



Survey Booklet One A: Antenatal – Diet and Physical Activity

1A

Thank you for taking the time to complete this survey. It will take you about **30 minutes** to complete it and your answers are **confidential**. If you have any questions about any part of this survey, or need help answering any of the questions, please feel free to call us on **087 2290989**.

The MAMMI survey has been approved by the Research Ethics Committees of the Coombe Women and Infants University Hospital and the Faculty of Health Sciences, Trinity College Dublin.

Please tick here if you do NOT wish to complete this or receive future surveys



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Structure of the MAMMI Study

The **Maternal health And Maternal Morbidity in Ireland (MAMMI)** study is in six (6) parts: there are 2 antenatal surveys (1) antenatal and (1A) antenatal diet (nutrition) and physical activity; (2) 3 months after the birth; (3) 6 months after the birth; (4) 9 months after the birth and (5) 12 months after the birth.

This is the diet and physical activity part of the study. It is about your diet and lifestyle **NOW** (antenatally) and before you became pregnant. It has four (4) sections, numbered A through to D:

- A questions about your general health, physical activity, food habits and life style;
- B your diet/nutrition and health **SINCE THE START** of your pregnancy;
- C Breast feeding intention;
- D Physical activity **DURING** your pregnancy;

You may notice that some questions are very similar or the same, however, the questions apply to **different times** in your life.

How to fill in the Survey

Most of the questions can be answered by putting a tick in the box next to the answer that best applies to you. For example:

Has tiredness been a problem for you in the past month?

Yes

No

This filled-in sample indicates that tiredness was a problem in the past month.

A few questions may ask you to fill in a number in a box. For example:

What is your date of birth?

Day /Month / Year
 / /

This filled-in sample represents a date of birth of 30th April 1980

Section A: This section is about your general health and diet in the 12 months BEFORE your pregnancy

A1 How would you describe your general health in the 12 months BEFORE your pregnancy?

Excellent	Very good	Good	Fair	Poor	Very poor
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

A2 What, if anything, do you think could have improved your health? (Please tick all that apply)

- Losing weight 1
- Gaining weight 2
- Regular checks from your family doctor 3
- Fewer changes in your life 4
- Less stress 5
- Employment 6
- More money 7
- More willpower 8
- A different job 9
- Less alcohol 10
- Less/stop smoking 11
- Less time in smoky places 12
- Someone to talk to 13
- Better information about where to go for health care 14
- 'Easier to read' health information 15
- Better information about how to stay healthy 16
- Less international/national pollution 17
- Less local pollution (e.g. noise) 18
- None of the above 19

In the 12 months BEFORE your pregnancy, were you told by a doctor (or healthcare professional) that you:

A3 Had high blood pressure?

Yes ¹ No ² I haven't had it checked ³

A4 Had high cholesterol?

Yes ¹ No ² I haven't had it checked ³

A5 a. In the 12 months BEFORE your pregnancy, did you follow any specific diet?

Yes ¹ No ² → Please go to A6

b. If YES, which of the following diets did you follow? (Please tick all that apply)

- Weight loss 1
 - Vegetarian 2
 - Vegan 3
 - Diet to control diabetes 4
 - Gluten Free 5
 - Cholesterol lowering 6
 - Other (please describe) 7
-

A6 In the 12 months BEFORE your pregnancy, how would you describe your diet?

- Very healthy 1
 - Healthy 2
 - Fair 3
 - Not so good 4
 - Bad 5
 - Very bad 6
 - Other (please describe) 7
-

A7 In the 12 months BEFORE your pregnancy, were you trying to lose weight?

Yes 1 No 2

A8 Did your weight change in the 12 months before your pregnancy?

a) I lost a lot of weight 1 I lost a few pounds/kgs 2 I stayed about the same weight 3 I gained a few pounds/kgs 4 I gained a lot of weight 5 Other (Please describe) 6

Other (Please describe)

b) I lost/gained:

kgs OR stones and pounds

A9 In the 12 months BEFORE your pregnancy, were you satisfied with your body image?

Always 1 Sometimes 2 Never 3

Please comment if you wish

A10 a. In the 12 months BEFORE pregnancy did you read food labels? (the nutritional information on the side/back of the food packaging that tells you what it contains)

Yes, always 1 Yes, sometimes 2

No, never 3 → **Please go to A11**

b. If YES, which of the following did you look for on the label? (Please tick ALL that apply)

- Ingredients 1
 - Nutrients (e.g. Fat, Fibre, Sugar) 2
 - Calorie value 3
 - Weight of food 4
 - Additives (e.g. E numbers) 5
 - Serving size 6
 - Instructions for competitions 7
 - Cooking Instructions 8
 - Other (please describe) 9
-

A11 In the 12 months BEFORE your pregnancy, how often did you have the following meals per week? (Please tick ONE response on EACH line)
 (A snack is a smaller meal consisting of, for example, a fruit, biscuit, bun, cake, yoghurt or sweets/candy.)

	Every day	1-3 times a week	4-6 times a week	Never
Breakfast	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Morning snack	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lunch	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Afternoon snack	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Dinner	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Night snack	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Any other meal	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

(Please, describe which ones)

A12 Can you afford to buy enough food for your household?

- Always 1
- Usually 2
- Sometimes 3
- Rarely 4
- Never 5

The next few questions ask about physical activities you may have done in the 12 months BEFORE your pregnancy.

If possible, we would like you to tell us the type and amount of exercise that you did in an average week:

In an average week...

A13 a. How many times did you walk continuously, for at least 10 minutes, for recreation, exercise or to get from place to place?

times₁ none₂ → Please go to A14

b. What do you estimate was the total time you spent walking in this way?

hours₁ minutes₂

A14 a. How many times did you do any vigorous gardening or heavy work around the house or garden which made you breathe harder or puff and pant?

times₁ none₂ → Please go to A15

b. What do you estimate was the total time you spent doing vigorous gardening or heavy work around the house or garden?

hours₁ minutes₂

A15 a. How many times did you do any strenuous household chores involving moderate physical activity? (For example, vacuum cleaning, washing windows, carrying shopping up several flights of stairs, scrubbing floors)

times₁ none₂ → Please go to A16

b. What do you estimate was the total time you spent doing these kinds of household chores?

hours₁ minutes₂

The next questions are about the types of exercise, if any, you did in the 12 months BEFORE your pregnancy

Intensity refers to the rate at which the activity is being performed or the amount of effort required to perform an activity or exercise. It can be thought of "*How hard a person works to do the activity*". The intensity of different forms of physical activity varies between people. The examples given below are provided as a guide only and will vary between individuals.

Moderate-intensity Physical Activity Requires a moderate amount of effort and noticeably accelerates the heart rate	Vigorous-intensity Physical Activity Requires a large amount of effort and causes rapid breathing and a substantial increase in heart rate
Examples of moderate physical activity include:	Examples of vigorous physical activity include:
• Walking	• Running
• Dancing	• Brisk Walking / climbing up a hill
• Cycling at a regular pace	• Fast cycling
• Jogging	• Aerobics
• Golfing	• Fast swimming
• Badminton	• Football, hockey, basketball
• Carrying / moving moderate loads	• Carrying / moving heavy loads

In an average week (on the 12 months BEFORE your pregnancy):

A16 a. How many times did you do any Moderate-intensity Physical Activity which made you breathe harder or puff and pant? (For example, jogging)

 times₁
 none₂ → **Please go to A17**

b. What do you estimate was the total time you spent doing these activities?

 hours₁
 minutes₂

A17 a. How many times did you do any other more Vigorous-intensity Physical Activity? (For example, fast swimming)

 times₁
 none₂ → **Please go to A18**

b. What do you estimate was the total time you spent doing these activities?

 hours₁
 minutes₂

A18 a. Did you do any regular exercise for 10 minutes or more at least ONCE a week?

Yes ₁ No ₂ —→ **Please go to A19**

b. If YES Please tick the types of exercise you did and how many times per week you did them)

Exercise	Yes	Times per Week
Fast walking		1
Jogging/running		2
Aerobics		3
Weight training		4
Dancing		5
Swimming		6
Cycling		7
Ball games (soccer, GAA, rugby)		8
Racket sports (tennis, badminton)		9
Weight lifting		10
Other		11

Other (Please describe) _____

Section B: DIET AND NUTRITION – This section is about your general eating habits since the START of your pregnancy.

B1 Have you experienced nausea during this pregnancy?

Yes ₁ No ₂ → **Please go to B5**

B2 Are you still experiencing nausea?

Yes ₁ No ₂

B3 In which week(s) were you most bothered with nausea?

From pregnancy week _____ to pregnancy week _____

B4 a. Did the feeling of nausea affect your appetite?

Yes ₁ No ₂ → **Please go to B5**

b. If yes, how was your appetite affected?

I ate less
than usual

I ate less but
more often

I ate the
same as usual

I ate more
than usual

₁

₂

₃

₄

Please comment if you wish: _____

B5 Have you vomited during this pregnancy?

Yes ₁ No ₂ → **Please go to B9**

B6 Are you still vomiting?

Yes ₁ No ₂

B7 In which week(s) did you vomit?

From pregnancy week _____ to pregnancy week _____

B8 a. Did the vomiting affect your appetite?

Yes ₁ No ₂ → **Please go to B9**

b. If yes, how was your appetite affected?

I ate less
than usual

₁

I ate less but
more often

₂

I ate the
same as usual

₃

I ate more
than usual

₄

Please comment if you wish: _____

B9 a. During your pregnancy have you been following/followed any specific diet?

Yes ₁ No ₂

b. If YES, which of the following diets? (Please tick all that apply)

Weight loss

₁

Vegetarian

₂

Vegan

₃

Diet to control diabetes

₄

Gluten Free

₅

Cholesterol lowering

₆

Other (please describe)

₇

B10 During your pregnancy, are you concerned that you might:

Gain too MUCH weight

1

Gain too LITTLE weight

2

Please comment if you wish:

B11 Now that you are pregnant, are you satisfied with your body image?

Always

1

Sometimes

2

Never

3

Please comment if you wish

B12 How often have you had the following meals per week since you became pregnant?

(Please tick ONE response on EACH line)

(A snack is a smaller meal consisting of, for example, a fruit, biscuit, bun, cake, yoghurt or sweets/candy.)

	Every day	1-3 times a week	4-6 times a week	Never
Breakfast	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Morning snack	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lunch	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Afternoon snack	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Dinner	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Night snack	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Any other meal	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

B13 How often do you eat fried food (i.e. use of oil or other fats when cooking)?

- | | | |
|------------------------------|--------------------------|---|
| Never | <input type="checkbox"/> | 1 |
| Less than once a month | <input type="checkbox"/> | 2 |
| One or several times a month | <input type="checkbox"/> | 3 |
| One or several times a week | <input type="checkbox"/> | 4 |
| Every day | <input type="checkbox"/> | 5 |

B14 What type of milk do you use most often?

- | | | |
|-------------------------|--------------------------|---|
| None | <input type="checkbox"/> | 1 |
| Whole milk/Full fat | <input type="checkbox"/> | 2 |
| Low fat | <input type="checkbox"/> | 3 |
| Skimmed | <input type="checkbox"/> | 4 |
| Super/fortified | <input type="checkbox"/> | 5 |
| Soya | <input type="checkbox"/> | 6 |
| Other (Please describe) | <input type="checkbox"/> | 7 |
-

B15 About how much milk do you drink each day?

- | | | |
|----------------------------|--------------------------|---|
| None | <input type="checkbox"/> | 1 |
| 250ml (half pint, ¼ litre) | <input type="checkbox"/> | 2 |
| 568ml (one pint) | <input type="checkbox"/> | 3 |
| 1000 ml (1 litre) | <input type="checkbox"/> | 4 |
| More than 1 litre | <input type="checkbox"/> | 5 |

B16 How often do you add salt to food while cooking?

- Always 1
- Usually 2
- Sometimes 3
- Rarely 4
- Never 5

B17 How often do you add salt to food while at the table?

- Always 1
- Usually 2
- Sometimes 3
- Rarely 4
- Never 5

B18 What type of spread do you usually use on bread? (Please tick ALL that apply or use most often)

- Butter or hard margarine 1
 - A low fat spread 2
 - A polyunsaturated spread 3
 - A cholesterol lowering spread 4
 - None 5
 - Other (Please describe) 6
-

B19 What type of fat/oil would you usually use for cooking? (Please tick ALL that apply OR use most often)

- | | | |
|----------------------------|--------------------------|---|
| Vegetable oil | <input type="checkbox"/> | 1 |
| Sunflower oil | <input type="checkbox"/> | 2 |
| Olive oil | <input type="checkbox"/> | 3 |
| Coconut oil | <input type="checkbox"/> | 4 |
| Rapeseed oil | <input type="checkbox"/> | 5 |
| Lard or dripping | <input type="checkbox"/> | 6 |
| Butter (or hard margarine) | <input type="checkbox"/> | 7 |
| Other | <input type="checkbox"/> | 8 |
| None | <input type="checkbox"/> | 9 |

B20 Now that you are pregnant, can you afford to buy enough food for your household?

- | | | |
|-----------|--------------------------|---|
| Always | <input type="checkbox"/> | 1 |
| Usually | <input type="checkbox"/> | 2 |
| Sometimes | <input type="checkbox"/> | 3 |
| Rarely | <input type="checkbox"/> | 4 |
| Never | <input type="checkbox"/> | 5 |

Please comment if you wish _____

The next section is still about your diet and eating habits since you became pregnant.

We know very little about what pregnant women in Ireland eat during pregnancy. Your answers to these questions will help us to learn more and will be really useful, thank you.

B21 Your diet during your pregnancy

For each food there is an amount shown, either what we think is a "medium serving" or a common household unit such as a slice or teaspoon. Please put a tick in the box to indicate how often, on average, you have eaten the specified amount of each food, to the nearest whole number during your pregnancy. If you think the portion of food you eat is greater or less than the indicated serving please tick in the box which best suits. Please estimate your average food consumption as best as you can. Please answer every question, do not leave ANY lines blank.

EXAMPLES:

The following are examples on how to estimate how often and how much bread and potatoes you ate SINCE YOU BECAME PREGNANT. Please estimate your food intake for all foodstuffs in the same way.

Example 1

Potatoes: If you ate a medium serving of potatoes 3 times per week during your pregnancy put a tick in the box "2-4 per week". If you think you usually ate more or less than a medium serving please try to estimate which box suits best.

Potatoes, Rice and Pasta (medium serving)									
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day
Boiled, instant or jacket potatoes				√					

Example 2

For white bread a medium serving is one medium sized slice. Therefore if you usually ate 1 medium slice 4 or 5 times per day, you should put a tick in the column headed "4-5 per day". If you ate 2 medium slices 4 or 5 times per day, then you should put a tick in the column "6+ per day".

BREAD AND SAVOURY BISCUITS (One slice or one biscuit)									
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day
White bread and rolls (including ciabatta bread)								√	

Please check that you put a tick (√) on every line

A. MEAT, FISH AND POULTRY (Medium serving – the size of a deck of cards OR palm of hands without fingers)

Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Beef roast										1
Beef: steak										2
Beef: mince										3
Beef: stew										4
Beef burger (1 burger)										5
Pork: roast										6
Pork: chops										7
Pork: slices/steak/escalopes										8
Lamb: roast										9
Lamb: chops										10
Lamb: stew										11
Chicken portion OR other poultry e.g. turkey: roast										12
Breaded chicken, chicken nuggets, chicken burger										13
Bacon										14
Ham										15
Corned beef										16
Luncheon meats										17
Sausages, Frankfurters (1 sausage)										18
Savoury pies (e.g. meat pie, pork pie, steak & kidney pie, sausage rolls)										19
Heart, kidney										20
Fish fried in batter, as in fish and chips										21
Fish fried in bread crumbs										22
Oven baked/grilled fish (in bread crumbs OR batter)										23
Fish fingers/fish cakes										24
Other white fish, fresh OR frozen (e.g. cod, haddock, plaice, sole, halibut, coli)										25

A. MEAT, FISH AND POULTRY (Medium serving – the size of a deck of cards OR palm of hands without fingers)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Oily fish (fresh) - (e.g. mackerel, kippers, tuna, salmon, sardines, herring)										26
Oily fish (canned) - (e.g. mackerel, kippers, tuna, salmon, sardines, herring)										27
Shellfish (e.g. crab, prawns, mussels)										28

Please check that you put a tick (✓) on every line

B. BREAD AND SAVOURY BISCUITS (One slice OR one biscuit)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
White bread and rolls (including ciabatta and pannini bread)										1
Brown bread and rolls										2
Wholemeal bread and rolls										3
Cream crackers, cheese biscuits										4
Crisp bread, e.g. Ryvita										5
Pancakes, muffins, oatcakes										6
Baguette										7

Please check that you put a tick (✓) on every line

C. CEREALS (One medium sized bowl)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Porridge, Readybrek										1
All Bran, Weetabix, Shredded Wheat										2

C. CEREALS (One medium sized bowl)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Branflakes, Bran Buds										3
Cornflakes, Rice Krispies										4
Muesli (e.g. Country Store, Alpen, sugar coated, Granola)										5
Sugar Coated Cereals (e.g. Frosties, Crunchy Nut Cornflakes, Crunchy Sugar Coated Muesli)										6

Please check that you put a tick (✓) on every line

D. POTATOES, RICE AND PASTA (Medium serving – about a cupful)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Boiled, instant or jacket potatoes										1
Mashed potatoes										2
Chips										3
Roast potatoes										4
Potato Salad										5
White rice										6
Brown rice										7
White/yellow/green pastas (e.g. spaghetti, macaroni, noodles)										8
Wholemeal pasta										9
Lasagne (meat based)										10
Lasagne (vegetarian)										11
Moussaka										12
Pizza										13
Macaroni Cheese										14

Please check that you put a tick (✓) on every line

E. DAIRY PRODUCTS AND FATS										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Cream (1 tablespoon)										1
Full-fat yoghurt OR Greek- style Yoghurt (125g carton)										2
Dairy desserts (125g carton)										3
Cheddar cheese (medium serving)										4
Low-fat cheddar cheese (medium serving OR 1 slice - 25g)										5
Eggs as boiled, fried, scrambled, poached (1)										6
Quiche (medium serving)										7
Light salad cream OR light mayonnaise (1 tablespoon)										8
Salad cream, mayonnaise (1 tablespoon)										9
French dressing										10
Other salad dressing										11
The following on bread OR vegetables										
Butter (1 teaspoon)										12
Light Butter e.g. Dawn light, Connacht Gold (teaspoon)										13
Sunflower margarine e.g. Flora (1 teaspoon)										14
Low-fat margarine e.g. low- low (1 teaspoon)										15
Cholesterol lowering spreads e.g. Flora Pro Active, Dairy Gold Heart (1 teaspoon)										16
Cream and vegetable oil spread e.g. Golden Pasture, Kerrymaid, Dairy Gold (1 teaspoon)										17
Olive oil spread e.g. Golden Olive (1 teaspoon)										18

Please check that you put a tick (✓) on every line

F. FRUIT (1 fruit OR medium serving)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Apples										1
Pears										2
Oranges, Satsuma, mandarins										3
Grapefruit										4
Bananas										5
Grapes										6
Melon										7
Peaches, plums										8
Apricots										9
Strawberries, raspberries, kiwi fruit										10
Tinned fruit										11
Dried fruit e.g. raisins										12
Frozen fruit										13

Please check that you put a tick (✓) on every line

G. VEGETABLES Fresh, frozen OR tinned (Medium serving – 2 tablespoons OR 4 desert spoons)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Carrots										1
Spinach										2
Broccoli, spring greens, kale										3
Brussel sprouts										4
Cabbage										5
Peas										6

G. VEGETABLES Fresh, frozen OR tinned (Medium serving – 2 tablespoons OR 4 desert spoons)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Green beans, broad beans, runner beans										7
Courgettes										8
Cauliflower										9
Parsnips, turnips										10
Leeks										11
Onions										12
Garlic										13
Mushrooms										14
Sweet peppers										15
Beansprouts										16
Green salad, Lettuce										17
Cucumber, celery										18
Tomatoes										19
Sweetcorn										20
Beetroot										21
Coleslaw										22
Baked beans										23
Dried lentils, beans, peas										24
Tofu, soya meat, TVP, veggieburger										25

Please check that you put a tick (✓) on every line

H. SWEETS AND SNACKS (Medium serving)										
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
Chocolate coated sweet biscuits e.g. digestive (1)										1
Plain sweet biscuits e.g. Marietta, Digestives, Rich										2

H. SWEETS AND SNACKS (Medium serving)									
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day
Tea (1)									
Cakes e.g. fruit, sponge									
Buns, pastries e.g. croissants, doughnuts									
Fruit pies, tarts, crumbles									
Sponge puddings									
Milk puddings e.g. rice, custard, trifle									
Ice cream, choc ices, Frozen desserts									
Chocolates, single OR square									
Sweets, toffees, mints									
Sugar added to tea, coffee, cereal (1 teaspoon)									
Sugar substitute e.g. Canderel added to tea, coffee, cereal (1 teaspoon)									
Crisps OR other packet snacks									
Peanuts OR other nuts									

Please check that you put a tick (✓) on every line

I. SOUPS, SAUCES AND SPREADS									
Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day
Vegetable soups: homemade/fresh (1 bowl)									
Vegetable soups: tinned/packet (1 bowl)									
Meat OR cream soups: homemade/fresh (1 bowl)									
Meat OR cream soups: tinned/packet (1 bowl)									
Sauces e.g. white sauce,									

I. SOUPS, SAUCES AND SPREADS

Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day
cheese sauce, gravy (1 tablespoon)									
Tomato based sauces e.g. pasta sauces									6
Curry-type sauces									7
Pickles, chutney (1 tablespoon)									8
Marmite, Bovril (1 tablespoon)									9
Jam, marmalade, honey, syrup (1 tablespoon)									10
Peanut butter (1 teaspoon)									11

Please check that you put a tick (✓) on every line

J. DRINKS

Average use during your pregnancy	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day
Tea (cup)									1
Coffee instant (cup)									2
Coffee ground (cup)									3
Coffee, decaffeinated (cup)									4
Coffee whitener e.g. coffee-mate (teaspoon)									5
Cocoa, Hot Chocolate (cup)									6
Horlicks, Ovaltine (cup)									7
Low calorie OR diet soft fizzy drinks (glass)									8
Fizzy Soft drinks e.g. Cocoa Cola (glass)									9
Pure fruit drinks e.g. orange juice (small glass)									10
Fruit squash (small glass)									11

B22 How many glasses of water would you say you drink per day/each day (small glass)?

- None 1
- 1-2 glasses 2
- More than 2 and less than 4 glasses 3
- More than 4 and less than 6 glasses 4
- More than 6 and less than 8 glasses 5
- More than 8 and less than 10 glasses 6
- More than 10 glasses per day 7
- Other 8

Please describe & comment if you wish _____

B23 Now that you are pregnant, would you say that you have changed your daily water intake?

- I used to drink more water – before pregnancy 1
- I drink about the same 2
- I used to drink less water – before pregnancy 3

Please describe & comment if you wish _____

B24 Other food items

It is difficult to ask about all the food you have eaten since you became pregnant. Please write down the names of any food items that you have eaten and that you have not yet been asked about.

Please, tick here **IF** you have **NOTHING ELSE** (any other food) to add → **Please go to B25**

Other foods										
<u>Name of food AND average use during your pregnancy</u>	Never or less than 1 a month	1-3 a month	1 a week	2-4 a week	5-6 a week	1 a day	2-3 a day	4-5 a day	6 or 7 a day	
										1
										2
										3
										4
										5
										6
										7
										8
										9
										10
										11

Please, comment if you wish _____

B25 Dietary changes during this pregnancy

Please mark if you have eaten more, less OR the same amount of the following food items compared to before becoming pregnant.

	Started since pregnant	Same	More	Less	Stopped since pregnant	Never eat
a. Milk, dairy products, cheese	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
b. Bread, cereals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
c. Biscuits	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
d. Fat	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
e. Meat	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
f. Fish	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
g. Eggs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
h. Vegetables	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
i. Fruits	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
j. Chocolate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
k. Other sweets	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
l. Coffee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
m. Tea	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
n. Juice	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
o. Soft drinks with sugar	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
p. Soft drinks (sugar free)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
q. Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

Please, comment if you wish _____

B26 a. Did you receive any advice about what to eat/not to eat, since you became pregnant?

Yes ₁ No ₂ —→ **Please go to B27**

b. If YES, did you get advice from the following people or sources? (Please tick all that apply)

General practitioner / local doctor ₁

Public Health Nurse ₂

GP Practice Nurse ₃

Dietician ₄

Midwife ₅

Other health professional ₆

Partner/husband ₇

Friend ₈

Sister ₉

Mother ₁₀

Neighbour ₁₁

Internet ₁₂

Other (Please describe) ₁₃

B27 a. Since you became pregnant, were you advised to stop eating/drinking any particular item?

Yes ₁ No ₂ —→ **Please go to B28**

b. If YES, what food and/or drink were you advised to stop eating?

B28 a. Since you became pregnant, were you advised to start taking any food/drink in particular?

Yes ₁ No ₂ —→ Please go to B29

b. If YES, what food(s) and/or drink(s) were you advised to start eating/drinking?

B29 Would you have liked more information about what to eat/drink or what NOT to eat/drink during pregnancy?

Yes ₁ No ₂

Please comment if you wish _____

B30 Dietary Supplements

A dietary supplement is intended to provide nutrients that may otherwise not be consumed in sufficient quantities. Supplements as generally understood include vitamins, minerals, fibre, fatty acids, or amino acids, among other substances.

a. Did you take any dietary supplements BEFORE your pregnancy?

Yes ₁ No ₂

b. If yes, please describe the supplements that you took

c. Have you taken or are you currently taking any dietary supplements DURING your pregnancy?

Yes ₁ No ₂ —→ Please go to B31

Please comment if you wish _____

d. If yes, please go to the table on the next page and describe the supplements that you took

Supplement	Times a week/day e.g. 1 a day or twice a week	Quantity	Where did you buy it? e.g. Chemist/ pharmacy, hospital, other	When did you start taking it?	When did you stop taking it? (if you have stopped) e.g 'when I became pregnant' or at X weeks pregnant
Pregnacare original					
Pregnacare Max					
Pregnacare plus-omega 3					
Clonfolic					
Folic Acid (400 mcg)					
Galfer or Galfer FA					
Pregnancy 1 plus (Boots)					
Pregnaplan (Sona)					
Pregnancy (Seven seas)					
Pharmaton (Matruelle)					
Sanatogen Mum to be					
Sanatogen Mum to be + Omega 3					
Spatone Iron Supplement (sache)					
Spatone Apple Liquid Iron Supplement with added Vitamin C					
Centrum Pregnancy Care Plus Omega-3					

Supplement	Times a week/day e.g. 1 a day or twice a week	Quantity	Where did you buy it? e.g. Chemist/ pharmacy, hospital, other	When did you start taking it?	When did you stop taking it? (if you have stopped) e.g 'when I became pregnant' or at X weeks pregnant
Flax seeds					
Flax Oil					
Other name and brand:					
Other name and brand:					
Other name and brand:					

B31 a. Were you advised to take dietary supplements during pregnancy?

Yes 1 No 2 → **Please go to B32**

b. If YES, who advised you? (Please tick ALL that apply)

General practitioner / local doctor 1

Public Health Nurse 2

GP Practice Nurse 3

Dietician 4

Midwife 5

Pharmacist 6

Other health professional 7

Partner/husband 8

Friend 9

Sister	<input type="checkbox"/>	10
Mother	<input type="checkbox"/>	11
Neighbour	<input type="checkbox"/>	12
Internet	<input type="checkbox"/>	13
Other (Please describe)	<input type="checkbox"/>	14

B32 Food cravings and aversions

A food craving is that strong feeling that you must have a specific food while an aversion is the complete incapacity to eat certain food (and sometimes even to smell it).

a. Since you became pregnant, did you have CRAVING(s) for any food or drink?

Yes 1 No 2

If **Yes**, please tell us about this _____

b. Since you became pregnant, did you have an AVERSION (a strong dislike) for any food or drink?

Yes 1 No 2

If **Yes**, please tell us about this _____

Section C: Breast feeding intention

C1 Are you planning to breast feed?

Yes ₁ No ₂

Please comment if you wish: _____

C2 a. Have you received any advice on breast-feeding?

Yes ₁ No ₂

Please comment if you wish: _____

b. If YES, who advised you? (Please tick all that apply)

General practitioner / local doctor ₁

Public Health Nurse ₂

GP Practice Nurse ₃

Dietician ₄

Midwife ₅

Lactation Consultant ₆

Partner/husband ₇

Friend ₈

Sister ₉

Mother ₁₀

Neighbour ₁₁

Internet ₁₂

Other (Please describe) ₁₃

Section D: Physical activity DURING your pregnancy in the LAST WEEK

This section is about the physical activity you did, if any, during the last week.

In the LAST WEEK...

- D1 a. How many times did you walk continuously, for at least 10 minutes, for recreation, exercise or to get from place to place?

--	--	--

 times₁

--

 none₂ → Please go to D2

- b. What do you estimate was the total time you spent walking in this way LAST WEEK?

--	--	--

 hours₁

--	--

 minutes₂

- D2 a. Are you still exercising?

Yes

--

₁No

--

₂ → Please go to D4

Please comment if you wish: _____

In the LAST WEEK...

- D3 a. How many times did you do moderate physical activity? (For example, gentle swimming)

--	--	--

 times₁

--

 none₂ → Please go to D4

- b. What do you estimate is the total time you spend doing these activities LAST WEEK?

--	--	--

 hours₁

--	--

 minutes₂

D4. If you are not doing any exercise now but did exercise earlier in pregnancy, please tell us about the type of exercise you did (for 10 minutes or more at least ONCE a week, DURING YOUR PREGNANCY), please tick the types of exercise you did/do and how many times per week you have done it.

Please, tick here **IF** you have **NOT EXERCISED AT ALL DURING** your pregnancy → **Please go to D5**

Exercise	Yes	Times per Week	
Fast walking			1
Jogging/running			2
Aerobics			3
Weight training			4
Dancing			5
Swimming			6
Cycling			7
Ball games (soccer, GAA, rugby)			8
Racket sports (tennis, badminton)			9
Weight lifting			10
Other (Please describe below)			11

Other (Please describe) _____

D5 a. Did you ask for advice on taking exercise during your pregnancy?

Yes 1 No 2

b. If Yes, please state who and what advice you were given

What date did you complete this survey on? _____

Please help me to keep in touch with you.

If your address or other contact details have changed (or you are about to move), please fill in the details below:

Your NEW address:	Your NEW phone number(s):
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Thank you for taking the time to complete this survey.

Please use the **reply paid (FREE POST)** envelope to send it back to me. If no envelope was enclosed with this survey or you have mislaid it, please text or call me, Jamile Marchi, at **087 2290989** and I will send you out another one.

I am very grateful for the time and trouble you have taken to participate in this part of the MAMMI study.

The results from this part of the study will not be available until all of the women taking part in the study have given birth. As soon as the first study results are available, I will let you know via the website and the study newsletter for women.

Please do call me if you have any questions about the study.

I look forward to contacting you again when your baby is three months old.

Best wishes.

The MAMMI study

087 2290989

www.mammi.ie

