(Only female respondents)

1. Have you been pregnant at any time since January 31, 2020?
   1 □ Yes 0 □ No

   a. [If yes] Are you currently pregnant?
      1 □ Yes
         [If yes] When is your due date? ______ /______ /_________  MM   DD   YYYY
      0 □ No
         [If no] When did your pregnancy end? ______ /______ /_________  MM   DD   YYYY

   [If no] How did your pregnancy end?
      1 □ Live Birth
      2 □ Still Birth
      3 □ Abortion
      4 □ Miscarriage
      5 □ Ectopic or Tubal
      6 □ Molar
      7 □ Other [Describe:] ____________________________________________

   [if 1 or 2]
   Were there restrictions on who could be present at your birth?
      1 □ Yes 0 □ No

      if yes,
   Were you informed of this ahead of time?
      1 □ Yes 0 □ No

   How detrimental was this to your birth experience?
   (1 = not at all, 10 = extremely)
   1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

   How did you cope given the restrictions on who could be with you?
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________
The following questions are about your current pregnancy.

2. Which of the following changes have you experienced as a result of the COVID-19 outbreak? *Mark all that apply*

1. □ I changed from planning a vaginal birth to a C-section
2. □ My planned C-section or labor induction was changed
3. □ I changed from planning a home birth to planning a hospital birth
4. □ I changed from planning a hospital birth to planning a home birth
5. □ My healthcare provider canceled some or all of my prenatal visits
6. □ I had more prenatal visits.
7. □ My prenatal visits changed from in-person to phone or telemedicine/video
8. □ No visitors, doulas, or other support were allowed in my hospital birth
9. □ My midwives or OB took new precautions during visits to prevent COVID-19 transmission
10. □ Nothing changed in my prenatal care or birth plan.

*If 1-9 are checked*

Do you feel you received all the information you needed about changes to your prenatal care and labor and delivery birthing experience?

1. □ Yes 0 □ No

3. Have you had any of the following conditions during your pregnancy? *Mark all that apply*

1. □ Gestational diabetes (high blood sugar)
2. □ Anemia (low blood cell count)
3. □ Vaginal bleeding
4. □ Nausea or vomiting
5. □ Preeclampsia (toxemia)
6. □ Fever
7. □ Preterm Delivery
8. □ Other condition (please specify): _________________________________
9. □ None of the above