1. Please describe your health and your pregnancy.

2. a. Is this your first pregnancy?
   - Yes (skip to question 3)
   - No (please answer questions b. through e. below)

   b. For births after 20 weeks, were any stillbirths or neonatal deaths?
      - Yes
      - No

   c. Were any born at or before 37 weeks?
      - Yes
      - No

   d. Were any born less than or equal to 5 pounds, 8 ounces?
      - Yes
      - No

   e. What was the date your last pregnancy ended? ____________________________

3. Do you have prenatal care for this pregnancy?
   - Yes, I started prenatal care in the _______ month of pregnancy.
   - No

OVER ⇑
4. Have you had any medical problems with this or any pregnancy?
   - Yes (please list) ________________________________
   - No

5. Do you take any medications now?
   - Yes (please list) ________________________________
   - No

6. Do you smoke cigarettes now?
   - Yes. How many per day? __________________________
   - No

7. Does anyone living in your household smoke inside the home?
   - Yes    - No

8. During this pregnancy have you had any beer, wine or hard liquor?
   - Yes. How many drinks do you have per week? ______
   - No

9. Have you used any drugs during this pregnancy?
   - Yes    - No

10. How do you plan to feed your baby when he or she is born?
    - Breastfeed  - Both breastfeed and formula feed
    - Formula feed - Undecided

11. What have you heard about breastfeeding?