First Visit

PRENATAL ALCOHOL SCREENING QUESTIONS

Today's Date _______________ **Chart No.** ________________

Patient should answer these questions honestly, so the best possible care can be provided.

1. Before you knew you were pregnant ...

How often, on average, do (did) you drink? (check only one)	On a day or night when you did drink, about how many drinks did you have? (A drink equals a bottle of beer, shot of hard liquor, glass of wine, or a wine cooler.)
___ Every day ___ At least once a week, but not daily ___ At least once a month, but not weekly ___ Less than once a month ___ Don't drink	___ At least 7 ___ 5 to 6 ___ 3 to 4 ___ 1 to 2 ___ Don't drink

2. Since you knew you were pregnant ...

How often, on average, do (did) you drink? (check only one)	On a day or night when you did drink, about how many drinks did you have? (A drink equals a bottle of beer, shot of hard liquor, glass of wine, or a wine cooler.)
___ Every day ___ At least once a week, but not daily ___ At least once a month, but not weekly ___ Less than once a month ___ Don't drink	___ At least 7 ___ 5 to 6 ___ 3 to 4 ___ 1 to 2 ___ Don't drink

3. When was the last time you had a drink? ________________________________

4. Have you ever been in treatment for alcohol or drugs? NO ___ YES ___ If yes, when?________

Verbal alcohol message given? Yes__ No__ Written information provided? Yes__ No__ Initials______

Subsequent Visits

Ask patient: "Have you had any drinks containing alcohol since your last visit?"

Date	Anything To Drink?	Verbal Alcohol Message Given?	Initials
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______
________	Yes __ No __	Yes __ No __	_______

Date	Clinical Comments/Additional Info/Referral	Initials
________	____	________
________	____	________
________	____	________

Prenatal Alcohol Screening Questions
Supported by the Minnesota Department of Health

Record additional comment on reverse side ------->

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Date	Clinical Comments/Additional Info/Referral	Initials