DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01105 (02/09)

STATE OF WISCONSIN

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-01105A.

SECTION I — GENERAL INFORMATION

To Be Completed by Health Professional

1. Name — Member (Last, First, Middle Initial)
2. Date of Birth — Member
3. Age — Member
4. Ethnicity ☐ Hispanic ☐ Non-Hispanic
5. Race ☐ American Indian ☐ Black ☐ White ☐ Asian ☐ Hawaiian / Pacific Islander ☐ Other

Lim Eng
A- <20
A- >39
E- H
R- AI,A, B,HPI,O

6. Education (Indicate highest grade completed.)
   ☐ Primary / Secondary (1-12) _____ ☐ College (1-4 or 5+) _____
7. Marital Status
   ☐ Single ☐ Married

Edu<12
MS- S

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)
    ☐ 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?

SECTION II — CURRENT PREGNANCY

1. When is your baby due?
2. What was the date of your last menstrual period?

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

3. If you could change the timing of this pregnancy, when would you want it?
   ☐ Earlier ☐ No change
   ☐ Later ☐ Not at all
4. When was your first medical appointment for prenatal care?
   _______ (month / year)
   ☐ I have not seen anyone yet.
   ☐ 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)?
   ☐ Yes ☐ No

BMI- <19.8
BMI- ≥26.1

7. Are you thinking about breastfeeding your baby?
   ☐ Yes ☐ No ☐ Undecided
8. Have you had a Human Immunodeficiency Virus (HIV) test during this pregnancy?
   ☐ Yes ☐ No
9. Have you had any bleeding or cramping?
   ☐ Yes ☐ No
10. Are you receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)?
    ☐ Yes ☐ No

WIC- Y

Continued

SECTION III — PREGNANCY HISTORY (If this is a first pregnancy, skip to Section IV.)

1. How many times have you been pregnant before?	2. Number of Full-Term Babies	3. Number of Babies Born More Than Three Weeks Early
4. Number of Miscarriages or Other Pregnancy Losses at 20 or More Weeks	5. Number of Miscarriages or Other Pregnancy Losses Before 20 Weeks	6. Number of Living Children
7. Number of Babies Weighing Less Than 5½ Pounds at Birth	8. Number of Babies Weighing More Than Nine Pounds at Birth	9. Date Last Pregnancy Ended

PreT
Loss 20+
LBW
Int<12m

10. Outcome of Last Pregnancy ☐ Live Birth ☐ Miscarriage / Other Loss

SECTION IV — CONCERNS

1. Do you have, or have you ever had, any of the following conditions? ☐ Yes ☐ No
   Check all that apply.
   ☐ Asthma.
   ☐ Chlamydia, gonorrhea, syphilis, or genital herpes.
   ☐ Diabetes.
   ☐ High blood pressure.
   ☐ Seizures / epilepsy.
   ☐ Urinary tract infection.
   ☐ Other illness, infection, or condition requiring medical care.
2. Do you have dental pain or bleeding gums when you eat or brush your teeth? ☐ Yes ☐ No
3. Before pregnancy, did you smoke cigarettes? ☐ Yes ☐ No
   If Yes, indicate the average number of cigarettes smoked per day. _________
4. Since you have been pregnant, have you smoked cigarettes? ☐ Yes ☐ No
   If Yes, indicate the average number of cigarettes smoked per day. _________
5. Does anyone in your household smoke? ☐ Yes ☐ No
6. In the three months before your current pregnancy, did you use any form of alcohol? ☐ Yes ☐ No
   If Yes, indicate the average number of drinks consumed per week. _________
7. Since you have been pregnant, have you used alcohol? ☐ Yes ☐ No
   If Yes, indicate the average number of drinks consumed per week. _________
8. In the past year, have you used street drugs? ☐ Yes ☐ No
9. Have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you? ☐ Yes ☐ No
10. Do you feel unsafe where you live? ☐ Yes ☐ No
11. During the past month, did you miss any meals, not eat when you were hungry, or use a food pantry because there was not enough food or money to buy food? ☐ Yes ☐ No
12. Have you had any housing problems in the past three months? ☐ Yes ☐ No
13. Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments? ☐ Yes ☐ No
14. Have you had problems with depression or received counseling or medications for mental health concerns? ☐ Yes ☐ No
15. During the past month, have you had little interest in doing things, or have you been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No
16. How do you rate your current stress level? ☐ High ☐ Medium ☐ Low
17. How many people can you count on when you need help? ☐ 0 ☐ 1-2 ☐ 3+

1 — Y
2 — Y
4 — Y
7 — Y
8 — Y
9 — Y
10 — Y
11 —- Y
12 — Y
13 — Y
14 — Y
15 — Y
16 — H
17 — 0

Continued

SECTION IV — CONCERNS (Continued)

18. Which of these things worry you a lot? Check all that apply.
    - ❑ Money problems.
    - ❑ My job.
    - ❑ My partner's job or unemployment.
    - ❑ My partner's drinking or drug use.
    - ❑ My own drinking or drug use.
    - ❑ My partner is in jail.
    - ❑ My relationship with my partner.
    - ❑ My partner did not want this pregnancy.
    - ❑ Labor and delivery.
    - ❑ Caring for this baby.
    - ❑ Caring for my other children.
    - ❑ 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.
    - ❑ Baby's growth and development.
    - ❑ Breastfeeding.
    - ❑ Caring for your newborn.
    - ❑ Family planning / birth control.
    - ❑ Getting health care for you and your baby.
    - ❑ How to stop smoking.
    - ❑ Effects of alcohol on mother and baby's health.
    - ❑ Labor and delivery.
    - ❑ Managing the discomforts of pregnancy.
    - ❑ Nutrition during pregnancy.
    - ❑ Managing stress.
    - ❑ Other ______________________________.

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