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Release Participant ID

Your answers to the following questions will provide useful and valuable information. Please fill in the box(es) that correspond to your answer. All information is confidential. Thank you for your time.

1. We are interested in knowing how much you weighed before you were pregnant (this pregnancy). Some people give us wrong information like their “ideal” weight or what they would like to weigh. That’s not what we want. We would like the most correct information about your weight before this pregnancy. A way to measure this might be to report how much you weighed at your last period. As best you can, **please tell us how much you weighed before you became pregnant.**

**[PPREGWT]**

<sub>0</sub> ≤ 137 lbs

lbs

<sub>2</sub> ≥ 246 lbs

2. Maternal Race / Ethnicity **[NEWRACE]**

<sub>1</sub>

Hispanic

<sub>2</sub>

Non-Hispanic African American

<sub>3</sub>

Non-Hispanic Caucasian

<sub>4</sub>

Other, more than one race

3. What is the age of your baby’s biological father? (*leave blank if unknown*) **[BDADAGE]**

<sub>0</sub> ≤ 26 years

years

<sub>2</sub> ≥ 43 years

4. Paternal Race / Ethnicity **[NEWDRAE]**

<sub>1</sub>

Hispanic

<sub>2</sub>

Non-Hispanic African American

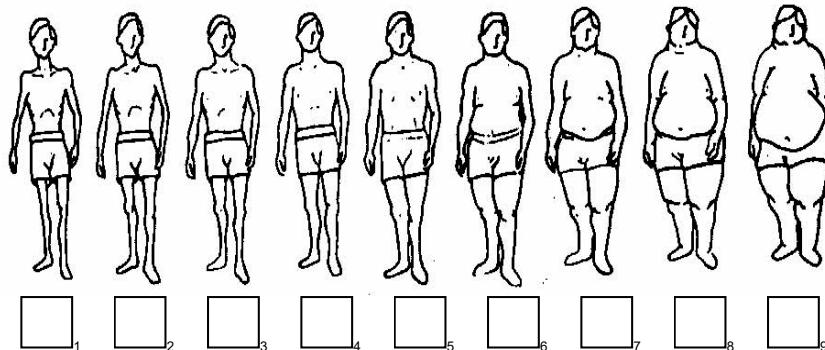
<sub>3</sub>

Non-Hispanic Caucasian

<sub>4</sub>

Other, more than one race

5. Please take a look at these silhouettes. Check the box for the silhouette that most closely resembles the usual weight of the biological father of your baby. **[BDADWT]**



6. What is your **current** marital status? **[BMARRY]**

<sub>1</sub>

Married

<sub>2</sub>

Not married and living with significant other

<sub>3</sub>

Separated/ Divorced/ Widowed

<sub>4</sub>

Not married

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7. With how many people do you share your family income? (Please include yourself, spouse, children, dependents, and any other adult sharing your income) **[INCSHAR]**

people

<sub>5</sub> ≥ 5 people

8. What is your approximate total family income for the past year? **[INCOME]**

<sub>1</sub>  
Less than \$25,000

<sub>2</sub>  
\$25,000 - \$74,999

<sub>3</sub>  
≥ \$75,000

9. Which of the following describes your current living situation? **[BLIVE]**

<sub>1</sub>  
Own single family house  
or townhouse or condo

<sub>2</sub>  
Rent

<sub>3</sub>  
Live in the home of your parents  
or other adults

10. College degree or higher: **[COLLEGE]**

<sub>1</sub>  
Yes

<sub>0</sub>  
No

11. How many televisions are in your home? **[BTVNUM]**

12. Do you have a telephone? (land line or cell phone) **[BPHONE]**

<sub>1</sub>  
Yes

<sub>0</sub>  
No

13. Do you have a computer? (desktop, laptop, tablet or smart phone) **[BCOMPUTER]**

<sub>1</sub>  
Yes

<sub>0</sub>  
No

14. Do you have internet access at home? **[BINTERNET]**

<sub>1</sub>  
Yes

<sub>0</sub>  
No

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15. Do you currently smoke cigarettes? **[BSMOKE]**

<sub>1</sub>

Yes

<sub>0</sub>

No

**If Yes,**

a. What is the average number of cigarettes/day in the last week?  
(Enter 0 if less than 1 cigarette per day) **[BCIGNUM]**

16. Do you currently drink alcohol? **[BDRINK]**

<sub>1</sub>

Yes

<sub>0</sub>

No

**If Yes,**

a. How many drinks in the last week?  
(Enter 0 if less than 1 drink) **[BDRKNUM]**

Questions 17-19: Here are several questions regarding any nausea and vomiting during your first trimester. Fill in the answer that best suits your situation from the beginning of your pregnancy.

17. On average in a day, for how long do you feel nauseated or sick to your stomach? **[BSICK]**

<sub>1</sub>

Not at all

<sub>2</sub>

≤ 1 hr or  
"1 hour or less"

<sub>3</sub>

2-3 hours

<sub>4</sub>

4-6 hours

<sub>5</sub>

> 6 hr or "more  
than 6 hours"

18. On average in a day, how many times do you vomit or throw up? **[BVOMIT]**

<sub>5</sub>

≥7 times or "7  
times or more"

<sub>4</sub>

5-6 times

<sub>3</sub>

3-4 times

<sub>2</sub>

1-2 times

<sub>1</sub>

I did not  
throw up

19. On average in a day, how many times do you have a retching or dry heaves without bringing anything up? **[BRETCH]**

<sub>1</sub>

None

<sub>2</sub>

1-2 times

<sub>3</sub>

3-4 times

<sub>4</sub>

5-6 times

<sub>5</sub>

≥7 times or "7 times  
or more"

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Questions 20-21: Here are two statements that people have made about their food situation. For these statements, please indicate whether the statement was often true, sometimes true, or never true for your household in the last 12 months.

20. We worried whether our food would run out before we got money to buy more. Was that often true, sometimes true, or never true for your household in the last 12 months? **[BFOODWOR]**

<sub>1</sub>                      <sub>2</sub>                      <sub>3</sub>                      <sub>4</sub>                      <sub>5</sub>

Often true                      Sometimes true                      Never true                      Refused                      Don't know

21. The food that we bought just didn't last, and we didn't have money to get more. Was that often, sometimes, or never true for your household in the last 12 months? **[BFOODOUT]**

<sub>1</sub>                      <sub>2</sub>                      <sub>3</sub>                      <sub>4</sub>                      <sub>5</sub>

Often true                      Sometimes true                      Never true                      Refused                      Don't know

OP Do you have any family history of high blood pressure or diabetes (high blood sugar)?

1. UK/NA = Unknown / Not applicable

	Brother or Sister			Mother			Father			Maternal Grand-mother			Maternal Grand-father			Paternal Grand-mother			Paternal Grand-father		
	Yes	No	UK/NA	Yes	No	UK/NA	Yes	No	UK/NA	Yes	No	UK/NA	Yes	No	UK/NA	Yes	No	UK/NA	Yes	No	UK/NA
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>[BBPSIB]</b>			<b>[BBPMOM]</b>			<b>[BBPDAD]</b>			<b>[BBPMGM]</b>			<b>[BBPMGF]</b>			<b>[BBPPGM]</b>			<b>[BBPPGF]</b>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>[BDIABSIB]</b>			<b>[BDIABMOM]</b>			<b>[BDIABDAD]</b>			<b>[BDIABMGM]</b>			<b>[BDIABMGF]</b>			<b>[BDIABPGM]</b>			<b>[BDIABPGF]</b>		

OP2. Do you use supplemental food sources? **[BSUPFOOD]**

<sub>1</sub>  
Yes

<sub>0</sub>  
No

**If Yes,**  
Specify: **(Check all that apply)**

<sub>1</sub>  
Women, Infants, and Children (WIC)  
**[BSUPWIC]**

<sub>1</sub>  
Food stamps  
**[BSUPFS]**

<sub>1</sub>  
Emergency food boxes  
**[BSUPEFB]**

<sub>1</sub>  
Other charitable sources  
**[BSUPOT]**

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OP3. Who purchases your food and controls your food budget? (Check all that apply)

<sub>1</sub>  
Yourself  
**[BBUDMOM]**

<sub>1</sub>  
Other household member  
**[BBUDOTHM]**

<sub>1</sub>  
Other non-household member  
**[BBUDOT]**

OP4. Are there children living in your house currently? **[BKIDHOME]**

<sub>1</sub>  
Yes

<sub>0</sub>  
No

**If Yes,**

To what extent are you following routines in your family?

	Almost every day	3-5 times per week	1-2 times per week	Almost never	Don't know
a. Children go to bed at the same time at night <b>[BBEDTM]</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
b. Children do the same things each morning as soon as they wake up <b>[BWAKE]</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
c. The family eats at the same time in the evening <b>[BEATM]</b>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

OP5. How often do you eat at fast food type restaurants? **[BFFOOD]**

<sub>1</sub>  
Less than once a week

<sub>2</sub>  
About once a week

<sub>3</sub>  
2 or more times a week

OP6. How often do you currently eat a meal together at home as a family? **[BEATALL]**

<sub>1</sub>  
Multiple times a day

<sub>2</sub>  
Almost every day

<sub>3</sub>  
3-5 times per week

<sub>4</sub>  
1-2 times per week

<sub>5</sub>  
Almost never

OP7. Do you plan to breastfeed? **[BBREAST]**

<sub>1</sub>  
Yes

<sub>0</sub>  
No

<sub>9</sub>  
Don't know