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Developmental Pathways for Health Research Unit
Department of Paediatrics and Child Health

**BIRTH TO TWENTY PLUS - YOUNG ADULT SURVEY
MEDICAL & PREGNANCY HISTORY QUESTIONNAIRE - 2012**

DATE: Day Month Year

BTT ID NUMBER:

BONE ID NUMBER:

Confidential

SECTION 1: Medical History

A. Have you ever been diagnosed with or treated for any of the following medical conditions?

| | Yes | No |
|--|------------|-----------|
| 1. Diabetes | | |
| 2. Epilepsy | | |
| 3. HIV or AIDS | | |
| 4. Malaria | | |
| 5. Tuberculosis | | |
| 6. Any congenital abnormality or genetic disease (born with the condition) | | |
| 7. Any disability (If YES, please specify) | | |
| 8. Any other clinical relevant condition (If YES, please specify) | | |

B. Please list all CHRONIC medications you are **currently** taking (i.e. any medication you have been taking for longer than a week):

| |
|--|
| |
|--|

Section 2: Early Life Experiences

These questions refer to when you were growing up (before 18 years of age).

| | Yes | No |
|--|-----|----|
| 1. Did a parent or other adult in the household often or very often ... Push, grab, slap, or throw something at you? OR Ever hit you so hard that you had marks or were injured? | | |
| 2. Did an adult or person at least 5 years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? OR Attempt or actually have oral, anal, or vaginal intercourse with you? | | |

SECTION 3: Menstrual Cycle & Pregnancy
For Females ONLY

1. Have you already started to have periods?

| | |
|-----|----|
| Yes | No |
|-----|----|

(If you answered “no”, skip to the end of the questionnaire)

2. Can you remember the date of your first period?

| | |
|-----|----|
| Yes | No |
|-----|----|

If yes please write the date (month/year): (_____/_____)

3. At what age did you have your first period? (tick one)

| | | | | | | | | | |
|---|---|----|----|----|----|----|----|----|---------------|
| 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | later than 16 |
|---|---|----|----|----|----|----|----|----|---------------|

4. Are you using **any** contraceptive methods:

| | |
|-----|----|
| Yes | No |
|-----|----|

4.1 If no, what are the reasons you are not using contraception?

| |
|--|
| |
|--|

4.2 If yes, are you using any of the following methods?

| | | Tick any that apply |
|----|--------------------------|---------------------|
| a. | Oral contraceptive pills | |
| b. | Injections | |
| c. | Contraceptive implants | |
| d. | Mirna coil or any IUD | |
| e. | Other (Please Specify) | |

4.3 Have you accessed any health services in the past 6 months for contraception (**pregnancy prevention**)? Please tick each health service used, and indicate the number of visits for each service listed below:

| | Health Service | Used in past 6 months | Number of visits in past 6 months |
|----|---|------------------------------|--|
| a. | Private doctor (General Practitioner) | | |
| b. | Government Clinic / Community Health Centre | | |
| c. | Mobile Clinic | | |
| d. | Government Hospital | | |
| e. | Adolescent Clinic or Youth Friendly Services | | |
| f. | Peer educator (loveLife groundBREAKER or other) | | |
| g. | Private clinic | | |
| h. | Private hospital | | |
| i. | Home or Community based care | | |
| j. | Chemist or Pharmacist | | |
| k. | Homeopath/Herbalist/ Inyanga | | |
| l. | Faith Healer | | |
| m. | Sangoma/Traditional Healer | | |
| n. | Social worker/counsellor | | |
| o. | Other (please specify): | | |

5. What was the average length of your cycle (number of days from the start of one period to the start of the next) in the last 12 months, **or if you are on hormonal contraception the 12 months prior to starting the contraception?**

| | Tick one | Code |
|--|----------|------|
| Generally 23 days or less | | 1 |
| Generally between 24 and 35 days | | 2 |
| Generally longer than 35 days | | 3 |
| Very irregular that no pattern can be identified | | 4 |

6. Have you **ever** been given the pill to regulate your periods?

| | |
|-----|----|
| Yes | No |
|-----|----|

Pregnancy
(For Females ONLY)

1. Are you, or do you think that you may be, pregnant?

| | |
|-----|----|
| Yes | No |
|-----|----|

(If Yes, skip to obstetric – next page)

If No, answer the following

1.1 Which of the following best describes your current situation?

| | Tick one | Code |
|--------------------------------|----------|------|
| Trying to get pregnant | | 1 |
| Wouldn't mind getting pregnant | | 2 |
| Trying to avoid pregnancy | | 3 |
| Don't know | | 4 |
| Abstinent/Not sexually active | | 5 |

1.2 If you found out that you were pregnant now, how would you feel?

| | Tick one | Code |
|------------------|----------|------|
| Very unhappy | | 1 |
| Somewhat unhappy | | 2 |
| Wouldn't care | | 3 |
| Somewhat happy | | 4 |
| Very happy | | 5 |

1.3 What would you do if you received a positive pregnancy test result now?

| | Tick one | Code |
|------------------------|----------|------|
| Choose abortion | | 1 |
| Continue to adoption | | 2 |
| Continue to parenthood | | 3 |
| Don't know | | 4 |

1.4 How much does your partner want you to be pregnant at this time?

| | Tick one | Code |
|----------------------|----------|------|
| Not at all | | 1 |
| Not much | | 2 |
| Doesn't mind | | 3 |
| A little | | 4 |
| Very much | | 5 |
| Don't know | | 6 |
| Don't have a partner | | 7 |

Obstetric History
(For Females ONLY)

1. Number of previous pregnancies (irrespective of miscarriage or still births), **excluding current pregnancy**

| |
|--|
| |
|--|

(If 0, skip Obstetric history)

2. For your **most recent pregnancy (excluding current pregnancy)**:
- a. How did this pregnancy end?

| | | |
|------------|-------------|-------------|
| Live Birth | Still Birth | Miscarriage |
|------------|-------------|-------------|

- b. Which health services did you access? Please tick all health services used, and indicate the number of visits for that pregnancy (including delivery if applicable).

| | Health Service | Used for last pregnancy | Number of visits for last pregnancy |
|----|---|-------------------------|-------------------------------------|
| a. | Self treatment | | |
| b. | Private doctor (General Practitioner) | | |
| c. | Government Clinic / Community Health Centre | | |
| d. | Mobile Clinic | | |
| e. | Government Hospital | | |
| f. | Adolescent Clinic or Youth Friendly Services | | |
| g. | Peer educator (loveLife groundBREAKER or other) | | |
| h. | Private clinic | | |
| i. | Private hospital | | |
| j. | Home or Community based care | | |
| k. | Chemist or Pharmacist | | |
| l. | Homeopath/Herbalist/ Inyanga | | |
| m. | Faith Healer | | |
| n. | Sangoma/Traditional Healer | | |
| o. | Social worker/counsellor | | |
| p. | Other (please specify): | | |

3. How many previous live births have you had?
(If 0, skip to Q6)

4. a) Have ANY of your babies weighed less than 2.5kg

| | |
|-----|----|
| Yes | No |
|-----|----|

b) Have ANY of your babies weighed more than 4.5kg

| | |
|-----|----|
| Yes | No |
|-----|----|

5. Have ANY of your babies been born preterm (too early; <37 weeks gestation)?

| | |
|-----|----|
| Yes | No |
|-----|----|

6. Have you had ANY stillbirths (died in the uterus) or neonatal deaths?

| | |
|-----|----|
| Yes | No |
|-----|----|

7. **During any previous pregnancy, have you been diagnosed with or treated for any of the following conditions**

a. Pre-eclampsia/eclampsia/HELLP (*High Blood Pressure during pregnancy*)

| | |
|-----|----|
| Yes | No |
|-----|----|

b. Gestational diabetes (*Sugar diabetes during pregnancy*)

| | |
|-----|----|
| Yes | No |
|-----|----|

c. Rhesus disease (*blood incompatibility between mother and fetus*)

| | |
|-----|----|
| Yes | No |
|-----|----|

d. Pyelonephritis or renal condition requiring bed rest >1 week or hospitalization (*kidney failure/condition during pregnancy*)

| | |
|-----|----|
| Yes | No |
|-----|----|

e. Severe anaemia that required hospitalization

| | |
|-----|----|
| Yes | No |
|-----|----|

f. Any other pregnancy-related condition requiring bed rest >1 week or hospitalization (*excluding delivery*)

| | |
|-----|----|
| Yes | No |
|-----|----|

Research Nurse:

Date: