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| **Maternal and Child Health Education Visit Questionnaire** | Date \_\_\_\_\_\_\_\_\_\_ |

| Please check the boxes that most closely match your answer to the questions. Health educators will use your answers to help guide your discussion today. All of the information you share is confidential! | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you pregnant? Yes No  Are you the primary care giver of the children qualifying for WIC services? Yes No | | | | | | | | | | |
| 1. When was the last time you visited the dentist? | | | | | | | | | | |
| * Within the last six months | | | * Less than one year ago | | | | | * I can’t remember | | |
| * More than a year ago | | | * Never | | | | |
| 2. When was the last time your children visited the dentist? | | | | | | | | | | |
| * Within the last six months | | | * Less than one year ago | | | | | * I can’t remember | | |
| * More than a year ago | | | * Never | | | | |
| 3. Have your children ever been tested for lead? | | | | | | | | | | |
| * Yes | | | * No | | | | | * Don’t know | | |
| 4. Has your current home (or place where your children spend a lot of time) ever been tested for lead? | | | | | | | | | | |
| * Yes | | | * No | | | | | * Don’t know | | |
| 5. How do you put your baby to sleep? (check all that apply) | | | | | | | | | | |
| * On their back | | | | | * On their belly | | | * On their side | | |
| * With a blanket | | | | | * With a sleep-sack | | | * In an adult bed | | |
| * Alone in their crib/pack ‘n play | | | | | * With another infant/child | | | * I do not have a baby | | |
| 7. Is your partner kind and respectful of your choices? | | | | | | | | | | |
| * Yes | | * No | | | | * Don’t know | * I do not have a partner | | | |
| 6. Do you feel safe at home? | | | | | | | | | | |
| * Yes | | | * No | | | | | * Don’t know | | |
| 8. Over the past 2 weeks, how often have you been bothered by the following? | | | | | | | | | |
| Feeling down, depressed, or hopeless | | | | | | | | | |
|  | * Not at all | | | * Several days | | | | |  |
|  | * More than half the days | | | * Nearly every day | | | | |
| Little interest or pleasure in doing things | | | | | | | | | |
|  | * Not at all | | | * Several days | | | | |  |
|  | * More than half the days | | | * Nearly every day | | | | |
| **Please answer questions on back.** | | | | | | | | | |
| **9. Do you currently use tobacco products (cigarettes, vapors, smokeless tobacco, hookah etc.)?** | | | | | | | | | |
| * Yes | | | | * No | | | | | * Don’t know |
| **10. Do you currently drink alcohol?** | | | | | | | | | |
| * Yes | | | | * No | | | | | * Don’t know |
| **11. Do you currently use medication without a prescription, or take drugs that are illegal?** | | | | | | | | | |
| * Yes | | | | * No | | | | | * Don’t know |
| **12. Are you enrolled in the *Pathway to a Healthy Pregancy* Program?** | | | | | | | | | |
| | * Yes | * No | * Don’t know | | --- | --- | --- | | | | | | | | | | |
| Thank you for completing the questionnaire.  Do you have any specific questions for our staff? Please use the space below to describe. | | | | | | | | | |

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| **Staff Section:** | | |
| Staff Initials: \_\_\_\_\_\_\_\_\_\_ | Start time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | End time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Topics Discussed: | | |
| * Oral Health | * Lead | |
| * Safe Sleep | * Safety | |
| * Depression | * Alcohol | |
| * Tobacco | * Medication without a prescription and/or other drugs | |
| * Pathways program | * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Notes: | | |