Finnish Institute for Health and Welfare

Background information questionnaire for maternity clinics

Basic information

Last name		First name
Personal identity code		Temporary personal identity code
Street address		
Postal code	Home municipality	Municipality of residence
E-mail address		Phone number
First language		

Preferred language

☐ Finnish ☐ Swedish ☐ English ☐ Sámi, please specify _____

☐ other, please specify (need for an interpreter) _____

Marital status

☐ single	☐ widowed
☐ married	☐ registered partnership
☐ cohabiting	☐ separated from a registered partnership
☐ separated	☐ widowed after a registered partnership
☐ divorced	☐ unknown

Citizenship	Year of entry into Finland

Occupation

Work situation

☐ full-time	☐ long-term unemployed
☐ part-time	☐ student
☐ temporary	☐ family leave or staying at home
☐ entrepreneur	☐ other
☐ unemployed jobseeker	_____

Who are your family members? (spouse, children, other)

Contact person's name: and your relationship with the contact person

Spouse/contact person's phone number	Spouse/contact person's mother tongue
Spouse/contact person's language to be interpreted	Spouse's occupation/position

Other members of the family

Previous pregnancies and childbirths

How many pregnancies have you had (number)?	Duration of your last pregnancy in gestational weeks
How many childbirths have you had (number)?	The year of the last childbirth?
What was your previous childbirth like?	
Number of children born of your last pregnancy	Birth weight of the child/children in grams
Previous breastfeeding ☐ full breastfeeding (duration in months) _____ ☐ no breastfeeding ☐ duration of the entire breastfeeding period in months/years _____	
How did you feel being pregnant, giving birth and after the baby was born (e.g., were you afraid of giving birth or did you have postnatal depression)?	
Have you had miscarriages? ☐ no ☐ yes, year	Have you had abortions? ☐ no ☐ yes, year

Current pregnancy

Your last period started on	
Last papa screening	Was any further action taken? ☐ yes ☐ no ☐ I don't remember
Contraception before pregnancy ☐ combined oral contraceptive ☐ vaginal contraceptive ring ☐ contraceptive patch ☐ progestin pills ☐ contraceptive capsule ☐ hormonal intrauterine contraceptive device	☐ other intrauterine contraceptive device ☐ condom ☐ sterilisation (female) ☐ sterilisation (male) ☐ other type of contraception ☐ no contraception
When contraception was discontinued	Have you used postcoital contraception? ☐ yes ☐ no
Have you undergone fertility treatments ☐ yes ☐ no What kind of fertility treatment ☐ ovulation induction ☐ insemination (injection of sperm into the uterus) ☐ IVF (in vitro fertility treatment) ☐ ICSI (intracytoplasmic sperm injection) ☐ frozen embryo transfer (FET/PAS) ☐ blastocyst culture (extended embryo culture)	☐ preimplantation genetic testing ☐ donated egg or embryo ☐ no information on the type of treatment ☐ other, please specify _____
Age of the egg donor at the time of donation (years)	

My health information

What is your height (cm)	What was your weight before pregnancy (kg)	At what age did you get your first period

Lifestyle affecting health

Nutrition

Do you have a special diet?

- ☐ lactose-free or low-lactose diet
- ☐ gluten-free diet
- ☐ vegetarian diet including dairy products and/or eggs
- ☐ vegetarian diet including fish
- ☐ vegan diet
- ☐ grain allergy diet
- ☐ milk allergy diet
- ☐ other diet due to a food allergy
- ☐ other special diet

Use and amount of dairy products or similar supplemented plant-based products (e.g., soy or oat) per day

How many meals do you eat per day (number)?

How many times a day do you eat vegetables (other than potatoes), fruit and berries?

- ☐ not every day
- ☐ 1–2 times a day
- ☐ 3–4 times a day
- ☐ 5 times a day or more

How many times a week do you eat fish?

- ☐ not every week
- ☐ once a week
- ☐ at least 2 times a week

How often do you consume juices, soft drinks or energy drinks and coffee or tea that contains caffeine?

- ☐ 3 times or more a day
- ☐ 1–2 times a day
- ☐ less frequently than daily
- ☐ never

Nutritional supplements

	Yes	No
Did you use folic acid supplement regularly before pregnancy?	☐	☐
Do you use folic acid products during pregnancy?	☐	☐
Do you use vitamin D products during pregnancy?	☐	☐
Do you use calcium products during pregnancy?	☐	☐
Do you use vitamin B12 products during pregnancy?	☐	☐
Do you use multivitamin supplements during pregnancy?	☐	☐
Do you use herbal supplements during pregnancy?	☐	☐

Physical activity

How many hours per week do you engage in brisk physical activity (hours)?

Physical activity

- ☐ competitive sports
- ☐ goal-oriented hobbyist
- ☐ hobbyist
- ☐ everyday physical activity
- ☐ I don’t participate in physical activity

Sleep/rest

How many hours per day do you sleep?	Do you feel that you get enough sleep and rest? ☐ Yes ☐ No

Substance use

Smoking

☐ I have never smoked or used e-cigarettes

☐ I have smoked or used e-cigarettes but quit before pregnancy

☐ I have smoked or used e-cigarettes and quit during pregnancy

☐ I smoke or use e-cigarettes during pregnancy

On average, how many cigarettes do you smoke per day (number/day)?	Are you exposed to tobacco smoke ☐ Yes ☐ No

Do you use nicotine products

☐ I have never used them

☐ I have used them but quit before pregnancy

☐ I have used them and quit during pregnancy

☐ I use nicotine products during pregnancy

How often do you consume alcohol? Describe your use of alcohol during the year before pregnancy.	Have you used or do you use alcohol during pregnancy?
☐ never	☐ No
☐ around once a month or less	☐ yes, but I have already quit
☐ 2–4 times a month	☐ Yes
☐ 2–3 times a week	
☐ 4 times a week or more	

Have you used or tried drugs or medicines for intoxication?

☐ Yes ☐ No

Have you used or do you use drugs or medicines for intoxication during pregnancy?

☐ No ☐ Yes, but I have already quit ☐ Yes and continue to use them

Oral healthcare

How many times a day do you brush your teeth?

☐ 2 times or more ☐ once a day ☐ less often than once a day

Do you use fluoride toothpaste when brushing your teeth? ☐ Yes ☐ No	When was the last time you had a dentist's or dental hygienist's examination? (specify the year)

Illnesses and medication

Have you been diagnosed with any of the following illnesses or risks? (You may select more than one option)

☐ diabetes

☐ heart defect or disease

☐ hypertension

☐ asthma

☐ epilepsy

☐ kidney disease

☐ liver disease

☐ bowel disease

☐ thromboembolism

☐ blood coagulation disorder (thrombophilia)

☐ thyroid disorder

☐ allergies (incl. allergies to medicines)

☐ congenital malformation

☐ occupational risks

☐ other, please specify

_____

Have you undergone any of the following?

- ☐ abdominal surgery
- ☐ Caesarean section
- ☐ other operation on the uterus
- ☐ operation on the uterine cervix
- ☐ weight loss operation
- ☐ breast surgery
- ☐ circumcision
- ☐ reconstructive surgery after circumcision
- ☐ blood transfusion
- ☐ procedure, surgery or hospitalisation abroad in the last 12 months
- ☐ other, please specify _____

Have you been diagnosed with any of the following illnesses?

- ☐ condyloma
- ☐ gonorrhoea
- ☐ chlamydia
- ☐ syphilis
- ☐ genital herpes
- ☐ hepatitis C
- ☐ hepatitis B
- ☐ HIV
- ☐ other illness or symptoms
- ☐ none of the above

Have you had chickenpox or received a chickenpox vaccine?

☐ Yes ☐ No ☐ I don't know

Have you been vaccinated against measles, rubella and mumps?

☐ Yes ☐ No ☐ I don't know

Are your other vaccinations up to date?

☐ Yes ☐ No ☐ I don't know

Have you been diagnosed with injuries or sensory disorders? (e.g., visual impairment, hearing impairment)

Have you experienced any of the following symptoms

- ☐ anxiety
- ☐ depression
- ☐ nervousness
- ☐ states of fear
- ☐ panic attack
- ☐ eating disorder
- ☐ other mental symptoms or illness
- ☐ none of the above

Do you have any medication prescribed by a doctor?

☐ No ☐ yes, please specify

Do you use any over-the-counter medications?

☐ No ☐ yes, please specify

Family wellbeing

What makes you joyful in life?

Are you worried about something?

What are the strengths of your family?

What comes to mind when you think about pregnancy?

What do you expect from your visits to the maternity clinic?