WOMEN'S HEALTH QUESTIONNAIRE

CLIENT LABEL

(For Data Entry Only)

DATE: _____ ☐Prenatal ☐Postnatal ***PIN:*** _____

This form asks you about your health. Your answers to these questions will help you and our staff to better identify and meet your needs. All information shared is confidential. *Please Mark Your Answers*.

Women's Health, Access to Health Care, Maternal Infections, Baby Spacing:

IF YOU ARE PREGNANT, SKIP TO QUESTION 4:

1. Do you want to become pregnant within the next 2 years? ☐ Yes ☐ No
   If yes, do you take Folic Acid? ☐ Yes ☐ No
2. Are you currently using any kind of birth control? ☐ Yes ☐ No
3. Do you know about the emergency contraception pill (Morning after pill)? ☐ Yes ☐ No
   Would you like more information on this? ☐ Yes ☐ No
****4. Do you think it is important to have an annual women's health check-up?** ☐ Yes ☐ No
5. Have you had a pap smear within the past 2 years? ☐ Never had one ☐ Uncertain ☐ Yes ☐ No
6. Have you ever had an abnormal pap smear? ☐ Uncertain ☐ Yes ☐ No
7. Do you ever Douche? ☐ Yes ☐ No
   7a. If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
8. Do you have a family history of breast cancer? ☐ Yes ☐ No
8a. Has your doctor asked if you have a family history of breast cancer? ☐ Yes ☐ No
9. Do you know how to examine your breasts for lumps? ☐ Yes ☐ No
9a. Have you ever had a breast lump? ☐ Yes ☐ No
   If yes, have you had a biopsy? ☐ Yes ☐ No
10. Do you ever eat non-foods items such as ice, cornstarch, laundry starch, clay or dirt? ☐ Yes ☐ No
11. Have you seen a dentist in the last year? ☐ Yes ☐ No
12. Do you have a doctor or health care provider when you are not pregnant? ☐ Yes ☐ No
    Are you able to talk comfortably with your health care provider? ☐ Yes ☐ No
13. Do you have medical insurance? ☐ Medicaid prior to Pregnancy ☐ Other Ins. ☐ None
    ☐ Medicaid during Pregnancy Only

Nutrition, Physical Activity, Healthy Behavior:

14. How many servings of fruits and vegetables do you eat a day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
15. Current Weight: _____lbs. Height: ____feet ____inches
    If pregnant: Pre-pregnancy Weight: _____lbs. BMI _____(To be completed by staff)
16. Do you exercise 20-30 minutes three times a week? ☐ Yes ☐ No
17. Do you smoke? ☐ Yes ☐ No

Women's Health Questionnaire (cont.)

Health Screening:

18. Have you been screened (checked) or treated for any of the following problems in the last 2 years? *Leave blank if unknown*.

	Checked	*Treated*		*Checked*	*Treated*
Bacterial Vaginosis	☐	☐	High Cholesterol	☐	☐
Group B Strep	☐	☐	Heart Problems	☐	☐
HIV/AIDS Infection	☐	☐	Asthma	☐	☐
STD infections	☐	☐	Liver problems or Hepatitis	☐	☐
Alcohol Abuse	☐	☐	Kidney disease	☐	☐
Substance Abuse	☐	☐	Seizures	☐	☐
Depression	☐	☐	Breast Cancer - Mammogram	☐	☐
Other Mental Health Issues	☐	☐	Blood in stool	☐	☐
Domestic violence	☐	☐	Other Cancers: _____	☐	☐
Underweight/Eating disorder	☐	☐	Anemia	☐	☐
Overweight/Obesity	☐	☐	Sickle Cell	☐	☐
High Blood Pressure	☐	☐	Dental Infections	☐	☐
Diabetes	☐	☐	Other: _____	☐	☐
Diabetes during pregnancy	☐	☐	Allergies	☐	☐

Stress and Mental Health:

19. Have any of the following problems affected you or someone you are close to in a way that caused you stress or worry during the past year? Check all that apply.

Relationships ☐
Care of an elderly family member ☐
Experience of discrimination: ☐
(Being prevented from doing something or being made to feel inferior based on gender, race / ethnicity, socioeconomic position or class, sexual preference)

Housing Concerns ☐
Homeless ☐
Unsafe neighborhood ☐
Eviction or threat of eviction ☐

Other: _____

Environment exposure:

20. Are there any weapons in your home? ☐ Yes ☐ No
    If yes, are they locked in a safe place? ☐ Yes ☐ No
21. Are there environmental hazards you may be exposed to? ☐ Yes ☐ No
    If yes, check all that apply:
    ☐ Lead ☐ Second hand smoke ☐ Mold ☐ Other _____

_____ _____
Signature of Staff Member Reviewing Form / Title: *Date:*