PREGNANT INTERVIEW

Name/Participant ID:

Assessed By:

Date:

HEALTH/MEDICAL

1a. How is your pregnancy going?

Listen, ask, and assess for

- *Obtaining prenatal care*
- *Nausea/Vomiting*
- *Heartburn*
- *Constipation*
- *Previous Pregnancies*

☐ 301 Hyperemesis Gravidarum

☐ 335 Multi-fetal Gestation

1b. ____Number of babies this pregnancy

***1c. Is this your first pregnancy?** ☐ Yes ☐ No

____*Number of previous pregnancies

____*Number of live births

____Number of pregnancies past 20 weeks/5 months

Date of last birth/abortion/miscarriage: _____

1d. With any past pregnancy, did you have any complications?

☐ 303 – Hx of gestational diabetes

☐ 311 – Hx of preterm delivery <37 wks

☐ 312– Hx of Low Birth Weight infant <5.5 lbs

☐ 339– Hx of congenital birth defects

☐ 345 – Hx of hypertension – chronic or pregnancy induced

☐ 304 – Hx of preeclampsia

☐ 321 – Hx of miscarriage, spontaneous abortion,neonatal loss

1e. How are you feeling this week?

Listen, ask, and assess for

- *Nausea*
- *Vomiting*
- *Discomfort*

How do you feel about your weight gain?

☐ 301– Hyperemesis Gravidarum

☐ 302– Gestational Diabetes

***1f. Have you been to the doctor yet?** ☐ Yes ☐ No

*Care began after 13 weeks ☐ Yes ☐ No

1g. Tell me about any medical problems or illnesses you have. Has your doctor diagnosed any medical problems? ☐ Yes ☐ No

Listen, ask, and assess for

- *Medical conditions (previous to pregnancy)*
- *Health concerns*
- *Disability*
- *Illness*

1h. Are you currently taking any medication? ☐ Yes ☐ No

1j. Do you ever have a hard time chewing or eating certain foods?

Listen, ask, and assess for

- *Oral health care/Referral*
- *Tooth decay*
- *Tooth loss*
- *Impaired ability to eat*
- *Gingivitis*

☐ 381– Dental Problems

NUTRITION PRACTICES

2a. Tell me what you like to eat and drink.

Listen, ask, and assess for

- *Appetite*
- *Timing of meals*
- *Meals, snack, and drinks*
- *Eating pattern*
- *Frequency*
- *Eating problems*
- *Food preparation*
- *Food likes and dislikes*
- *Pica*

2b. What would you like to change about your eating?

2c. Is there anything you would like to eat more or less of?

***2d. In the month before you became pregnant with this baby, how many times a week did you take a multi vitamin?**

☐ 1x/week
☐ 2x/week
☐ 3x/week
☐ 4x/week
☐ 5x/week
☐ >7x/week
☐ Unknown

***2e. Have you taken any vitamins/minerals in the past month?**

☐ Yes ☐ No ☐ Unknown

2f. Do you take any herbs or dietary supplements now?

☐ Yes ☐ No ☐ Unknown

Nutrition Practices:

☐ 427a – consuming supplements with harmful consequences
☐ 427b – consuming diet low in calories
☐ 427c – compulsively ingesting non-food items (pica)
☐ 427d – inadequate vitamin/mineral supplementation
☐ 425e – Ingesting potentially harmful foods (Food Safety)
☐ 353– Food allergy: wheat, corn, soy, peanuts, eggs, milk, entire food group
☐ 401– Failure to meet Dietary Guidelines for Americans (>=24 m of age)

LIFE STYLE

***3a. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day?** ____Cigarettes/day

***3b. How many cigarettes do you smoke on an average day now?** ____Cigarettes/day

***3c. Does anyone living in your household smoke inside the home?** ☐ Yes 904 environmental smoke ☐ No

***3d. In the 3 months before you were pregnant, how many alcoholic drinks did you have in an average week?**

____Drinks/week

***3e. Have you consumed alcohol during this pregnancy?** ☐ Yes 372A Use of Alcohol ☐ No

***3f. How many alcoholic drinks do you have in an average week now?**

____Drinks/week

3g. In the three months before you were pregnant, did you use street drugs? How about now? ☐ 372B Illegal Drug Use

3h. What do you do for physical activity?

Listen, ask, and assess for

- *Physical activities*
- *Walking*
- *Playing with children*
- *Safe parks*
- *Access to fitness centers*
- *Activity frequency*

BREASTFEEDING PREPARATION

4a. What have you heard about breastfeeding? ☐ Interested in Breastfeeding

Listen, ask, and assess for

- *Interest in breastfeeding*
- *Myths*
- *Concerns*
- *Support systems*

4b. Do you have previous breastfeeding experience? ☐ Yes ☐ No

☐ 338 pregnant woman currently breastfeeding ____Length of time in weeks

Reason for Stopping:

4c. If previously breastfed, how did it go?

- *Affirm and praise*

4d. What does your family, friends, or partner say about breastfeeding?

4e. Tell me about the changes you have noticed or concerns you have about your breasts.

Listen, ask, and assess for

- *Flat*
- *Inverted*
- *Pierced*
- *Surgeries*
- *Pain/discharge*
- *Size*

SOCIAL ENVIRONMENT

5a. What else can I help you with?

Listen, ask, and assess for

- *Abuse/neglect in the last 6 months*
- *Limited ability to make appropriate feeding decision or prepare foods*
- *Family planning*

(ask only if a peer counselor program is available in your agency)

We have moms who have breastfed before and can help you with breastfeeding. I will have one call you.

Interested in Breastfeeding Peer Counselor Program ☐ Yes ☐ No