please expand this list as necessary as treatment regiments evolve.

Oseltamivir	◯ Yes ◯ No
Hydroxychloroquine / chloroquine therapy	◯ Yes ◯ No
Remdesivir	◯ Yes ◯ No
Azithromycin	◯ Yes ◯ No
Convalescent plasma	◯ Yes ◯ No
Other antiviral	◯ Yes ◯ No
Unfractionated heparin	◯ Yes ◯ No
Low molecular weight heparin	◯ Yes ◯ No
Tocilizumab	◯ Yes ◯ No
Bevacizumab	◯ Yes ◯ No
Eculizumab	◯ Yes ◯ No
Ruxolitinib	◯ Yes ◯ No
Dexamethasone	◯ Yes ◯ No
Methylprednisolone	◯ Yes ◯ No
Hydrocortisone IV / injection	◯ Yes ◯ No
Other immune modulator	◯ Yes ◯ No
Other corticosteroid	◯ Yes ◯ No
Other (please specify)	◯ Yes ◯ No
Specify other	_____

Highest Level of Respiratory Support for COVID-19	○ None ○ Blow-by ○ Oxygen by cannula / oxyhood / mask ○ High flow nasal cannula ○ Continuous positive airway pressure ○ Bilevel positive airway pressure ○ Ventilation

Maternal Outcomes

Delivery Route	◯ Vaginal - non-operative ◯ Vaginal - operative ◯ Pre-labor cesarean / cesarean without labor ◯ Intrapartum cesarean
If cesarean, indication for cesarean (Tier 2)	☐ COVID-19 ☐ Maternal Indication ☐ Fetal Indication ☐ Other (select all that apply)
Specify other indication	_____

Onset of Labor (Tier 2)

Labor Type	◯ No labor ◯ Spontaneous ◯ Spontaneous, augmented ◯ Induced
Primary indication for induction	◯ COVID-19 infection ◯ Hypertension / preeclampsia ◯ IUGR ◯ Non-reassuring fetal status ◯ PROM ◯ IUFD/ Stillbirth ◯ Congenital malformations / fetal anomaly ◯ Oligohydramnios ◯ Abruption ◯ Chorioamnionitis ◯ Elective ◯ Cholestasis ◯ Polyhydramnios ◯ Diabetes / Macrosomia ◯ Other maternal medical complications ◯ Post term (>=41 weeks)

Maternal Complications [select all that apply]

- ☐ Cerebral venous sinus thrombosis
- ☐ Renal failure requiring dialysis
- ☐ Arterial thrombosis cerebrovascular accident (CVA)
- ☐ Cardiomyopathy
- ☐ Pulmonary embolism
- ☐ Deep vein thrombosis
- ☐ Encephalopathy
- ☐ Disseminated intravascular coagulation (DIC)
- ☐ Myocardial infarction
- ☐ Superficial incisional surgical site infection
- ☐ Deep incisional surgical site infection
- ☐ Multisystem inflammatory syndrome (< 18 years of age)
- ☐ HELLP syndrome
- ☐ Eclampsia
- ☐ Severe hypertension (BP>= 160/110) with acute administration of anti-hypertensive medication
- ☐ Pulmonary edema
- ☐ Hepatic rupture
- ☐ Impaired liver function (liver enzymes 2X ULN)
- ☐ Renal insufficiency (serum creatinine > 1.1 mg/dL or doubling)
- ☐ Thrombocytopenia (platelets < 100,000)
- ☐ Sepsis (infection with organ dysfunction)
- ☐ Bacteremia
- ☐ Endometritis requiring IV antibiotic therapy for > 24 hours
- ☐ Pelvic abscess
- ☐ Death

After delivery discharge [select all that apply]

- ☐ Uterine packing
- ☐ Intrauterine balloon tamponade
- ☐ Uterine artery ligation
- ☐ Uterine compression sutures
- ☐ Laparotomy
- ☐ Evacuation of hematoma
- ☐ Arterial embolization
- ☐ Uterine evacuation
- ☐ Hysterectomy
- ☐ Death
- ☐ Other (specify)

Specify Other

_____

Obstetric Pregnancy Outcomes

Major Congenital Malformation	◯ Yes ◯ No
Specify	_____
Clinical Chorioamnionitis (Tier 2)	◯ Yes ◯ No

Neonatal Characteristics

Sex	◯ Male ◯ Female
Birth Weight	_____ (g)
Length	_____ (cm)
Head Circumference (Tier 2)	_____ (cm)

Neonatal Covid19 Testing

Date(s) of Testing	
Test Date	_____ (MMDDYYYY)
COVID-19 Test Result	◯ Positive ◯ Negative
Type of Test (Tier 2)	◯ Molecular (e.g., PCR) ◯ Serology (e.g. antigen, antibody)

Neonatal Outcomes

Highest Level of Care Required	◯ Well baby nursery / routine care ◯ NICU / intermediate nursery ◯ Baby died before admission to NICU ◯ Fetal death
Highest Level of Respiratory Support	◯ Room air, no support ◯ Supplemental Oxygen ◯ Non-invasive intermittent positive pressure ◯ Mechanical ventilation / intubation

Neonatal Morbidities

Mark Yes/No/Unknown to denote if the neonate had any of the following conditions:

	Yes	No	Unknown
Preterm delivery (< 37 weeks gestation)	◯	◯	◯
Infant received surfactant	◯	◯	◯
Seizure	◯	◯	◯
Pneumothorax	◯	◯	◯
Intraventricular hemorrhage (IN)	◯	◯	◯
Periventricular leukomalacia (PVL)	◯	◯	◯
Pneumonia confirmed by X-ray or CT scan	◯	◯	◯

If yes, select the highest stage of intraventricular hemorrhage (IN):	◯ 1 ◯ 2 ◯ 3 ◯ 4

	Yes	No	Unknown
Proven early onset sepsis < =7 days	◯	◯	◯
Proven late onset sepsis >7 days	◯	◯	◯
Proven NEC	◯	◯	◯
Retinopathy of prematurity	◯	◯	◯
Infant transfused with PRBC	◯	◯	◯
Phototherapy for hyperbilirubinemia	◯	◯	◯

If yes, select the highest stage of retinopathy:	◯ I ◯ II ◯ III ◯ IV ◯ V

	Yes	No	Unknown
Hypotension requiring pressor support	○	○	○
Hypoxic-ischemic encephalopathy	○	○	○
Meconium aspiration syndrome	○	○	○
Respiratory distress syndrome (RDS)	○	○	○
Transient tachypnea of the newborn (TTN)	○	○	○
Other (specify)	○	○	○

Specify other

_____

Antiviral Medications

Mark yes/ no/ unknown to denote if the patient received any of the following COVID-19 treatments.

Please note that these options reflect the available treatments in October 2020. Please expand this list as necessary as treatment regiments evolve.

	Yes	No	Unknown
Oseltamivir	○	○	○
Tamiflu, Zanamavir	○	○	○
Relenza	○	○	○
Peramivir	○	○	○
Other (specify)	○	○	○

Specify other

_____

Final Status of Infant

Stillbirth? ○ Yes ○ No

Infant death? ○ Yes ○ No

Date of death

_____
(MMDDYYYY)

If infant died, cause of death (time frame: up to a year)

Select one primary cause of death:

- ○ COVID-19
- ○ Congenital anomaly
- ○ Extreme prematurity
- ○ Sepsis not related to COVID-19
- ○ Lethal chromosome abnormality
- ○ HIE
- ○ Other (specify)

Specify Other

_____

Select one secondary cause of death:	◯ COVID-19 ◯ Congenital anomaly ◯ Extreme prematurity ◯ Sepsis not related to COVID-19 ◯ Lethal chromosome abnormality ◯ HIE ◯ Other (specify)
Specify Other	_____
Select all that apply for any additional causes of death:	☐ COVID-19 ☐ Congenital anomaly ☐ Extreme prematurity ☐ Sepsis not related to COVID-19 ☐ Lethal chromosome abnormality ☐ HIE ☐ Other (specify) (select all that apply)
Specify Other	_____

Socioeconomic Status, Housing, and Emergent Financial Strain

COVID-19 Pregnancy Registry | Psychosocial Recommended Measures

A hierarchical approach was used to select the recommended measures herein, with top preference for 1) known, validated instruments, followed by 2) measures from COVID-19 studies already in the field, 3) modified versions of existing measures, and 4) developing our own measures.

A subset of measures included here are designated as "Tier 2." Those without this designation-i.e., "Tier 1" measures-are recommended for all studies that may include women of reproductive age and pregnant women. Tier 2 measures are suggested additional measures for studies focused exclusively on COVID-19 in pregnancy and/or for any study interested in taking a "deeper dive" in certain domains.

Footnotes provide the source for each measure; the original validated measure was used where appropriate and language was updated as needed. In some instances, the working group was unable to find an appropriate validated measure and instead provided a Working Group Recommendation.

Education Level

What is the highest grade or level of school you have completed or the highest degree you have received?

- ◯ Never attended / Kindergarten only
- ◯ 1st grade
- ◯ 2nd grade
- ◯ 3rd grade
- ◯ 4th grade
- ◯ 5th grade
- ◯ 6th grade
- ◯ 7th grade
- ◯ 8th grade
- ◯ 9th grade
- ◯ 10th grade
- ◯ 11th grade
- ◯ 12th grade, no diploma
- ◯ High school graduate
- ◯ GED or equivalent
- ◯ Some college, no degree
- ◯ Associate degree: occupational, technical, or vocational program
- ◯ Associate degree: academic program
- ◯ Bachelor's degree (example: BA, AB, BS, BBA)
- ◯ Master's degree (example: MA, MS, MENG, MED, MBA)
- ◯ Professional school degree (example: MD, DDS, DVM, JD)
- ◯ Doctoral degree (example: PHD, EDD)

Financial Strain / Material Hardship

How difficult is it to meet each of the following needs for you and/or your family during this pregnancy?

	Not Difficult	Somewhat Difficult	Very Difficult
Have enough money for food	◯	◯	◯

Have enough money to pay for electricity or heating or water	○	○	○
Have enough money to pay for housing	○	○	○
Get help from community organizations that you trust	○	○	○
Get help from family members and friends	○	○	○
See a healthcare provider if you or your family needs it	○	○	○
Get routine / essential medications	○	○	○
Get transportation when you need it	○	○	○
Use the internet for things like work, school, medical visits, socializing	○	○	○

Thinking about the future, over the next 3 months, because of coronavirus, how challenging will it be to make ends meet?

- ○ A lot more challenging than usual
- ○ A little more challenging than usual
- ○ No more challenging than usual
- ○ Don't know

Postpartum Only

How difficult is it to meet each of the following needs for you and/or your family after your recent pregnancy?

	Not Difficult	Somewhat Difficult	Very Difficult
Have enough money for food	○	○	○
Have enough money to pay for electricity or heating or water	○	○	○
Have enough money to pay for housing	○	○	○
Get help from community organizations that you trust	○	○	○
Get help from family members and friends	○	○	○
See a healthcare provider if you or your family needs it	○	○	○
Get routine / essential medications	○	○	○

Get transportation when you need it	○	○	○
Use the internet for things like work, school, medical visits, socializing	○	○	○

Household Income

Thinking about members of your family living in this household, about how much is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

If you are not sure, make your best guess.

- ☐ $0 to $9,999
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $199,999
- ☐ $200,000 or more

Government Assistance

As a result of COVID-19 have you received:

	Yes	No	Not Sure	Decline to answer
Enrollment in the Special Supplemental Nutrition Program for Women, Infants, and Children, known as WIC?	○	○	○	○
One or more stimulus checks from the government?	○	○	○	○
Any amount of unemployment benefits from the government?	○	○	○	○

Loss / Change of Housing

Has the coronavirus pandemic led to any of the following?

Relocation or moving from where you lived before the pandemic (e.g., downsizing, moving in with family, etc.)	○ Yes	○ No
Facing possible eviction	○ Yes	○ No
Becoming homeless	○ Yes	○ No

Household Crowding (Tier 2)

How many total people (adults and children) currently live in your household, including yourself?

_____
(Please enter a number)

How many people under 18 years old currently live in your house, including yourself?

_____
(Please enter a number)

How many bedrooms are in the place where you currently live?

If you live in a place that does not have separate rooms or bedrooms, please enter 0

_____
(Please enter a number)

Food Security

The following are several statements that people have made about their food situation. Please tell me whether the statement was often, sometimes, or never true for (you / you and other members of your household) in the last 12 months, since (date 12 months ago)

	Often true	Sometimes true	Never true	Don't know
1. The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more.	○	○	○	○
2. (I/we) couldn't afford to eat balanced meals.	○	○	○	○

3. In the last 12 months, since (date 12 months ago) did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

- ○ Yes
- ○ No (skip to 5)
- ○ Don't know (skip to 5)

If yes, please answer the following questions. If no, skip to question 5 below

3a. How often did this happen - almost every month, some months but not every month, or in only 1 or 2 months?

- ○ Almost every month
- ○ Some months but not every month
- ○ Only 1 or 2 months
- ○ Don't know

4. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?

- ○ Yes
- ○ No
- ○ Don't know

5. In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food?

- ○ Yes
- ○ No
- ○ Don't know

6.In the last 12 months, if you didn't have enough to eat or what you wanted to eat, why was that? Choose all that apply.
(select all that apply)

☐ Couldn't get out to buy food (for example, didn't have transportation, or had mobility or health problems that prevented you from getting out)
☐ Afraid to go or didn't want to go out to buy food
☐ Afraid to go out because of the chance of contracting COVID-19
☐ Couldn't get groceries or meals delivered to me
☐ The stores didn't have the food I wanted
☐ Other(specify)
☐ I always had enough to eat and what I wanted to eat

Specify other

_____

Current Employment

What is your current employment situation?

◯ Working now
◯ Only temporarily laid off, sick leave, or maternity leave
◯ Looking for work, unemployed
◯ Retired
◯ Disabled, permanently, or temporarily
◯ Keeping house / home maker / stay at home parent
◯ Student
◯ Other(specify)

Specify other

_____

Changes in Employment Situation

SELF:

Which of the following changes in employment have occurred due to the COVID-19 outbreak for yourself?

	Yes	No	Not Applicable
(1) Move to remote work, telework	◯	◯	◯
(2) Loss of hours	◯	◯	◯
(3) Decreased pay	◯	◯	◯
(4) Loss of job	◯	◯	◯
(5) Decreased job security	◯	◯	◯
(6) Disruptions due to childcare challenges	◯	◯	◯
(7) Increased hours	◯	◯	◯
(8) Another change	◯	◯	◯

How bothersome or distressful were changes to your family's employment?	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much

COVID-19 Exposure Risk due to Occupation

Does your job or occupation require you to be in person and face-to-face with others? If yes, please answer the following questions. If no, no further questions for this data element	◯ Yes ◯ No
Are you able to practice physical distancing at work (stay at least 6 feet away from other people)?	◯ Yes ◯ No
Do you consistently use Personal Protective Equipment (PPE) (like a mask or face shield or gloves) you need to limit your exposure to the coronavirus in your workplace?	◯ Yes ◯ No ◯ Sometimes

Zip Code

What is the zip code where you currently live?	_____

Healthcare Access

Health Insurance Status

Are you currently covered by any of the following types of health insurance or health coverage plans?

Please exclude plans that pay for only one type of service - such as, nursing home care, accidents, family planning, or dental care, and plans that only provide extra cash when hospitalized)

	Covered	Not Covered	Not Sure
a. Insurance through a current or former employer or union (of yours or another family member's). This would include COBRA coverage.	○	○	○
b. Insurance purchased directly from an insurance company (by you or another family member). This would include coverage purchased through an exchange or marketplace, such as HealthCare.gov or [IF THE RESPONDENT IS IN A STATE WITH STATE-SPECIFIC NAMES, INSERT PROGRAM NAME].	○	○	○
c. Medicare, for people 65 and older, or people with certain disabilities.	○	○	○
d. Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP), or any kind of state or government-sponsored assistance. plan based on income or a disability. You may know this type of coverage as [IF THE RESPONDENT IS IN A STATE WITH STATE-SPECIFIC NAMES, INSERT PROGRAM NAME].	○	○	○
e. TRICARE or other military health care, including VA health care.	○	○	○
f. Indian Health Service.	○	○	○

g. Any other type of health insurance coverage or health coverage plan	○	○	○

Changes to Health Insurance (Tier 2)

During this pregnancy, have you had a change in your health insurance coverage? ○ Yes ○ No

If yes, please answer the following question. If no, no further questions for this data element

What change occurred?

- ☐ Loss of your health insurance
- ☐ Fewer benefits / less coverage from the insurance
- ☐ Gaining insurance, for example as part of emergency coverage of Medicaid expansion

Access to Medical Care

During this pregnancy, has the coronavirus led to any of the following changes in your prenatal care or problems accessing medical care? ○ Yes ○ No

If yes, please answer the following question. If no, no further questions for this data element

If yes, was it because:
[select all that apply]

- ☐ My healthcare provider canceled some or all of my prenatal visits
- ☐ I had more prenatal visits
- ☐ My prenatal visits changed from in-person to phone or telemedicine/video
- ☐ I could not afford to pay for care
- ☐ I was scared I might get infected with the coronavirus at the health care facility
- ☐ The healthcare facility was closed because of the coronavirus pandemic
- ☐ I had symptoms of COVID-19, so I stayed home
- ☐ I cancelled the appointment(s) to avoid being around others
- ☐ I cancelled the appointment because I did not want to be in a healthcare setting
- ☐ I felt okay or good enough and didn't need care
- ☐ I had difficulty arranging childcare and couldn't attend prenatal care visit(s)
- ☐ I had no transportation to get to the healthcare provider's office
- ☐ I had no one to go with me or help me during appointments
- ☐ I was scared I might get infected with the coronavirus on public transportation
- ☐ I forgot to go / just missed my appointment
- ☐ Changed format of prenatal care (i.e. no group classes)
- ☐ Cancellation of hospital tours

Postpartum Only

Since you gave birth, has the coronavirus led to any of the following problems accessing medical care? ○ Yes ○ No

If yes, please answer the following question. If no, no further questions for this data element

If yes, was it because:
[select all that apply]

- ☐ I could not afford to pay for care
- ☐ I was scared I might get infected with the coronavirus at the health care facility
- ☐ The healthcare facility was closed because of the coronavirus pandemic
- ☐ I had difficulty arranging childcare
- ☐ I had no transportation to get to the healthcare provider's office
- ☐ I was scared I might get infected with the coronavirus on public transportation
- ☐ My provider recommended decreasing the usual number of prenatal visits
- ☐ My provider switched to telehealth visits
- ☐ I had no one to go with me or help me

Distress about changes to Medical Care (Tier 2)

	Not at all	A little bit	Somewhat	Quite a bit	Very much
How bothersome or distressful were those changes to prenatal care and problems accessing medical care?	○	○	○	○	○

Changes to Delivery Plan due to COVID-19 (Tier 2)

Which of the following changes did you experience as a result of the COVID-19 outbreak?
[select all that apply]

- ☐ I changed from planning a vaginal birth to a C-section
- ☐ My planned C-section or labor induction was changed
- ☐ I delivered in the hospital instead of at home
- ☐ I delivered at home instead of in the hospital
- ☐ My support people (e.g., spouse/partner, family) were not permitted to attend delivery or visit after delivery
- ☐ I didn't get to have skin to skin contact right after baby was born
- ☐ I was separated from my baby immediately after delivery, to avoid exposure because I had COVID-19
- ☐ I was not able to room-in with the baby
- ☐ I changed from planning to breastfeeding to feeding only formula
- ☐ I changed from planning to feed only formula to breastfeeding
- ☐ Nothing changed in my prenatal care, birth or newborn plans

Distress About Changes to Delivery Plan (Tier 2)

	Not at all	A little bit	Somewhat	Quite a bit	Very much
How bothersome or distressful was that experience?	○	○	○	○	○

Impact On Parenting

Breastfeeding

What method do you plan to use to feed your new baby in the first few weeks?

- ◯ Breastfeed only (baby will not be given formula)
- ◯ Formula feed only
- ◯ Both breast and formula feed
- ◯ Don't know yet

	Yes	No	Don't Know
Were you ever advised you should not breastfeed your new baby(ies), for example if you have a health condition that prevents it?	◉	◉	◯

Postpartum only

Did you ever breastfeed or pump breast milk to feed your new baby (or babies if you had twins or more) after delivery, even for a short period of time?

◉ Yes ◉ No

If mother has multiple babies, direct the mother to answer based on the baby they breastfed the most

Feelings of Attachment to Newborn

Postpartum Only

Please indicate how often the following are true for you.

There are no 'right' or 'wrong' answers. Choose the answer which seems right in your recent experience:

	Always	Very often	Quite often	Sometimes	Rarely	Never
I feel close to my baby	◉	◉	◉	◉	◉	◉
	Always	Very often	Quite often	Sometimes	Rarely	Never
I wish the old days when I had no baby would come back	◉	◉	◉	◉	◉	◉
The baby doesn't seem to be mine	◉	◉	◉	◉	◉	◉
My baby winds me up	◉	◉	◉	◉	◉	◉
	Always	Very often	Quite often	Sometimes	Rarely	Never
I love my baby to bits	◉	◉	◉	◉	◉	◉
I feel happy when my baby smiles or laughs	◉	◉	◉	◉	◉	◉
	Always	Very often	Quite often	Sometimes	Rarely	Never

My baby irritates me	○	○	○	○	○	○
My baby cries too much	○	○	○	○	○	○
I feel trapped as a mother	○	○	○	○	○	○
I resent my baby	○	○	○	○	○	○

	Always	Very often	Quite often	Sometimes	Rarely	Never
My baby is the most beautiful baby in the world	○	○	○	○	○	○

	Always	Very often	Quite often	Sometimes	Rarely	Never
I wish my baby would somehow go away	○	○	○	○	○	○

Impact of Pandemic on Children's Education (Tier 2)

Do you have children living in your home that you are responsible for? ○ Yes ○ No

If yes, please answer the following questions. If no, move on to next question.

How many? _____

What is the age of the youngest child? _____ (years)

What is the age of the oldest child? _____ (years)

What is your household's current situation for childcare and/or schooling? (select all that apply)

- ☐ I or someone in my household care for my child(ren) full-time
- ☐ I or someone in my household care for my child(ren) part-time
- ☐ I or someone in my household try to balance childcare/home schooling and work/telework responsibilities at home
- ☐ Someone from outside my household (friend, family, nanny) cares for my child(ren) in my home
- ☐ My child(ren) goes to a childcare center or someone else's home for childcare
- ☐ My child(ren) does not need childcare; they take care of themselves
- ☐ My child(ren) goes to school in-person
- ☐ My child(ren) goes to school virtually (online)

Distress About Impact of Pandemic on Children's Education (Tier 2)

How bothersome or distressful is the current situation for childcare and/or schooling?

- ○ Not at all
- ○ A little bit
- ○ Somewhat
- ○ Quite a bit
- ○ Very much

Impact of Pandemic on Childcare

How has the COVID-19 outbreak affected your regular childcare?
(select all that apply)

☐ I had difficulty arranging for childcare
☐ I had to pay more for childcare
☐ My spouse/partner or I had to change our work schedule to care for our children ourselves
☐ My regular childcare has not been affected by the COVID-19 outbreak
☐ I do not have a child in childcare

Distress About the Impact of the Pandemic on Childcare (Tier 2)

How bothersome or distressful have the changes to your regular childcare been?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ My regular childcare has not been affected by the COVID-19 outbreak
◯ I do not have a child in childcare

Stressful Life Events

Racial / Ethnic Harassment and Discrimination

In your day to day life, how often do any of the following things happen to you?

	Almost everyday	At least once a week	A few times a month	A few times a year	Less than once a year	Never
You are treated with less courtesy or respect than other people.	○	○	○	○	○	○
You receive poorer service than other people at restaurants or stores.	○	○	○	○	○	○
People act as if they think you are not smart	○	○	○	○	○	○
People act as if they are afraid of you.	○	○	○	○	○	○
You are threatened or harassed.	○	○	○	○	○	○

Please answer the below question for each experience that you marked as "A few times a year" or more.

If you did not answer "A few times a year" or more to any question, no further questions for this data element

What do you think is the main reason for these experiences?
[select all that apply]

- ☐ Your ancestry or national origins
- ☐ Your gender
- ☐ Your race
- ☐ Your age
- ☐ Your religion
- ☐ Your height
- ☐ Your weight
- ☐ Some other aspect of your physical appearance
- ☐ Your sexual orientation
- ☐ Your education or income level
- ☐ A physical disability
- ☐ Your shade of skin color
- ☐ Your tribe
- ☐ Other (specify)

Specify other _____

Intimate Partner Violence

Has your current partner ever threatened you or made you feel afraid? (For example, threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages)	◯ No ◯ Yes
Has your partner ever hit, choked, or physically hurt you?	◯ No ◯ Yes
Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?	◯ No ◯ Yes
Does your partner support your decision about when or if you want to become pregnant?	◯ No ◯ Yes
Has your partner ever tampered with your birth control or tried to get you pregnant when you didn't want to be?	◯ No ◯ Yes

Now I would like to ask you some questions about experiences with your partner or spouse. In the last 12 months, how often has a partner or spouse

	Never	Almost never	Sometimes	Fairly often	Very often
Yelled at you or said things to you that made you feel bad about yourself, embarrassed you in front of others, or frightened you?	◯	◯	◯	◯	◯
Done things like push, grab, hit, slap, kick, or throw things at you during an argument or because they were angry with you?	◯	◯	◯	◯	◯

Change in Frequency of Abuse (Tier 2)

In the last 12 months has the frequency of these behaviors increased, decreased or stayed the same?

◯ Increased
◯ Decreased
◯ Stayed the same

Mental Health Stress

Antepartum / Postpartum Depression

In the past 7 days:

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 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

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 been anxious or worried for no good reason

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

I have felt scared or panicky for no very good reason

◯ Yes, quite a lot
◯ Yes, sometimes
◯ No, not much
◯ No, not 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, have been coping as well as ever

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 felt sad or miserable

◯ Yes, most of the time
◯ Yes, quite often
◯ 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

The thought of harming myself has occurred to me

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

COVID-19 Related Anxiety

Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then indicate how distressing each difficulty has been for you.

DURING THE PAST SEVEN DAYS with respect to the COVID-19 pandemic, how much were you distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Other things kept making me think about it.	◯	◯	◯	◯	◯
2. I thought about it when I didn't mean to.	◯	◯	◯	◯	◯
3. I tried not to think about it.	◯	◯	◯	◯	◯
4. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	◯	◯	◯	◯	◯
5. I had trouble concentrating.	◯	◯	◯	◯	◯
6. I felt watchful and on-guard.	◯	◯	◯	◯	◯

General Anxiety Disorder Symptoms

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	◯	◯	◯	◯
2. Not being able to stop or control worrying	◯	◯	◯	◯

3. Worrying too much about different things	○	○	○	○
4. Trouble relaxing	○	○	○	○
5. Being so restless that it's hard to sit still	○	○	○	○
6. Becoming easily annoyed or irritable	○	○	○	○
7. Feeling afraid as if something awful might happen	○	○	○	○

Coping Mechanisms

What have you done to cope with your stress related to the COVID-19 outbreak?
[select all that apply]

☐ Meditation and/or mindfulness practices
☐ Talking with friends and family (e.g., by phone, text, or video)
☐ Engaging in more family activities (e.g., games, sports)
☐ Increased television watching or other screen time activities (e.g., video games, social media)
☐ Getting exercise
☐ Eating more often, including snacking
☐ Increasing time reading books, or doing activities like puzzles and crosswords
☐ Going outside, enjoying nature and the outdoors
☐ Drinking alcohol
☐ Using tobacco (e.g., smoking, vaping)
☐ Using marijuana (e.g., vaping, smoking, eating) or cannabidiol (CBD)
☐ Talking to my healthcare providers more frequently, including mental healthcare provider (e.g., therapist, psychologist, counselor)
☐ Volunteer work
☐ I have not done any of these things to cope with the COVID-19 outbreak

These items deal with ways you've been coping with the stress in your life since the onset of the coronavirus pandemic.

Consider how well the following statements describe your behavior and actions.

	Does not describe me at all	Does not describe me	Neutral	Describes me	Describes me very well
I look for creative ways to alter difficult situations.	○	○	○	○	○
Regardless of what happens to me, I believe I can control my reaction to it	○	○	○	○	○
I believe I can grow in positive ways by dealing with difficult situations	○	○	○	○	○

I actively look for ways to replace the losses I encounter in life.	○	○	○	○	○

Sources of Support

In the past month, has there been someone you can talk to about things that are important to you, someone you can count on for understanding or support?

- ☐ Very infrequently
- ☐ Infrequently
- ☐ Neutral
- ☐ Frequently
- ☐ Very frequently

In the past month, please describe how often...

There is someone around to help you if you need it (like taking you to the doctor, taking you grocery shopping, or making meals, watching your kids)

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Don't Know

Do you have someone who you can depend on in an emergency (going into labor, Emergency expense of more than you can afford?

- ☐ Definitely
- ☐ Most likely
- ☐ Unsure
- ☐ Most likely not
- ☐ Definitely not

Loneliness / Social Isolation (Tier 2)

	Hardly Ever	Some of the Time	Often
How often do you feel that you lack companionship: Hardly ever, some of the time, or often?	○	○	○
How often do you feel left out: Hardly ever, some of the time, or often?	○	○	○
How often do you feel isolated from others: Hardly ever, some of the time, or often?	○	○	○

Health Related Behaviors

Pre-Pregnancy and Current Alcohol Use (Tier 2)

In the month before you became pregnant, how often did you have a drink containing alcohol?	◯ Never - skip the next 2 questions ◯ Monthly or less ◯ 2-4 times a month ◯ 2-3 times a week ◯ 4 or more times a week
In the month before you became pregnant, how many standard drinks containing alcohol did you have on a typical day? (A standard drink is one 12-oz bottle/can of beer, one 5 oz glass of wine, or one 1.5 oz shot of liquor)	◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more
In the month before you became pregnant, how often did you have four or more standard drinks on one occasion? (A standard drink is one 12-oz bottle/can of beer, one 5 oz glass of wine, or one 1.5 oz shot of liquor)	◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily
In the past month, how often did you have a drink containing alcohol?	◯ Never - skip the next 2 questions ◯ Monthly or less ◯ 2-4 times a month ◯ 2-3 times a week ◯ 4 or more times a week
In the past month how many standard drinks containing alcohol did you have on a typical day? (A standard drink is one 12-oz bottle/can of beer, one 5 oz glass of wine, or one 1.5 oz shot of liquor)	◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more
In the past month, how often did you have four or more standard drinks on one occasion? (A standard drink is one 12-oz bottle/can of beer, one 5 oz glass of wine, or one 1.5 oz shot of liquor)	◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily

Current Opioid Use (Tier 2)

In the past month, how frequently have you used opiates, heroin, or other narcotics? (including prescription narcotics like Vicodin and OxyContin, etc.)	◯ Never ◯ Rarely ◯ Once a month ◯ Several times a month ◯ Once a week ◯ Several times a week ◯ Once a day ◯ More than once a day

Current Weekday Hours of Sleep (Tier 2)

In the past seven days was your sleep was restless?	◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much
In the past seven days what was your sleep quality?	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good