

**FORWARDHEALTH
 PRENATAL CARE COORDINATION
 PREGNANCY QUESTIONNAIRE**

Instructions: Type or print clearly. Before completing this form, read the Prenatal Care Coordination Program Pregnancy Questionnaire Completion Instructions, F-1105A.

SECTION I — GENERAL INFORMATION

1. Name — Member (Last, First, Middle Initial)		2. Date of Birth — Member	3. Age — Member
4. Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	5. Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian		<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hawaiian / Pacific Islander <input type="checkbox"/> Other
6. Education (Indicate highest grade completed.) <input type="checkbox"/> Primary / Secondary (1-12) _____ <input type="checkbox"/> College (1-4 or 5+) _____		7. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
8. Address — Member (Street, City, State, ZIP Code)			9. County
10. Telephone Number — Member		11. Other Telephone Number — Member	
12. What is the best way to contact you? When is the best time to contact you?		13. Name and Telephone Number — Emergency Contact Person	
14. Name — Medical Provider or Clinic (Doctor, Nurse Practitioner, Midwife) <input type="checkbox"/> I do not have a medical provider.		15. Member Identification Number	
16. How many times have you been to a dentist or dental clinic in the last two years?			

To Be Completed by Health Professional
 Lim Eng
 A- <20
 A- >39
 E- H
 R- AI,A,
 B,HPI,O
 Edu<12
 MS- S

SECTION II — CURRENT PREGNANCY

1. When is your baby due?	2. What was the date of your last menstrual period?
3. If you could change the timing of this pregnancy, when would you want it? <input type="checkbox"/> Earlier <input type="checkbox"/> No change <input type="checkbox"/> Later <input type="checkbox"/> Not at all	4. When was your first medical appointment for prenatal care? _____ (month / year) <input type="checkbox"/> I have not seen anyone yet. <input type="checkbox"/> I have an appointment set for _____. (MM/DD/YY)
5. Your Weight Before Pregnancy _____ Your Current Weight _____ Your Height _____	6. Are you pregnant with more than one baby (Twins, Triplets)? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you thinking about breastfeeding your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided	8. Have you had a Human Immunodeficiency Virus (HIV) test during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you had any bleeding or cramping? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Are you receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)? <input type="checkbox"/> Yes <input type="checkbox"/> No

Tim- L,NAA
 PNC- 2,3,N

BMI- <19.8
 BMI- ≥26.1

WIC- Y

Continued

SECTION IV — CONCERNS (Continued)

18. Which of these things worry you a lot? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Money problems. | <input type="checkbox"/> My relationship with my partner. |
| <input type="checkbox"/> My job. | <input type="checkbox"/> My partner did not want this pregnancy. |
| <input type="checkbox"/> My partner's job or unemployment. | <input type="checkbox"/> Labor and delivery. |
| <input type="checkbox"/> My partner's drinking or drug use. | <input type="checkbox"/> Caring for this baby. |
| <input type="checkbox"/> My own drinking or drug use. | <input type="checkbox"/> Caring for my other children. |
| <input type="checkbox"/> My partner is in jail. | <input type="checkbox"/> Other _____. |

19. What worries you the most?

20. What do you do to deal with your problems?

21. Who can you count on for help with everyday activities, such as child care, meals, laundry, or transportation?

22. What topics would you like to learn more about? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Baby's growth and development. | <input type="checkbox"/> Labor and delivery. |
| <input type="checkbox"/> Breastfeeding. | <input type="checkbox"/> Managing the discomforts of pregnancy. |
| <input type="checkbox"/> Caring for your newborn. | <input type="checkbox"/> Nutrition during pregnancy. |
| <input type="checkbox"/> Family planning / birth control. | <input type="checkbox"/> Managing stress. |
| <input type="checkbox"/> Getting health care for you and your baby. | <input type="checkbox"/> Other _____. |
| <input type="checkbox"/> How to stop smoking. | |
| <input type="checkbox"/> Effects of alcohol on mother and baby's health. | |

23. Additional Information

SECTION V — TO BE COMPLETED BY HEALTH PROFESSIONAL

Is the member eligible for Prenatal Care Coordination (PNCC) services?

- Yes, based on a number of factors _____ or age _____.
 No.

SIGNATURE — Staff Completing Assessment

Date Signed

SIGNATURE — Qualified Health Professional (If Different from Above)

Date Signed
