

Healthy Start Mandatory Background Information Form | Dec 2020

OMB Control No. 0915-0338, Expiration Date 09/30/2026

INFORMATION IN THIS BOX IS FOR GRANTEE RECORDS ONLY—DO NOT UPLOAD

Name of This Primary Participant: _____ Date of Birth: _____

Name(s) & Date(s) of Birth of Other Linked Primary Participants (up to 2 people, as applicable):

Name of Other Linked PP: _____ Date of Birth: _____

Name of Other Linked PP: _____ Date of Birth: _____

Name of Interviewer: _____

Names and dates of birth are included above for grantee tracking purposes only and should not be submitted to HRSA. The primary participant for this form is a woman (reproductive age female) who is enrolled for preconception, prenatal, postpartum, or parenting/interconception health; an enrolled father/male partner; or other non-enrolled adult who has primary responsibility for/custody of an enrolled child.

Public Burden Statement: The purpose of this information collection is to obtain performance data for the following: HRSA grantees and cooperative agreement recipients, program operations, and reporting requirements. In addition, these data will facilitate the ability to demonstrate alignment between MCHB discretionary programs and the Healthy Start Program to quantify outcomes across MCHB. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0338 and it is valid until 09/30/2026. Public reporting burden for this collection of information is estimated to average 0.46 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

INSTRUCTIONS

- This form must be administered by a trained case worker or other Healthy Start grantee staff member to ensure consistency in responding across participants and grantees when questions or misunderstandings arise. It should not be self-administered or administered by untrained staff.
- Every form should include the primary participant's Unique ID# (UID). Each person's UID should remain the same across phases and years, and should be in the format described in Question G2.
- If there is more than one primary participant in the family unit, the UIDs must appear together on this form so that all associated UIDs can be linked in the database.
- Regardless of which reproductive phase she/he is in, every primary participant should complete this form according to her/his own experiences.
- Complete the 'Pregnancy/Childbirth History' and 'Previous Births' sections for enrolled mothers only; not for fathers/male partners or other non-enrolled adults with responsibility for/custody of enrolled children.
- Items in italics are questions for, or statements to, the participant. Instructions to staff may be [bracketed].

See the next page for instructions on completing form updates.

Form Update

- When a participant experiences a phase change, is up for annual rescreening, exits the program, or continues enrollment after an enrolled child exits, please complete:
 - *General Information*: Question G8 (and G9, if exiting)And, rescreen the following questions/sections:
 - *General Information*: Questions G3, G4, and G10
 - *Participant General Information*: Question 2
 - *Participant Health Care*: All Questions (Q6-Q10)
 - *Personal Well-Being*: All Questions (Q11-Q20)
 - *Reproductive Life Planning*: All Questions (Q21-Q26)
 - *Pregnancy and Childbirth History*: For enrolled women only - All Questions (Q27-Q28)
- For other updates: To update a specific question(s) or section(s), such as when a participant experiences a major life event or a significant change in health status, please complete Question G8, "Other update," and revise the relevant question(s) and/or section(s).

Annual Rescreening

- Annual rescreening - A participant must be rescreened per the instructions above when a year has passed since they were last screened and no phase change has occurred. If a participant experiences a phase change, they must be rescreened as soon as possible per the instructions above, and complete all additional data collection forms that correspond with their current phase (e.g., if a woman becomes pregnant, she should be rescreened following the procedures above and complete a prenatal form).

Other Linked Primary Participant or Custodial Adult Updates

- To add an "other linked primary participant," complete Question G8, "Other update," and add the other linked primary participant's UID in Question G3.
- To change/remove an "other linked primary participant," email HealthyStartData@hrsa.gov using the subject line, "Technical Support Request for HSMED-II" with your requested change/removal.
- If the custodial adult or other linked primary participant changes, a new background form will need to be completed with a new UID for that person.

Participant Re-Enrollment

If a participant exits the program and then re-enrolls at a later date, the completion of the background form should be treated like an update. To perform the "re-enrollment":

- Select "other update" in Question G8 of the Background Form
 - Add the date of the update ("re-enrollment")
 - For update reason, indicate "re-enrollment after exit"
 - Remove the exit information from Question G9
 - Re-screen all sections of the form **except** for Questions G2, G5-G8, 1-1a, and 3-5
- **Note: The participant's PPUID should never change; use the same PPUID as when first enrolled.**

[GENERAL INFORMATION to be completed by staff before uploading data for this participant:]

G1. PARTICIPANT TYPE:

Primary Participant

- ☐ Enrolled woman (primary person receiving support is/identifies as a female)
- ☐ Enrolled man (primary person receiving support is/identifies as a male)
- ☐ Other adult with primary custody of enrolled child, Specify _____

G2. THIS PRIMARY PARTICIPANT'S UNIQUE ID#: _____

[Enter as One Number: Grantee Org Code + PP + Client's Unique ID (e.g., 123PP45678)]

G3. OTHER PARTICIPANTS' (IF APPLICABLE) UNIQUE ID NUMBERS THAT SHOULD BE LINKED TO THIS PRIMARY PARTICIPANT (ENTER UP TO 2 & USE FORMAT INDICATED IN QUESTION G2):

- ☐ Other Linked PP ID#: _____
- ☐ Other Linked PP ID#: _____
- ☐ Or, no other participants are linked to the primary participant completing this form

G4. THIS PARTICIPANT HAS AT LEAST ONE ENROLLED CHILD ATTACHED TO HER/HIM:

- ☐ Yes, currently [Staff: Complete Parent/Child Form]
- ☐ No, never
- ☐ Formerly, but no longer

G5. DATE OF THIS PRIMARY PARTICIPANT'S ENROLLMENT IN HEALTHY START:

⇒ Date _____ [Staff: Leave blank if not enrolled]

G6. WHAT PHASE OF THE REPRODUCTIVE CYCLE WAS THE PRIMARY PARTICIPANT IN WHEN HE/SHE FIRST ENROLLED IN HS? (SELECT ALL THAT APPLY)

Preconception

- ☐ Woman (no prior pregnancies)
- ☐ Man (no prior children)

Prenatal

- ☐ Currently pregnant
- ☐ Partner is currently pregnant

Postpartum

- ☐ Has a live infant less than 6 months old
- ☐ Partner has a live infant less than 6 months old
- ☐ Had a pregnancy loss less than 6 months ago
- ☐ Partner had a pregnancy loss less than 6 months ago

Parenting/Interconception

- ☐ Has child(ren) 6-18 months enrolled in HS
- ☐ Has children, but they are not enrolled in or are not eligible for HS services
- ☐ A woman with no live children but who had a pregnancy loss 6 or more months ago
- ☐ A man with no live children but whose partner had a pregnancy loss 6 or more months ago
- ☐ An non-enrolled adult who has primary responsibility for/custody of an enrolled child

G7. INITIAL COMPLETION OF THIS FORM:

⇒ Date of initial completion of this Background Information form: _____

[Staff: This is the date that the form (all applicable parts) has been completed in its entirety.]

G8. THIS FORM HAS BEEN UPDATED WITH THE PRIMARY PARTICIPANT FOLLOWING ITS INITIAL COMPLETION BASED ON [select below as applicable]:

- ☐ Enrolled woman enters prenatal phase
⇒ Date updated: _____
- ☐ Enrolled woman ends prenatal phase
⇒ Date updated: _____
- ☐ Already enrolled child turns 6 months
⇒ Date updated: _____
- ☐ Other update (e.g., primary participant continues enrollment after enrolled child exits program, annual rescreening occurs with no phase change on primary participant's part, major life event such as death of spouse/partner or divorce, significant change in health status, added/removed other linked primary participant)
⇒ Date updated: _____
⇒ Specify reason for update: _____

G9. UPDATE THIS FORM WHEN THE PARTICIPANT EXITS HS:

⇒ Date of exit from HS services: _____

⇒ Reason for exit: _____

G10. AGE CLASSIFICATION:

- Based on date of birth entered on first page, please indicate which age group below the participant falls into:
 - ☐ 10-14 years
 - ☐ 15-19 years
 - ☐ 20-24 years
 - ☐ 25-34 years
 - ☐ 35-44 years
 - ☐ 45+ years

[Staff: Please read the following statement to the participant:]

Thank you for participating in the Healthy Start program. The purpose of these forms is to examine how well the Healthy Start program is meeting its goals of helping families improve their health and the health of their babies. This questionnaire should take about 25 minutes to complete. Any information you provide will be kept confidential. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits.

Participant General Information

[Staff: Please read the following:]

First, I'd like to ask you a few general background questions. Asking these questions gives us a better idea of who our Healthy Start participants are, so we can serve you better.

1. What is your sex?

[Select one.]

- ☐ Female
- ☐ Male
- ☐ Don't know
- ☐ Declined to answer

1a. [Staff: Indicate here if participant expresses discomfort with or reluctance to use the male/female binary classification.]

- ☐ Participant prefers not to use the male/female binary categorization (including 'I'm not sure/don't know/don't want to answer' responses)
- ☐ No, the participant seemed comfortable with the binary male/female designation
- ☐ Unable to determine

2. Now I'd like to ask some questions about your education. What is the highest grade or level of school that you have completed?

- ☐ No formal schooling
- ☐ 8th grade or less
- ☐ Some high school (Grades 9, 10, 11, & 12)
- ☐ High school diploma (Completed 12th grade)
- ☐ G.E.D.
- ☐ Some college or 2-year degree
- ☐ Technical or trade school
- ☐ Bachelor's degree
- ☐ Graduate or professional school
- ☐ Don't know
- ☐ Declined to answer

3. Are you of Hispanic or Latino/a origin?

[Select one.]

- ☐ Yes, Hispanic or Latino
- ☐ No, Not Hispanic or Latino
- ☐ Don't know
- ☐ Declined to answer

4. What is your race?

[Select all that apply.]

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Don't know
- ☐ Declined to answer

5. Which ONE racial classification below do you identify with the most?

[Select one.]

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ More than one race/biracial/multiracial
- ☐ Other: _____
- ☐ Don't know
- ☐ Declined to answer

Participant Health Care

Next, I'd like to ask you some questions about your current health care. Collecting this information gives us a better idea of our participants' experiences and needs, so we can improve the services we offer.

6. Is there a place that you USUALLY go for care when you are sick or need advice about your health?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

7. Where do you USUALLY go first?

[Select one.]

- | | |
|---|---|
| <input type="checkbox"/> Doctor's Office | <input type="checkbox"/> School (Nurse's Office, Athletic Trainer's Office) |
| <input type="checkbox"/> Hospital Emergency Room | <input type="checkbox"/> Some other place* |
| <input type="checkbox"/> Hospital Outpatient Department | _____ |
| <input type="checkbox"/> Clinic or Health Center | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Retail Store Clinic or "Minute Clinic" | <input type="checkbox"/> Declined to answer |

[Staff: If participant says 'urgent care,' mark this as 'some other place' and write in 'urgent care.' If participant does not know what a 'Minute Clinic' is, explain that it is a walk-in clinic at a local pharmacy or store.]

8. DURING THE PAST 12 MONTHS, were you EVER covered by ANY kind of health insurance or health coverage plan?

- ☐ Yes, I was covered all 12 months
- ☐ Yes, but I had a gap in coverage
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

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

[Select all that apply.]

	Insurance Type	Check if currently have
a.	Private health insurance from my job or the job of my spouse or partner	<input type="checkbox"/>
b.	Private health insurance from my parents	<input type="checkbox"/>
c.	Private health insurance from the <State> Health Insurance Marketplace or <state website> or HealthCare.gov	<input type="checkbox"/>
d.	Medicaid (Title XIX) (required: state Medicaid name_____)	<input type="checkbox"/>
e.	CHIP (Title XXI)	<input type="checkbox"/>
f.	Subsidized ACA plan (also called 'subsidized premium or subsidized coverage through the Affordable Care Act')	<input type="checkbox"/>
g.	TRICARE or other military health care	<input type="checkbox"/>
h.	*Indian Health Service or tribal [also check 'I do not have health insurance now' below if the participant does not have other insurance type]	<input type="checkbox"/>
i.	Other health insurance. Please tell us:_____	<input type="checkbox"/>
j.	I do not have health insurance now	<input type="checkbox"/>
k.	Don't know	<input type="checkbox"/>
l.	Declined to answer	<input type="checkbox"/>

[Staff Note: If the participant uses Indian Health Service, please indicate above. We understand that Indian Health Service (IHS) does not constitute insurance. If a participant uses IHS, please check both the IHS and the 'I do not have health insurance now' boxes, if the participant does not have other insurance. This will enable HS to track IHS as a separate item in addition to being counted as not having health insurance.]

10. During the past 12 months, did you see a doctor, nurse, or other health care professional for PREVENTIVE medical care, such as a physical or well-visit checkup? A preventive check-up is when you are not sick or injured, such as an annual or sports physical, or well-visit.

[Select one.]

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Declined to Answer

[Staff: A visit for PREVENTIVE medical care DOES NOT include prenatal care.]

Personal Well-Being

Next, I'm going to ask you some questions about how you're doing in day to day life, that is, your own sense of personal well-being. I'll start with a couple of questions about income because the financial resources available to us can have a big impact on stress in our daily lives.

11. First, can you tell me, during the past 12 months, what was your yearly total household income before taxes? Please include all sources of income, including your income, your spouse's or partner's income, your parents' income (if in same household), and any other income you may have received. All information will be kept private and will not affect any services you are now getting.

[Select one.]

- ☐ \$0 to \$16,000
- ☐ \$16,001 to \$20,000
- ☐ \$20,001 to \$24,000
- ☐ \$24,001 to \$28,000
- ☐ \$28,001 to \$32,000
- ☐ \$32,001 to \$40,000
- ☐ \$40,001 to \$48,000
- ☐ \$48,001 to \$57,000
- ☐ \$57,001 to \$60,000
- ☐ \$60,001 to \$73,000
- ☐ \$73,001 to \$85,000
- ☐ \$85,001 or more
- ☐ Don't know
- ☐ Declined to answer

12. During the past 12 months, how many people, including yourself, depended on this income?

[Staff: Enter number of people.]

- ☐ _____ people
- ☐ Don't know
- ☐ Declined to answer

13. Of the people who depended on this income during the past 12 months, how many are:

- ☐ Adults age 18 or older: _____ [Note: A pregnant woman counts as one person]
- ☐ Children age 17 or younger: _____
- ☐ Don't know
- ☐ Declined to answer

14. [Staff: If participant currently has children, ask:] Do you have any children less than 18 months old who are enrolled or that you would like to enroll in Healthy Start?

[Select one.]

- ☐ Yes, How many? _____ [Staff: Participant will need to complete the mandatory Parent/Child Form if the child is, or will be, enrolled in HS]
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

Next I'm going to ask you a couple of questions about how your mood has been lately.

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

[Staff: Read each item to participant, and check one response for each item. A Total Score of 3 or more indicates additional screening and possible referral is needed.]

	Mood	Not at all	Several Days	More than half the days	Nearly every day	TOTAL	Declined to answer
a.	Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		<input type="checkbox"/>
b.	Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		<input type="checkbox"/>
TOTAL SCORE							

16. [Staff: Has this participant responded to the items of the depression screening in the previous question?]

- ☐ Yes, both items
- ☐ Yes, but only one item
- ☐ No, was not able to administer this

17. [Staff: Please indicate which response best reflects the need for referral and/or follow-up services related to possible depression.]

- ☐ Participant's total score was less than 3 and so did not indicate a need for referral
- ☐ Participant's total score of 3 or more indicates that additional screening and referral is needed and referral WAS PROVIDED
- ☐ Participant's total score of 3 or more indicates that additional screening and referral is needed but referral was WAS NOT PROVIDED because:
 - ☐ Client is already receiving services for possible depression
 - ☐ Client declined referral

The next couple questions are sensitive in nature and can be uncomfortable to answer. Please know that I ask everyone the same questions. It's important to answer honestly, so we can provide the best services to you. Your answers will not change what I think of you or how we work together. Your answers will not change our relationship or how you're viewed or treated.

The first questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the types of substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

18. In the past 12 months, how often have you...? [Staff: Read substance types and answers to the participant, and enter one response for each type of substance.]

	Substance Type	Daily or Almost Daily	Weekly	Monthly	Less than Monthly	Never	Declined to answer
a.	Used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	For women: Had 4 or more drinks containing alcohol in one day? For men: Had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Used marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Used any illicit drugs including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Used any prescription medications just for the feeling, more than prescribed, or that were not prescribed for you? Prescription medications that may be used this way include: Opioid pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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We are concerned about the safety of all participants. Please answer the following questions so that we can help you if needed.

19. During the past 12 months, has anyone...

	During the past 12 months has anyone...	Current or Former Intimate Partner	Other Family Member	Someone Else	No-one	Declined to answer
a.	Threatened you or made you feel unsafe in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Made you feel frightened for your safety or your family's safety because of their anger or threats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Tried to control your daily activities, for example, control who you could talk to or where you could go?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Forced you to take part in touching or any sexual activity when you did not want to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. [Staff: Indicate IPV screening status below]:

- ☐ Screening completed (all questions answered)
- ☐ Screening not completed due to
 - ☐ Presence of partner
 - ☐ Presence of family member/friend
 - ☐ Participant declined to answer one or more questions
 - ☐ Other reason, please specify _____

[Staff: If any of the above screenings was not completed, please screen on next visit.]

Reproductive Life Planning

Next, I have a few questions about your thoughts about having (more) children. This information will help me support you in making decisions about whether and when you might have (more) children.

21. Do you want any (more) children?

- ☐ Yes [Go to next question]
- ☐ No [Skip to Question 24]
- ☐ Unable to get pregnant [Skip to Question 25]
[Check "No" and answer Question 24 if participant has sought/will seek sterilization via procedure]
- ☐ Don't know [Skip to Question 24]
- ☐ Declined to answer [Skip to Question 24]

22. →If you want (more) children... How many (more) children do you want?

- ☐ _____ (# of children)
- ☐ Don't know
- ☐ Declined to answer

23. →If you want (more) children... How long do you plan to wait until you become pregnant (again)?

- ☐ _____ months [Staff: Convert response to # of months; round to nearest whole number]
- ☐ Don't know
- ☐ Declined to answer

24. →What kind of birth control are you using now to keep from getting pregnant before you are ready? Or, if you are currently pregnant, what method do you plan to use following your pregnancy to prevent becoming pregnant again before you are ready?

[Select all that apply.]

- ☐ Tubes tied or blocked (female sterilization or Essure®)
- ☐ Vasectomy (male sterilization)
- ☐ Birth control pills
- ☐ Condoms
- ☐ Shots or injections (Depo-Provera®)
- ☐ Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- ☐ IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
- ☐ Contraceptive implant in the arm (Nexplanon® or Implanon®)
- ☐ Natural family planning (including rhythm method)
- ☐ Withdrawal (pulling out)
- ☐ Not having sex (abstinence)
- ☐ Other, Please specify _____
- ☐ None
- ☐ Don't know
- ☐ Declined to answer

25. All participants... Are you currently using a condom to prevent sexually transmitted infections?

[Select one.]

- ☐ Yes
- ☐ No
- ☐ N/A—not sexually active
- ☐ Don't know
- ☐ Declined to answer

26. [Staff: Has this participant responded to the questions in this section, as relevant, to create a satisfactory Reproductive Life Plan (RLP)? That is, if she does not want (more) children, she has identified a method of birth control to use to prevent pregnancy (Q 24); or, if she does want (more) children, she has thought about how many (Q 22), their spacing (Q 23), and how to prevent pregnancy until she is ready (Q 24).]

- ☐ Yes, participant has completed all relevant items to create a satisfactory RLP
- ☐ No, participant responded to at least some of the questions but the RLP leaves her/him vulnerable to unplanned pregnancies
- ☐ No, was not able to administer this

[Staff: If the participant has not yet created a satisfactory RLP, flag this item and work with her at a later time (e.g., the next visit) until she has, and then update these questions accordingly.]

[Staff: Note the following directions based on participant type:

- Enrolled men and non-enrolled persons with custody of an enrolled child: This form is now complete. Complete the Parent/Child Form if he/she has an enrolled child.
- Enrolled women: Continue on to the next section.]

Pregnancy and Childbirth History

[Staff: Complete for enrolled women only]

Next, I'd like to ask you some questions about your pregnancy and childbirth history.

27. Are you pregnant now?

[Select one.]

- ☐ Yes [Participant will need to complete the mandatory Prenatal Form]
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

28. Have you ever had any of the following?

[Select all that apply.]

- ☐ Live birth, Number _____
- ☐ Pregnancy that did not result in a live birth
 - ☐ Ectopic or tubal pregnancy, Number _____
 - ☐ Miscarriage (pregnancy ended spontaneously before 20 weeks), Number _____
 - ☐ Stillbirth or fetal death (pregnancy ended at 20 weeks or more), Number _____
 - ☐ Termination of pregnancy, Number _____
- ☐ None of the above (no prior pregnancies)
- ☐ Don't know
- ☐ Declined to answer

[Staff: Note the following directions based on response to Question 28:

- If participant has had no live births (Question 28), this form is complete.
 - ☐ If the participant is currently pregnant, complete the Prenatal Form.
- If participant has had a live birth (Question 28), continue on to the next section.]

Previous Births

[Staff: Complete only for enrolled women who have had a previous live birth (Question 28).]

[Staff: If participant becomes distressed at any point, empathize and provide emotional support. If necessary, complete any additional required forms at a later time (e.g., the next visit).]

Next, I'd like to ask you a few questions about your previous births.

29. A preterm delivery is one that occurs before the 37th week of pregnancy. As far as you know, have you had a preterm delivery in the past?

[Select one.]

- ☐ Yes, Number of prior preterm deliveries: _____
- ☐ No, Number of prior full term deliveries: _____
- ☐ Don't know
- ☐ Declined to answer

30. Did any of your babies weigh LESS than 5 pounds, 8 ounces [2500 grams] at birth?

[Select one.]

- ☐ Yes, How many babies: _____
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

31. [Staff: Skip this question if mother has not had previous babies born less than 5 lb, 8 oz] *Thinking about your babies who were born weighing less than 5 pounds, 8 ounces, how many of them weighed LESS THAN 3 pounds, 5 ounces [1500 grams] at birth?*

[Select one.]

- ☐ Yes, How many babies: _____
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

32. *Did any of your babies weigh more than 9 pounds 4 ounces [4500 grams] at birth?*

[Select one.]

- ☐ Yes, How many babies: _____
- ☐ No
- ☐ Don't know
- ☐ Declined to answer

33. *Did any of your babies stay in the hospital after you came home?*

[Select one.]

- ☐ Yes, How many _____, Please specify reason _____
- ☐ No
- ☐ Declined to answer

34. *Sometimes parents lose babies or children after they are born. This is heartbreaking. In order to offer you the best, most sensitive service I can, can you tell me if you've ever lost a baby or child after they were born?*

- ☐ Yes [go to next question]
- ☐ No [this form is complete]
- ☐ Declined to answer [this form is complete]

35. [Staff: If mother indicates the prior loss of a child in previous question, sensitively ask about the number of babies/children she has lost.]

- ☐ Number of babies/children she has lost: _____

36. [Staff: Sensitively ask about the child's or children's age(s) at death and record below:]

- ☐ Number of children who died **within 0 to 27 days** of life (neonatal): _____
- ☐ Number of children who died **28 to 364 days after birth** (infant): _____
- ☐ Number of children who died at **12 months or older** (post-infancy): _____

[Staff: Note the following directions based on woman's phase of the reproductive cycle:

- If the woman is currently pregnant, complete the Prenatal Form.
- If the woman has an enrolled child, complete the Parent/Child Form.]

The Healthy Start Mandatory Background Information Form is Complete. Thank you!