

**Women's Health Screening and Referral Program - Care Questionnaire**

The Rhode Island Department of Health would like you to fill out this form while you wait. Your answers will help you and your provider identify services you may need and will help us plan new programs for women. Your answers will be confidential. If you have any concerns, please feel free to discuss it with your provider or call the Family Health Information Line at 1-800-942-7434.

Today's date: \_\_\_/\_\_\_/\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_

1. Are you trying to get pregnant?  Yes  No
2. Are you and your partner using birth control now?  Yes  No
3. What will you do if you are pregnant?  
 Keep the baby and raise a family with the father     Keep the baby as a single mother  
 Place the baby for adoption     Other     Don't know
4. Do you have health insurance?  Yes  No
5. If you are pregnant, do you have someone to help you?  Yes  No
6. Do you ALWAYS have heat, hot water, electricity, and access to a phone?  Yes  No
7. Have you skipped meals or eaten less because you do not have enough money for food?  Yes  No
8. Do you have any concerns about nutrition or diet?  Yes  No
9. Have you visited a doctor in the past year?  Yes  No
10. Do you have any medical or health problems?  Yes  No
11. Do you take a multi-vitamin with folic acid every day?  Yes  No
12. Do you have problems getting to the doctor because of transportation, child care, or other reasons?  Yes  No
13. Do you smoke?  Yes  No  
If no, do you spend time with other smokers?  Yes  No
14. Do you drink beer, wine or hard liquor or use marijuana, cocaine, heroin, or other drugs?  Yes  No
15. Do you use condoms every time you and your partner(s) have sexual intercourse?  Yes  No
16. Have you or your partner(s) had Hepatitis, a **positive** HIV test, or AIDS?  Yes  No
17. At home, do you feel physically or verbally threatened or abused?  Yes  No
18. Do you feel depressed or have other mental health problems?  Yes  No
19. Did you ever have a serious complication with previous pregnancy or birth?  Yes  No
20. Did you ever deliver a premature baby, a sick baby or have a baby die?  Yes  No
21. Has anyone in your family or your partner's family had any birth defects, mental retardation or developmental delay?  Yes  No

**FOR OFFICE USE ONLY**

Patient Number: \_\_\_\_\_ Service Site Number: \_\_\_\_\_

- Positive Pregnancy Test
- Prenatal Care     Home Visiting Program  
 Options Counseling     Adolescent Self-Sufficiency Program  
 Rite Care
- Negative Pregnancy Test
- Family Planning     Teen Prevention Program  
 Preconception Counseling     Other     No Referral Available
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- Home Visiting Program (+)     Other (+/-)     No Referral (-)
- Home Visiting Program (+)     Community Action Program (+/-)
- WIC (+)     Community Action Program (+/-)  
 Local Food Bank (+/-)     Other (+/-)
- WIC (+)     Nutrition Education (-)     Other (-)     No Referral (-) Available
- Early Prenatal Care (+)     Medical Provider (-)
- Early Prenatal Care (+)     Medical Provider (-)
- Multivitamin (+/-)     Folic Acid Education (+/-)
- Home Visiting Program (+)     Other (-)     No Referral (-) Available
- Tobacco Cessation Program (+/-)     Tobacco Cessation Education (+/-)     No Referral (-) Available
- Substance Abuse Education (+/-)     Substance Abuse Assessment (+/-)     No Referral (-) Available
- STD/HIV Education (+/-)     HIV/STD Counseling/Testing (+/-)
- Early Prenatal Care (+)     Medical Provider (-)
- Domestic Violence Hotline (+/-) 1-800-494-8100
- Mental Health Provider (+/-)     No Referral (-) Available
- Early Prenatal Care (+)     Preconception Counseling (-)     No Referral (-) Available
- Early Prenatal Care (+)     Preconception Counseling (-)     No Referral (-) Available
- Genetics Counseling (+/-)     No Referral (-) Available

I give permission to release this information to the community referral agencies indicated above.

Please sign your name (voluntary): \_\_\_\_\_