The Questionnaire

Name _____

Date of birth (DD/MM/YYYY) ____ / ____ / ____ (____ years old)

Address 〒 _____

_____

Phone number ____ (____) ____

Occupation _____

Weeks of pregnancy weeks ____ weeks

Due date _____

Name of hospital _____

1, Is your pregnancy going well?

☐ Yes

☐ No → What is the problem? _____

_____

2, Do you regularly go to the hospital to get maternity checkups?

☐ Yes → When will your next checkup be? _____

☐ No → Why? _____

3, Are you currently receiving any treatments for any diseases?

☐ Yes → Please specify. _____

☐ No

4, Do you have any concerns about maternity or any other things in your daily life?

☐ Yes → Please specify. _____

_____

☐ No

5, Is there anyone you can talk to or ask for help about your problem?

☐ Yes → husband/partner , parents , brothers , sisters , friends , other(　　)

☐ No

6, Do you have anything else you want to consult us about?

☐ Yes → Please provide a daytime phone number.

☐ No

7, Please tell us about your family members.

	age	occupation	health condition
1, myself			☐good ☐not good(　　)
2, husband /partner			☐good ☐not good(　　)
3,			☐good ☐not good(　　)
4,			☐good ☐not good(　　)
5,			☐good ☐not good(　　)
6,			☐good ☐not good(　　)
7,			☐good ☐not good(　　)