Table 6. Pregnancy late term questionnaire

Natural Population Cohort Survey in Southwest China

（birth cohort）

Late Pregnancy Survey

Personal code:..-..-.....-□1 -□0 □4
The first 1-2 digits from the left are the survey city (state) code, with a value unit of 0-9; The third and fourth digits are the code of the survey agency, with a value range of 0-9; The 5th to 9th digits are the serial number of pregnant women surveyed, with a range of 0-9; each institution is numbered from 00001; The 10th digit is the identification code of the research subject (1 for mother), 2 for the first child, 3 for the second child (and so on for multiple births); the questionnaire for multiple births should be filled out for each birth. The 11th and 12th digits are the questionnaire number: baseline table 01, early pregnancy table 02, mid-pregnancy table 03, late pregnancy table 04, birth table 05, postpartum and infant table 06, six months table 07, one year table 08.
Name of pregnant woman:_____ Hospitalization: No□ Admitted□, admission number：_____ Pregnant ID number: □□□□□□□□□□□□□□□□□□ Current gestational age:_____Zhou Mobile phone number:_____
Name of the survey institution:_____

Investigators signature:_____	date：_____year ____moon ____ sun
QC Officer signature:_____	date：_____year ____moon ____ sun

Start time of investigation (24-hour system):□□ time □□ component

Part I: Health Surveys

A01	Have you had any vaginal bleeding during pregnancy (not counting "showing red" before delivery)?___ 0. No---jump to (A02) 1. Is the first bleeding time:___1. Early Pregnancy 2. Mid-Pregnancy 3. Late Pregnancy cause： ___ 1 Threatened abortion 2 Threatened preterm birth 3 Placenta previa 4 Placental abruption 5 Others, please specify; whether medication is used___, 0 No (jump to A02) 1 Yes,___Type 2. Unclear

Name of drug	Dosage and frequency of medication	First medication (gestational week)	How many days are actually shared
		be pregnant ___ circumference	
		be pregnant ___ circumference	
		be pregnant ___ circumference	
		be pregnant ___ circumference	

A02	Since the last questionnaire, have you experienced vomiting:____ 0. No---jump to (A03) 1. Yes, mild (from the first trimester of pregnancy____Zhouji to the 1st____circumference ） 2. Yes, severe (from the first trimester of pregnancy___Zhouji to the 1st___Week) whether medication was used___, 0. No (jump to A03) 1 Yes.___a surname

Name of drug	Dosage and frequency of medication	First medication (gestational week)	How many days are actually shared
		be pregnant ___ circumference	
		be pregnant ___ circumference	
		be pregnant ___ circumference	

A03	Have you had a fever since becoming pregnant_____ 0 No (go to A04) 1 Yes The highest temperature is_ ， last _Heaven: Whether to use medication_, 0. No 1. Yes,_Type 2. Unclear

Name of drug	Dosage and frequency of medication	First medication (gestational week)	How many days are actually shared
		be pregnant ___ circumference	
		be pregnant ___ circumference	
		be pregnant ___ circumference	

A04	Since the last questionnaire, have you had amniotic fluid diagnosis:_____ 0. No-jump to A05 1. Yes, reason_____ Time of amniocentesis: Day__Pregnancy week diagnosis:_____
A05	Since the last questionnaire, have you been told that you have gestational hypertension?___0 No (please jump to A08) 1. Yes→

	A06. Diagnostic time:_____year ____moon ____ sun A07. Do you receive treatment for this (multiple choices)?____0. No 1. Yes, dietary restrictions (e.g., no salt) 2. Yes, bed rest 3. Yes, hospital care 4. Yes, medication 5. Yes, other methods, please specify:____
A08	Since the last questionnaire, have your doctor informed you of having preeclampsia?____ 0. No (please jump to A11) 1. Yes → A09. Diagnostic time:____year ____moon ____ sun A10. Do you receive treatment for this (multiple answers)?____0. No 1. Yes, dietary restriction 2. Yes, bed rest 3. Yes, hospital care 4. Yes, medication 5. Yes, other methods, please indicate:____
A11	Since the last questionnaire, have you been told by your doctor that you have eclampsia?____0 No (please jump to A14) 1. Yes→ A12. Diagnostic time:_____year ____moon ____ sun A13. Do you receive treatment for this (multiple answers)?____0. No 1. Yes, dietary restriction 2. Yes, bed rest 3. Yes, hospital care 4. Yes, medication 5. Yes, other methods, please indicate:____
A14	Since the last questionnaire, have you been told that you have gestational diabetes?____0 No (please jump to A18) 1. Yes→ A15. Diagnostic time:____year ____moon ____ A16. The diagnosed diseases are:____ 1. Diabetes mellitus with pregnancy 2. Gestational diabetes mellitus A17. Have you received treatment for this (multiple answers)?____0. No 1. Yes, diet control 2. Yes, exercise 3. Yes, drug therapy, please indicate:____ 1). Insulin 2). Metformin 3). Others 4. Yes, inpatient care
A18	Have you been vaccinated since becoming pregnant?_____ 0. No (please jump to A19) 1. Yes: Please fill in the name of the vaccine_____Not clear, time of inoculation:_____year _____moon
A19	Whether there are pregnancy complications or comorbidities during pregnancy:_____ 0. No 1. Yes: Please select the specific disease:_____ 1. Gestational hypothyroidism 2. Gestational hyperthyroidism 3. Intrahepatic cholestasis of pregnancy 4. Anemia in pregnancy (select the specific name____ 4.1 Iron deficiency anemia 4.2 Thalassemia 4.3 Others) 5. Others

Part II: Behavioral and environmental exposures

A. smoke

A01	Since the last time you filled out the questionnaire, have you ever smoked?____ (At least one cigarette per day, smoking continuously for more than one month) 0. No (Please jump to A05) 1. Yes → A02. When did you start smoking:____year ____Month (please fill in the date after the last survey) A03. Have you stopped smoking? 0 No 1 Yes, when:____year ____Month (if not finished, leave blank) A04. How many cigarettes do you smoke a day?____Days/month

A05	Since the last questionnaire, have you ever been exposed to a smoking environment?____ 0 No (please jump to B01) 1. Yes → A06. Has your husband ever smoked in front of you?____0 No (please jump to A10) 1 Yes A07. How long do you usually smoke in front of you every day?____Hours/day A08. When to start smoking in front of you:____Year Month (please fill in the date after the last survey) A09. Whether to end smoking in front of you____0. No 1. Yes end time:____year ____Month (if not finished, leave blank) A10. Do people smoke in front of you in your work environment and in public places you go to?____ 0 No (please jump to B01) 1. Yes A11. Average weekly exposure to smoke____Hours/week

B. drink

B01	Since the last time you filled out the questionnaire, do you drink alcohol regularly? (average of at least 1 time per week) 0. No (please jump to C01) 1. Yes→ B02. When to start drinking:_____year ____Month (please fill in the date after the last survey) B03. Whether to stop drinking alcohol 0 No (go to C01) 1 Yes Stop drinking time:_____year _____moon For the following types of alcohol, how many times a week do you drink on average? How many ounces do you drink each time?

Wine varieties	Next/Week	Two per session
B04. Beer		
B05. Foreign wines		
B06. Spirits		
B07. Wine		

C. drink tea

C01	Since the last time you filled out the questionnaire, do you drink tea often? (For example, at least 3 times a week) 0. No (Please jump to D01) 1. Yes→ C02. When to start drinking tea:_____year _____Month (please fill in the date after the last survey) C03. Whether to stop drinking tea_____ 0 No (go to D01) 1 is the end of tea time_____year _____moon C04. What kind of tea do you drink? (Choose one)____ 1. Green tea 2. Black tea 3. Oolong tea 4. Camellia sinensis 5. Pu'er tea 6. Black tea The amount of green tea is similar 7. White tea 8. Camellia sinensis The amount of green tea is similar 9. Camellia sinensis The amount of black tea is similar 10. Others

D. alima

D01	Since the last questionnaire, do you take vitamin or mineral supplements regularly? 0. No (go to D02) 1. Yes→____ (like folic acid, Fufu, calcium tablets, iron supplements and so on)
D02	Please write down the name of the vitamin or mineral supplement you take regularly, when you take it and how often you usually take it a week. 1.folic acid ____(1 folic acid tablets, 2 Ailewei, 3 Materna 4 others 5 unknown), weekly____Next, co-servicing____circumference

	2. Financial Aid for the TOEFL_____(1 Other 2 Not known), weekly____Next, co-servicing_____circumference 3.calcium tablet ____(1 calcium carbonate D3 tablets 2 calcium carbonate D3 granules 3 calcium acetate capsules 4 calcium lactate granules 5 calcium gluconate zinc oral solution 6 others 7 unknown), weekly____Next, co-servicing____circumference 4.chalybeate ____(1 dextran iron oral solution 2 ferrous lactate capsules 3 iron succinate oral solution 4 ferrous succinate sustained-release tablets 5 others 6 unknown), weekly____Next, co-servicing____circumference 5. Other: Please indicate:_____
E. Sports activities and electronic product use	
E01	Since the last time you filled out the questionnaire, how often do you walk on average per week___hour；
E02	Since the last questionnaire, have you been physically active (at least 3 times a week for at least 30 minutes each time, excluding walking)___ 0 No 1 Yes
E03	Since the last time you filled out the survey, your average phone usage___hour
E04	Since the last time we filled out the survey, you average how much you use a tablet___hour
E05	Do you leave your phone, tablet or other electronic devices near you at night, such as on your bed/bedside table___0 No (please jump to E06) 1. Yes (the status of the electronic product is_____A. Turn off B. Turn on C. Charge D. Flight mode)
E06	Since the last time you filled out the questionnaire, how many days on average have you used a computer___hour
E07	Since the last time you filled out the questionnaire, how many hours on average do you watch TV per day___hour
E08	Have you worn a radiation suit since the last questionnaire?___ 0 No (please jump to F01) 1 Yes
E09	Since the last questionnaire, how long on average have you worn a radiation suit per day?__hour
F. occupational exposure	
F01	Have you been working since the last time you filled out the questionnaire____ 0 No (please jump to G01) 1. Yes → Have you changed jobs or positions____0. No (please jump to F10) 1. Yes (1 time□ 2 Next□）

Please fill in the information about your work since you last completed the questionnaire

Title	question	Latest new job	Last new job
F02	Name of your work unit		
F03	Address of your work unit	_market _distinguish __street	_market _distinguish __street
F04	What is your job position?		
F05	Please describe the specific tasks of your work		
F06	When did you start this job?	__year __moon	__year __moon

F07	When did you finish this job? (If not finished, fill in)	__year __moon	__year __moon
F08	Which of the following best describes the intensity of physical activity required for your job?	1. Sitting dominates 2. Small amounts 3. Intermediate 4. High	1. Sitting dominates 2. Small amounts 3. Intermediate 4. High
F09	Whether your work requires an overnight shift	0. No 1 Yes	0. No 1 Yes
F10	Have your working hours changed since the last questionnaire_____ (0 No-jump to F11 1 is (1 time 2 times 3 times)) (Fill in as many times as the number of changes): From the first pregnancy...____ The Thoughtful Pregnancy____ Zhou, working daily____hour Since becoming pregnant_The Thoughtful Pregnancy_Zhou, working daily_hour Since becoming pregnant_The Thoughtful Pregnancy_Zhou, working daily_hour		
F11	What is your most commonly used transportation for work and travel? (Multiple choices)_ A. Walking B. Bicycle/electric vehicle C. Bus D. Subway E. Car F. Bicycle		
F12	How long does it take you to get from home to work:__hour		
F13	Since the last questionnaire, work in noisy factories, bars or frequent exposure to loud noise:____0 No 1 Yes		
F14	How loud is the noise:____1. Most of the time it is not large 2. Can hear the sound of speech, the noise is loud 3. Can not hear the sound of speech, can tolerate 4. Can not hear the sound of speech, the noise is unbearable 5. Uncertain		
F15	Since the last questionnaire, have been exposed to dust in work (including field work):____0. No 1. Yes 2. Don't know		
F16	Since the last questionnaire, exposure to harmful gases at work (including field work):____0 No 1 Yes 2. Don't know		

G. Living conditions

G01	Have you moved since the last questionnaire?_____0 No (please jump to G15) 1 Yes

Please fill in the following information about your place of residence since you last completed the questionnaire:

Title	question	(1) Current residence	(2) Last residence
G02	Name of city, district and street	market：_distinguish：_street	market：_distinguish：_street
G03	Start time of residence	__year __moon __ sun	__year __moon __ sun
G04	floor space	^{2}__m	^{2}__m
G05	Residential floor	_____layer	_____layer
G06	The residence is close to the main traffic road (four lanes in both directions)	1. <50m 2. 50-100m 3. 101-150m 4. >150m	1. <50m 2. 50-100m 3. 101-150m 4. >150m

G07	What kind of fuel do you mainly use to cook at this residence?	1. Gas or natural gas 2. Coal briquettes or coal lumps 3. Electric or induction cooker 4 Other _____	1. Gas or natural gas 2. Coal briquettes or coal lumps 3. Electric or induction cooker 4. Others _____
G08	What is the cooking oil you use most often at home?	1. Vegetable oil 2. Lard 3. Peanut oil 4. Soybean oil 5. Blended oil 6. Other oils	1. Vegetable oil 2. Lard 3. Peanut oil 4. Soybean oil 5. Blended oil 6. Other oils
G09	Do you use a range hood when cooking?	0. No 1 Yes	0. No 1 Yes
G10	The time when the last decoration was finished (if you don't know the month and day, you can fill in 99)	__year __moon __ sun	__year __moon __ sun
G11	The decoration materials used in your home (multiple choices)	A Paint B Wallpaper C Wood Panel D Glue E Solid Wood F Marble G Granite I Other (specify)____	A Paint B Wallpaper C Wood Panel D Glue E Solid Wood F Marble G Granite I Other (specify)____
G12	Can you smell the decoration when you move in after decorating your house?	Mild refers to the smell of decoration, moderate refers to the irritation and pungency, and severe refers to the occurrence of dizziness and other symptoms 0. No 1. Mild 2. Moderate 3. Severe	0. No 1. Mild 2. Moderate 3. Severe
G13	Last time furniture was added (not sure to fill in 99)	__year __moon __ sun	__year __moon __ sun
G14	Materials of your furniture (multiple choices)	A artificial board B solid wood C glass D others	A artificial board B solid wood C glass D others
G15	How long your house has its Windows open	Working days: __ hours/day; Non-working day: __ hours/day	Working days: __ hours/day; Non-working day: __ hours/day
G16	Does your home use air purification facilities	0. No (please jump to G18) 1. Yes	0. No (please jump to G18) 1. Yes
G17	How long your home has been using air purification facilities	Working days: __ hours/day; Non-working day: __ hours/day	Working days: __ hours/day; Non-working day: __ hours/day
G18	Does your home have heating (including air conditioning, electric heaters, coal stoves, etc.)	0. No (please jump to G22) 1. Yes	0. No (please jump to G22) 1. Yes
G19	When your home heating started	__year __moon __ sun	__year __moon __ sun

G20	When your home heating ends	__year __moon __ sun	__year __moon __ sun
G21	Please choose your home heating method: (multiple choices)	A coal stove, with chimney B coal stove, without chimney C electric heating D air conditioning E others _____	A coal stove, with chimney B coal stove, without chimney C electric heating D air conditioning E others _____
G22	Do you have pets at home	0. No 1. Yes, the pet is_____	0. No 1. Yes, the pet is_____
G23	Are there any places around your home (within a radius of one kilometer from the residence) that pollute the air?____ (Choose more than one)	A. No B. There is a power plant C. There is a smelter D. There is a chemical plant E. There is a gas station F. Others____	A. No B. There is a power plant C. There is a smelter D. There is a chemical plant E. There is a gas station F. Others____
G24	Since the last questionnaire, how many hours on average you spend cooking (breakfast, lunch and dinner) per week at home: Since becoming pregnant_The Thoughtful Pregnancy_Zhou, cooking weekly__hour Since becoming pregnant_The Thoughtful Pregnancy_Zhou, cooking weekly__hour		
G25	Since the last questionnaire, your average weekly time spent cooking (breakfast, lunch, dinner) is: Since becoming pregnant_The Thoughtful Pregnancy_Zhou, you cook every week_hour Since becoming pregnant_The Thoughtful Pregnancy_Zhou, you cook every week_hour		
G26	Since the last time the questionnaire was filled out, what is your average daily time spent at home? (Including sleep and other activity time) Since becoming pregnant____The Thoughtful Pregnancy____Week, stay at home weekly weekday____Hours of rest____hour Since becoming pregnant____The Thoughtful Pregnancy____Week, stay at home weekly weekday____Hours of rest____hour		
G27	Is there any elderly person (both parents) in the family to take care of you during this pregnancy?____(0. No 1. Yes) Do you live with your parents?____(0. No 1. Yes)		
G28	Since the last time you filled out the questionnaire, have you dyed or permed your hair?____0 No 1 Yes		
G29	Since the last time you filled out the questionnaire, do you often wear makeup? 0. No 1. Yes (including contact with lipstick, nail polish, cosmetics, etc.)_		
Part III. Prenatal education			
H01	Did you do fetal education for your baby during pregnancy?____ 0 No (please jump to I1) 1 Yes		
H02	When did you start doing fetal education?____1. Within the first 13 weeks of pregnancy 2. Between the 14th and 26th weeks of pregnancy 3. After the 26th week of pregnancy		
H03	How often do you give birth to a baby?_		
H04	What prenatal education have you done for your baby?____1. Sing to the baby, listen to music 2. Read to the baby, talk to the baby 3. Touch the fetus, interactive games 4. Appreciate literary and artistic works by yourself 5. Light the abdomen to stimulate the fetus 6. Others, please explain_		
H05	Did your husband participate in fetal education?____1. Participated, he was very enthusiastic about fetal education 2. Participated, but his enthusiasm was mediocre 3. Not participated		
Part IV Pittsburgh Sleep Scale			

sleep quality		not have	<1 time per week	1-2 times per week	⩾3 times per week
I01	Difficulty falling asleep at night (can not fall asleep within 30 minutes)				
I02	Waking up easily or early at night				
I03	Get up at night to go to the bathroom				
I04	You can't breathe properly at night				
I05	Coughing or snoring at night				
I06	Feel cold at night while sleeping				
I07	It feels too hot to sleep at night				
I08	Have nightmares at night				
I09	Pain and discomfort during sleep at night				
I10	Other conditions that affect nighttime sleep (if yes, please state____)				
I11	Need to take medication (including from a doctor's prescription or over-the-counter) to fall asleep?				
I12	It is difficult to stay awake while driving, eating or participating in social activities				
I13	How do you feel about your sleep quality at night?	1. Very good 2. Good 3. Poor 4. Very poor			
I14	Do you have difficulty in actively accomplishing things?	1.No 2. One point 3. Relatively difficult 4. Very difficult			

End time of survey(24-hour system): … … minutes