### MSS Post Pregnancy Screening Guide

**Client (Women’s) Questions**

**Clarification Notes:** Depending on the client’s situation or background, questions need to be adapted. Here are examples of specific situations to keep in mind.

- This pregnancy resulted in fetal loss or miscarriage—decide which questions need to be adjusted or skipped before talking with a client. Spend time supporting the woman and her plans related to future pregnancies.
- Client seen by MSS in the post-pregnancy period only—You need to adjust questions and ask about prior pregnancy/parenting history.

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**I am going to ask some questions to better understand how I might support you. Please let me know if you have any concerns or questions as we go along.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Risk and Purpose</th>
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<tbody>
<tr>
<td>1. How are you feeling?</td>
<td><strong>Rapport building</strong></td>
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<tr>
<td>- Physically and Emotionally</td>
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<td>- In the last month, have you experienced loss of appetite, poor sleep</td>
<td><strong>Rapport building, Baby</strong></td>
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<td>not related to infant care, felt down, depressed or hopeless?</td>
<td><strong>Mental Health</strong></td>
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<td>□ Y or □ N (If yes) Client needs standardized depression screening</td>
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<td>completed. If possible, screen all women for depression.</td>
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<td>2. How did your delivery go?</td>
<td><strong>Postpartum Warning Signs i.e.</strong></td>
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<td>- Any issues related to delivery? (Infection, pain, incision, etc.)</td>
<td><strong>fever, increased bleeding, etc.</strong></td>
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<td>3. When did the doctor want to see you for follow up after your delivery?</td>
<td><strong>Delivered multiples</strong></td>
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<tr>
<td>Did you go? □ Y or □ N When is the next appointment?</td>
<td></td>
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<td>4. Did you experience any health concerns or medical conditions</td>
<td><strong>Gestational Diabetes Gestational</strong></td>
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<td>with this pregnancy? (review chart and clarify with client if anything</td>
<td><strong>Hypertension Postpartum Hypertension</strong></td>
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<td>else to add)</td>
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<tr>
<td>- If medical issues known to provider then ask, “How has your__________</td>
<td></td>
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<tr>
<td>been since delivery?”</td>
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<td>- If new concern, “tell me more about_______________________”</td>
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<tr>
<td>5. Do you have any medical concerns or diagnosis not related to your</td>
<td><strong>Diabetes, hypertension, Severe</strong></td>
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<td>pregnancy (hypertension, diabetes, asthma, TB, mental health symptoms,</td>
<td><strong>Mental Illness, depression</strong></td>
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<td>etc.)? □ Y or □ N</td>
<td></td>
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<tr>
<td>If yes, how has your____________________________________been since</td>
<td></td>
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<tr>
<td>your delivery?</td>
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<td>6. Are you currently taking any prescribed medications, over the</td>
<td><strong>Medications related to psychiatric</strong></td>
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<tr>
<td>counter medications, supplements, vitamins, and/or home remedies?</td>
<td><strong>issues, diabetes, and hypertension.</strong></td>
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<tr>
<td>□ Y or □ N (If no) go to Q #7</td>
<td><strong>Non-prescriptive use of prescription drugs</strong></td>
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<td>(If yes) What are they and how much/often do you take them?</td>
<td><strong>Drugs/ breast feeding</strong></td>
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<tr>
<td>Have you discussed taking these meds/supplements with your medical</td>
<td></td>
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<td>provider? □ Y or □ N</td>
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**Notes:**

- **Bold** = MSS Risk factor
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<th>Question</th>
<th>Description</th>
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| 7. | Have you discussed birth control methods with your doctor and/or partner? □ Y or □ N  
- Do you have a family planning method selected? □ Y or □ N  
  If so, which method do you plan to use? ____________________________  
- What do you know about the importance of birth spacing?  
- What do you know about family planning resources available to you? |
| 8. | Who can you count on for help/support?  
- Do you get all the help you need with the baby?  
- Who can you talk to about stressful things in your life?  
- How is the FOB feeling about the new baby?  
- What advice are you getting from family and/or friends? |
| 9. | Have you ever received mental health services, counseling, and/or treatment? □ Y or □ N  
If yes, client needs clinical assessment. |
| 10. | In the last year, has your partner or FOB physically threatened or tried to hurt you? □ Y or □ N  
If so, tell me more ____________________________ |
| 11. | Have you ever smoked or used tobacco or nicotine products? □ Y or □ N (If no) skip to Q #12  
- (If yes) Did you use during the three months before you became pregnant? □ Y or □ N  
  Are you currently using tobacco or nicotine? □ Y or □ N (If no) skip to Q #12  
  (If yes) Are you trying to quit? □ Y or □ N (If yes) tell me more, ____________________________  
  (If no) Are you concerned about relapse? □ Y or □ N ____________________________ |
| 12. | Does anyone who takes care of the baby smoke? □ Y or □ N  
Does anyone smoke inside your home or car with the baby present? □ Y or □ N |
| 13. | When was the last time you drank alcohol?  
- Are you currently drinking alcohol? □ Y or □ N (If no) skip to Q #14  
  (If yes) How much and how often? ____________________________ |
| 14. | When was the last time you used drugs? (If never) skip to Q #15  
(If used drugs) are you currently using drugs? □ Y or □ N (If no, skip to Q #15)  
- (If yes) Are you interested in getting help to stop? □ Y or □ N  
- (If no) Are you concerned at all about relapse? □ Y or □ N |
| 15. | Do you ever run out of food before the end of the month or cut down on the amount you eat to feed others? Y or N (If yes) Tell me more ____________________________  
Depending on feedback, follow up with:  
- Are you currently on WIC? □ Y or □ N  
- Basic Food Program (food stamps)? □ Y or □ N  
- Are you aware of other food programs in the area? □ Y or □ N |
| 16. | Is there any information or resources you would like us to help you with? □ Y or □ N  
(If yes) What? |

If a client is seen by MSS in the post pregnancy period only (not seen by MSS during this pregnancy) then the provider will need to cover the following information/questions:  
1. Maternal Race  
2. Pre-pregnancy BMI and total pregnancy weight gain  
3. When did the client’s prenatal care start  
4. Is this the client’s 1st pregnancy Y or N  
5. If this is not the client’s 1st pregnancy, ask about pregnancy and parenting history  
   ➢ How many times has the client been pregnant?  
   ➢ Have any of the pregnancies been miscarriages, stillbirths or early infant deaths? Y or N.  
   ➢ (If yes) How many and when? ____________________________  
   ➢ When did your last pregnancy end? ____________________________ |

Staff Signature: ____________________________ Date: ____________________________
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<tr>
<th>MSS INFANT QUESTIONS</th>
<th>PURPOSE</th>
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<td>17. How is your baby doing?</td>
<td>Rapport building</td>
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| 18. How much did your baby weigh at birth? _______ How long was he/she? _______  
Current weight: ___________ | LBW infant ( < 5 lbs 8 oz)  
Slow Weight gain  
*All infants should have 2 newborn screening heel sticks- the first shortly after birth and then again around 1-2 weeks of age.  
Refer back to medical care provider as needed.  
Health message on wellness checks and infant screening. |
| 19. Did your baby have any of the following tests:  
- Newborn screening heel stick? □ Y or □ N If yes, when? _______  
Results _______  
- Jaundice? □ Y or □ N  
- Hearing test? □ Y or □ N  
(If yes) Do you know your baby’s hearing results? □ Y or □ N _______  
Were any more hearing tests recommended? □ Y or □ N  
If needed, when will you follow up with more hearing testing? | Infant with health issue – Hearing loss, genetic disease, etc. |
| 20. Does your baby have an appointment with his/her doctor? □ Y or □ N  
(If yes) When? ___________ Continue to Q#21  
(If no) When do you plan on taking your baby in to see the doctor? | Importance of wellness checks  
Medical care |
| 21. Has the doctor identified any concerns or medical conditions for your baby? □ Y or □ N  
(If yes) Tell me more.  
Is your baby taking any medications? □ Y or □ N (If yes) Tell me more. | Infant health issue |
| 22. Do you know what signs to look for that might mean your baby is sick or needs to be seen by a doctor? □ Y or □ N | Health message |
| 23. How is breastfeeding going?  
- How often does the baby feed in 24 hours? _______  
- How long does your baby nurse? _______  
- Are you having any problems breastfeeding? □ Y or □ N (If yes) Tell me more.  
If formula feeding, “How do you mix the formula”?  
- How much does your baby drink? _______  
- How do you know when your baby is hungry? Full?  
- Do you always hold your baby when feeding? □ Y or □ N (If no) Tell me more. | Development & Feeding Relationship  
Exclusive breastfeeding or not  
Breastfeeding Complications- inadequate milk transfer/ineffective suck  
Incorrect mixing of formula  
Very Restrictive Feeding  
Propping of bottle |
| 24. What else do you give your baby to drink? _______  
Do you ever put cereal in the bottle? □ Y or □ N | Evaluate for/health message- cow’s milk, goat’s milk, sports drinks, sweetened drinks, water |
| 25. How many wet diapers does your baby have in 24 hours?  
How many dirty diapers (bowel movements) does your baby have in 24 hours?  
What do the dirty diapers (bowel movements) look like? | Breastfeeding Complications- Inadequate stooling |
| 26. Do you have any questions or concerns about your baby’s:  
Feeding?  
Growth?  
Health?  
Care?  
Other? | Parents needs |
| 27. Have you applied for the baby’s birth certificate?  
Social Security #?  
Do you have the baby’s immunization card?  
Have you notified HCA about the change of circumstances in your pregnancy? Are you considering traveling out of the country? | Important Documents |

Staff Signature: ____________________________ Date: ________________