

PREGNANCY QUESTIONNAIRE

Client Name: _____ Date: _____

Staff Name: _____

1. Age: _____
2. Highest education level you have attained: _____
3. Do you know if you have a learning disability? _____ If yes, please describe disability:

4. Date of last menstrual cycle: _____
5. Do you know your due date? _____ If so, when is it? _____
6. What pregnancy symptoms have you noticed so far? _____

7. Are any of those symptoms severe? _____
8. Are you getting prenatal care? _____
9. Do you have any questions about standard prenatal care testing? _____
10. Where are you getting prenatal care? _____
11. Do you take prenatal vitamins? _____
12. Are you aware of the signs of premature labor? _____ If so, have you noticed any signs of premature labor? _____
13. Is your pregnancy considered to be "high risk" at your prenatal care office? _____
14. Do you have someone who helps provide support (example, someone to talk to, emotional support or someone who helps with scheduling appointments? _____ If so, who and their relationship to you?

15. Is this your first pregnancy? _____ If not, how many children do you have? _____

16. Have you had any miscarriages? _____
17. For previous deliveries, did you have C-section or Vaginal deliveries? _____
18. Would you like information on postpartum care for yourself? _____
19. Have you ever experienced postpartum depression with any of your other pregnancies? _____ If so, what were your symptoms? _____

20. Do you plan to breast or bottle feed? _____
21. Would you like information on preventing SIDS (Sudden Infant Death Syndrome)? _____
22. Are you interested in parenting classes? _____
23. Would you like information on newborn care? _____
24. Do you have a car seat to take baby home? _____
25. Do you understand how to install a car seat? _____
26. Do you need the phone numbers for resources to get baby items? _____
27. Do you smoke cigarettes? _____ If so, how many packs per day? _____ Have you used any illicit substances during the past 9 months? _____ If so, what have you used, how often and how much? _____

28. Are you on medication assisted therapy (examples...methadone, suboxone)? _____, if so, what medication(s)? _____
29. Are you interested in WIC? _____
30. Are you interested in Help Me Grow? _____
31. Do you have medical insurance? _____
32. Do you receive assistance from ODJFS? _____ If so, what type of assistance do you receive?

33. Are you in need of a food voucher? _____

34. Are you in need of a clothing voucher? _____

35. Are you homeless? _____

36. Are you in need of housing or assistance in finding housing? _____

37. Do you feel safe? _____

38. Do you have any other questions or concerns? _____

