

# Women's Heart Health Survey

Thank you for your interest in this study. You have been invited to participate because you have recently been admitted to Prentice Women's Hospital or have recently given birth there. The purpose of this study is to survey women who have recently given birth to learn about their heart health during pregnancy and to find out what they know about heart disease. This survey will ask you questions about heart disease risk factors, actions that you might take to prevent heart disease, your feelings about your personal risk of getting heart disease in the future, and your most recent pregnancy.

In this survey, by 'heart disease' we mean heart attack, coronary artery disease, heart failure, or stroke. Please answer all questions to the best of your ability. You may end your participation in this survey at any time.

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Are you currently admitted on the Labor and Delivery floor of Prentice Women's Hospital?

- Yes  
 No

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In general, how much do you know about heart disease in women? Would you say you are:

- Very well informed  
 Well informed  
 Moderately informed  
 A little informed  
 Not at all informed

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In the past 12 months, where have you seen, heard, or read about heart disease in women?

Check all that apply.

- In a magazine or newspaper  
 On the radio  
 On TV  
 Information provided by a doctor, nurse, or other healthcare professional  
 On the internet  
 On social media  
 On a podcast  
 Information from a friend or relative  
 Other  
 Did not see, hear, or read anything about heart disease in women

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If you selected "other," please specify:

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Please briefly describe any conversations you have had with a health care professional related to your personal risk for heart disease.

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We would like you to think about your own personal risk of getting heart disease. Compared to the average woman your age, what is your personal risk of getting heart disease later in life (at 50 years of age or older)?

- Much higher than the average woman  
 Somewhat higher than the average woman  
 The same risk as the average woman  
 Somewhat lower than the average woman  
 Much lower than the average woman

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Please briefly explain your reason(s) for your response above:

\_\_\_\_\_

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Do you plan to follow up with a health care professional within the next two years about your personal risk of heart disease?

- Yes  
 No

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Which health care professional(s) do you plan to follow up with about your personal risk of heart disease?

Check all that apply.

- Family doctor/internal medicine doctor  
 OB/Gyn  
 Cardiologist  
 Nurse practitioner or physician's assistant  
 Nurse  
 Other

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If you selected "other," please specify:

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**If you are taking this survey on a mobile device, please flip your phone to the horizontal position to answer this question.**

**We would like you to think about women in the general public and NOT about your own personal risk of getting heart disease. Which statement most closely reflects your view of how each item affects the risk of heart disease for women in the general public?**

**Check the box for each statement that best describes your opinion.**

	Increases or raises the risk	Has NO effect on risk	Decreases or lowers the risk	Don't know/not sure
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menopause	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having diabetes or high blood sugar during pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising regularly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being overweight or obese	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delivering a baby that is smaller than average	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a low cholesterol level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a c-section	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having high blood pressure during pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not getting enough sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delivering a baby more than 3 weeks before your due date	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breastfeeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

As far as you know, what is the leading cause of death for women of all ages?

- Accidental death
- AIDS
- Alzheimer's
- Breast cancer
- Cancer (general)
- Diabetes
- Drug addiction/Alcoholism
- Heart disease/Heart attack
- Lung cancer
- Osteoporosis
- Smoking
- Stroke
- Violent crime
- Suicide
- Other
- Don't know

If you selected "other," please specify:

\_\_\_\_\_

**We would now like to ask you some questions about your general health and lifestyle choices before, during, and after your most recent pregnancy.**

**Before your pregnancy, were you ever told by a doctor, nurse, or other health care professional that you have any of the following conditions?**

	Yes	No	Don't Know/Not Sure
High blood pressure or hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Type 1 diabetes, type 2 diabetes, or prediabetes (not gestational diabetes, or diabetes that started during pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart disease (heart attack, stroke, coronary artery disease, or heart failure)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Have any of your close family members who are related to you by blood (mother, father, sisters, or brothers) ever had any of the conditions listed below?**

	Yes	No	Don't Know/Not Sure
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary artery disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In the two years before you got pregnant with your new baby, did you have any regular visits with a doctor, nurse, or other health care professional?

- Yes  
 No

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In the two years before you got pregnant with your new baby, which health care professional(s) did you see regularly?

Check all that apply.

- Family doctor/internal medicine doctor  
 OB/Gyn (outside of pregnancy-related care)  
 Cardiologist/heart doctor  
 Nurse practitioner or physician's assistant  
 Nurse  
 Other

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If you selected "other," please specify:

\_\_\_\_\_

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About how tall are you without shoes? Select feet, then inches.

- 4 feet    5 feet    6 feet

- 0 inches    1 inch    2 inches  
 3 inches    4 inches  
 5 inches    6 inches  
 7 inches    8 inches  
 9 inches    10 inches  
 11 inches

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Just before your most recent pregnancy, how much did you weigh (in lbs)?

\_\_\_\_\_

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Have you smoked any cigarettes or used other electronic nicotine products such as e-cigarettes in the past two years?

- Yes    No

**Did you smoke cigarettes and/or use e-cigarettes during the time periods listed below?****Check all that apply.**

	Yes, I smoked cigarettes	Yes, I used e-cigarettes	No, I did not smoke cigarettes or use e-cigarettes
During the three months before you got pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the last three months of your pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the last month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you are taking this survey on a mobile device, please flip your phone to the horizontal position to answer this question.**

**How often did you do at least 30 minutes of moderate or vigorous exercise each week during the time periods listed below? For example, walking for exercise, swimming, cycling, dancing, or jogging.**

	Less than 1 day per week	1-2 days per week	3-4 days per week	5 or more days per week	I was told by a health care worker not to exercise
During the three months before you got pregnant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
During the last three months of your pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
During the last month	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How many times have you been pregnant?  1  2  3  4 or more



**During your most recent pregnancy, did you experience any of the following complications?**

	Yes	No	Don't Know/Not Sure
Gestational diabetes (diabetes that started during this pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure (that started during this pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pre-eclampsia (high blood pressure and protein in your urine during pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eclampsia (seizures during pregnancy related to high blood pressure)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preterm birth (labor started naturally and baby was delivered more than 3 weeks before your due date)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**During any previous pregnancy (NOT including your most recent pregnancy), did you experience any of the following complications?**

	Yes	No	Don't Know/Not Sure
Gestational diabetes (diabetes that started during the pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure (that started during the pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pre-eclampsia (high blood pressure and protein in your urine during pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eclampsia (seizures during pregnancy related to high blood pressure)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preterm birth (labor started naturally and baby was delivered more than 3 weeks before your due date)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During your most recent pregnancy, how many babies did you give birth to?

- One baby  
 Two babies  
 Three babies  
 Four or more babies

How much did your baby weigh at birth? Select pounds, then ounces.

- 1 lb  
 2 lbs  
 3 lbs  
 4 lbs  
 5 lbs  
 6 lbs  
 7 lbs  
 8 lbs  
 9 lbs  
 10 lbs  
 11 lbs

- 0 oz  
 1 oz  
 2 oz  
 3 oz  
 4 oz  
 5 oz  
 6 oz  
 7 oz  
 8 oz  
 9 oz  
 10 oz  
 11 oz  
 12 oz  
 13 oz  
 14 oz  
 15 oz

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How much did baby A weigh at birth? Select pounds, then ounces.

- 1 lb
- 2 lbs
- 3 lbs
- 4 lbs
- 5 lbs
- 6 lbs
- 7 lbs
- 8 lbs
- 9 lbs
- 10 lbs
- 11 lbs

- 
- 0 oz
  - 1 oz
  - 2 oz
  - 3 oz
  - 4 oz
  - 5 oz
  - 6 oz
  - 7 oz
  - 8 oz
  - 9 oz
  - 10 oz
  - 11 oz
  - 12 oz
  - 13 oz
  - 14 oz
  - 15 oz

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How much did baby B weigh at birth? Select pounds, then ounces.

- 1 lb
- 2 lbs
- 3 lbs
- 4 lbs
- 5 lbs
- 6 lbs
- 7 lbs
- 8 lbs
- 9 lbs
- 10 lbs
- 11 lbs

- 
- 0 oz
  - 1 oz
  - 2 oz
  - 3 oz
  - 4 oz
  - 5 oz
  - 6 oz
  - 7 oz
  - 8 oz
  - 9 oz
  - 10 oz
  - 11 oz
  - 12 oz
  - 13 oz
  - 14 oz
  - 15 oz

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How much did baby C weigh at birth? Select pounds, then ounces.

- 1 lb
- 2 lbs
- 3 lbs
- 4 lbs
- 5 lbs
- 6 lbs
- 7 lbs
- 8 lbs
- 9 lbs
- 10 lbs
- 11 lbs

- 
- 0 oz
  - 1 oz
  - 2 oz
  - 3 oz
  - 4 oz
  - 5 oz
  - 6 oz
  - 7 oz
  - 8 oz
  - 9 oz
  - 10 oz
  - 11 oz
  - 12 oz
  - 13 oz
  - 14 oz
  - 15 oz

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If you gave birth to four or more babies, please enter their weights in this box, separated by commas: \_\_\_\_\_

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Relative to your due date, when did you give birth?

- On time (within one week before or after your due date)
- Early (more than one week before your due date)
- Late (more than one week after your due date)

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How many weeks into your pregnancy did you give birth?

- 38 weeks (2 weeks early)
- 37 weeks (3 weeks early)
- 36 weeks (4 weeks early)
- 35 weeks (5 weeks early)
- 34 weeks (6 weeks early)
- Other

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If you selected 'other,' please specify: \_\_\_\_\_

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Was your labor induced?

- Yes
- No

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What is the name of the OB practice or clinic where you received prenatal care during your most recent pregnancy? \_\_\_\_\_

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During your most recent pregnancy, did your doctor tell you to take aspirin to lower your risk of pregnancy complications?

- Yes  
 No

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If your doctor told you to take aspirin during your most recent pregnancy, did you take it?

- Yes, daily  
 Yes, sometimes  
 No

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During your most recent pregnancy, how much weight did you gain (in lbs)?

\_\_\_\_\_

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Are you currently breastfeeding or pumping?

- Yes  
 No

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Did you ever try to breastfeed or pump?

- Yes  
 No

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How long did you breastfeed and/or pump for?

- Less than 4 weeks  
 4 weeks - 6 months  
 6 months - 12 months  
 Greater than 12 months

**Now we would like to learn a little more about you:**

Which of the following would you say is your race/ethnicity?

Check all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic/Latinx
- Native Hawaiian or Other Pacific Islander
- White
- Other
- Decline to answer

If you selected 'other,' please specify:

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From what country or region did you or your ancestors come?

Check all that apply.

- Mexico
- Cuba
- Puerto Rico
- Guatemala
- Costa Rica
- Honduras
- Nicaragua
- Panamanian
- Spain
- Other
- Decline to answer

If you selected 'other,' please specify:

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From what country or region did you or your ancestors come?

Check all that apply.

- China
- The Philippines
- India
- Vietnam
- Korea
- Japanese
- Other
- Decline to answer

If you selected 'other,' please specify:

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What is the highest level of education you have completed?

- No formal education
- Grade school
- High school or equivalent (GED)
- Vocational or trade school
- College or university
- Graduate or professional school
- Decline to answer

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Which of the following income categories best describes your total 2019 household income (before taxes)?

- Less than \$15,000
- \$15,000 to \$24,999
- \$25,000 to \$34,999
- \$35,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$124,999
- \$125,000 to \$149,999
- \$150,000 to \$199,999
- \$200,000 to \$249,999
- \$250,000 or more
- Decline to answer

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Which of the following best describes your relationship status?

- Married
- Living with partner
- Widowed
- Divorced
- Separated
- Single
- In a relationship but not living with partner
- Decline to answer

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Which best describes the type of health insurance that you currently have?

- Private insurance (ex: Blue Cross Blue Shield, United)
- Medicare
- Medicaid
- None
- Decline to answer

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What is your current zip code?

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Please provide an email address to receive your gift card:

\_\_\_\_\_