CONFIDENTIAL WOMEN'S HEALTH QUESTIONNAIRE: PERINATAL

Cuestionario Confidencial De Salud De La Mujer: Perinatal

Today we are asking questions important to your health. Your answers will be kept private between you and your health care team.
Hoy estamos haciendo preguntas importantes para su salud. Sus preguntas se mantendrán en privado entre usted y su equipo de atención médica.

Name/ Nombre _____

1.	Did your **parents** have a problem with alcohol, marijuana or other drugs? *¿Tuvieron sus **padres** problemas con alcohol, marihuana u otras drogas?*	☐ NO	☐ YES
2.	Do any of your close **friends** have a problem with alcohol, marijuana or other drugs? *¿Alguno de sus **amigos** cercanos tiene problemas con el alcohol, marihuana u otras drogas?*	☐ NO	☐ YES
3.	Does/did your current or past **partner(s)** use tobacco, alcohol, marijuana or other drugs? *¿Usó o usa su **pareja(s)** actual o anterior tabaco, alcohol, marihuana u otras drogas?*	☐ NO	☐ YES
4.	Have you ever had difficulties in your life due to alcohol, marijuana or other drugs including prescription medications? *¿Alguna vez en su vida ha tenido dificultades con alcohol, marihuana u otras drogas incluyendo medicamentos recetados?*	☐ NO	☐ YES
5.	Have you used **tobacco** products in the past three months? *¿Ha usado productos de **tabaco** en los últimos 3 meses?*	☐ NO	☐ YES
6.	Have you used **marijuana** products in the past three months? *¿Ha usado productos de **marihuana** en los últimos 3 meses?*	☐ NO	☐ YES
7.	Have you used **drugs** other than marijuana or alcohol in the past three months? *¿Ha usado **drogas**, diferentes de* marihuana *o alcohol, en los últimos 3 meses?*	☐ NO	☐ YES
8.	In the past month, have you had **alcohol** to drink? / *¿En el último mes, ha consumido **alcohol**?* If yes, on average how many standard drinks do you have: /*¿Cuántas bebidas en promedio tomó?* In a day? *¿En un día?* ☐ 1 to 2 ☐ 3 ☐ 4 or more/*o más* In a week? *¿En una semana?* ☐ 1 to 4 ☐ 5 to 7 ☐ 7 or more/o más	☐ NO	☐ YES
9.	In the past month, has **worry, anxiety, depression or sadness** made it difficult for you to do your work, get along with people, or take care of things at home? *¿En el último mes, la **preocupación, ansiedad, depresión o tristeza** le ha causado dificultades para hacer su trabajo, para llevarse bien con la gente, o para cuidar de los asuntos de su casa?*	☐ NO	☐ YES
10.	Are you currently or have you ever been in a relationship where you were **physically and/or emotionally hurt** such as choked, threatened, controlled, or made to feel afraid? *¿Está o en alguna ocasión estuvo en una relación donde usted fue **físicamente y/o emocionalmente lastimada**, como ahorcada, amenazada, controlada o que le hayan hecho sentir miedo?*	☐ NO	☐ YES

Office Use Below

Date of Visit _____
Practice Site _____
Staff Initials _____
Mother's Date of Birth _____
Primary Language Eng Sp _____
Trimester 1 2 3
Post-P wk _____
If not pregnant list BC method:

☐ Update care plan
☐ Brief intervention
clear & unambiguous recommendation
"No use is safe during pregnancy"
☐ Internal referral to behavioral health
Referral Treatment
☐ alcohol ☐ other drugs
Circle patient's willingness to change:
likely undecided unlikely

Facilitated referral made to (check all that apply):

☐ MotherToBaby California	1-866-626-6847
☐ Smoke Free Babies	575-6043 ext.19
☐ Drug Free Babies	565-7463
☐ Public Health Nursing	565-4440
☐ California Parenting Institute	585-6108
☐ Family Justice Center	565-8255
☐ Verity-sexual assault services	545-7273

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Cuestionario Confidencial De Salud De La Mujer: Perinatal

MAIL THIS FORM TO:

MATERNAL, CHILD, & ADOLESCENT HEALTH PROGRAM
SONOMA COUNTY DEPARTMENT OF HEALTH SERVICES
625 5TH STREET, SANTA ROSA, CA 95404-4428

1.	Did your **parents** have a problem with alcohol, marijuana or other drugs? *¿Tuvieron sus **padres** problemas con alcohol, marihuana u otras drogas?*	☐ NO	☐ YES	
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