Pregnancy History and Assessment

Prenatal: ______ DOB: ______ Enrollment Date: ______ Home Visitor ______

Address: ______ Phone 1: ______ Phone 2: ______ County: ______

Spouse/partner ______ Number in Household ______ Language: ______ English Prof. ______

Insurance ______ Services received: ______

Prenatal Care Provider ______ Address ______ Phone: ______ Fax: ______

Dentist ______ Address ______ Phone: ______ Fax: ______

1=Potential 2=Significant

ASSESSMENT	COMMENTS	Initial	Second	Third
A. Previous Pregnancy				
1. Number of Previous Pregnancies				
2. Number of Term Deliveries (after 37 weeks)				
3. Number of Premature Deliveries (20-37 weeks)				
4. Number of Live Births				

ASSESSMENT	COMMENTS	Initial	Second	Third
B. Current Pregnancy				
1. First Prenatal Appointment				
2. Last Dentist Appointment				
3. Barriers to Care				
(Transportation, Childcare, Weather, Forgot, Illness, Job/School Hours, Language, Other)				
4. Bedrest or hospitalization				
5. Substance Use				
(Tobacco, Secondhand smoke, Alcohol, Drugs, Prescription or OTC Drugs)				
6. Allergies				
7. Employment				
8. Job Hazards				
9. Perceived Support Level				
Do you feel your support is adequate/ inadequate?				
10.Support Person				
11. Male Involvement				
12. Domestic Violence				
13. Perceived Health Status				
Is your general health excellent, very good, good, fair or poor?				
14. Perceived Mental Health Status				
Mental health includes stress, depression and problems with emotions. For how many days during the past month was your mental health not good?				
15. Perceived Stress Level				
none, some, moderate, high, very high				

B. Complications

	Current	Prev.		Current	Prev.		Current	Prev.
Swelling			Depression			Neonatal Death		
Pain			Diabetes			Preg-induced Diabetes		
Bleeding			Hypertension			Preg-induced Hypertension		
C-section			Sickle Cell			Weight Problems		
Fatigue			Anemia			Preterm Labor		
Infections			Headache			Other______		

Initial	Second	Third

Previous bedrest/hospitalization? ____

Due to ______

Nutrition	COMMENTS	Initial	Second	Third
		1=Potential 2=Significant		
eal and Eating Habits				
1. How many times per day do you eat?				
______ meals ______ snacks				
2. How many meals do you eat fast food each week?				
3. Are there any foods that you think you don't eat engouh of?				
___milk, yogurt, cheese ___bread, cereal, rice, pasta ___fruits or veg				
___meat, fish eggs, bean ___salty food ___sugary foods ___other				
4. Are you following a special diet? If yes, describe				
5. Do you crave any non food items or large amounts of ice?				
6. What foods do you like?				
7. What foods do you dislike?				
8. Are there any foods you can not eat and why?				
9. Has there been any change in your appetite in the last month?				
10. Do you have any of the following problems?				
___poor appetite ___nausea ___vomiting ___heartburn				
___difficulty chewing or swallowing ___gastrointestinal problems				
___pain in the mouth/gums ___other eating problems				
11 How often do you eat a food from each of the following food groups each **day**?				
milk, yogurt, cheese	0 1 2 3 4+			
meat, poultry, fish, eggs, dried beans/peas, peanut butter	0 1 2 3 4+			
bread, cereal, pasta, rice, grits, tortillas	0 1 2 3 4+			
greens, carrots, broccoli, squash, pumpkin, sweet potatoes	0 1 2 3 4+			
oranges, grapefruit, tomatoes, citrus fruit juices	0 1 2 3 4+			
other fruits, juices and vegetables	0 1 2 3 4+			
oil, butter, margarine, lard	0 1 2 3 4+			
cakes, cookies, sodas, chips, candy	0 1 2 3 4+			
everage				
1. What kind of milk do you drink(skim, 2%, whole, etc.) and how often each day?				
2. What other beverages do you drink in a typical day?				
___Water ___Fruit drinks ___Beer/Wine ___Juice				
___Diet soda ___Regular soda ___Coffee/tea ___Other				
3. How much water do you drink each day?				
4. Main source of drinking water (city, well, bottled)				
ood Supply and Safety				
1. Are you participating in any food and nutrition program? (WIC, food stamps, food pantry)				
2. Do you eat any of the following foods?				
___raw fish/shellfish ___raw vegetable sprouts ___unpasteurized milk/juices				
___uncooked deli meats/hot dogs ___raw or undercooked meat/eggs				
3. Do you have equipment for food storage and preparation?				
xercise and Weight				
1. In a typical day, how many minutes are you physically active?				
___None ___1-30 ___31-60 ___More than 60				
2. Height				
3. Pre-pregnancy weight				
4. Current weight				
5. How much weight do you think you should gain with this pregnancy?				

REFERRALS

ate	Referral	Date	Referral	Date	Referral	Date	Referral
	Adoption		Dentist		Housing		post partum care
	Adult Education		DFC/ Food Stamps/ TANF		Insurance		shelter, homeless
	Alcohol/Drug Abuse Services		Domestic Violence Services		Literacy or Education		social services
	Assistance to Families of Incarcerated		Emergency		Marriage Education		smoking cessation
	Baby items		Employment/Job Training		Mental Health Services		Substance Abuse Prevention
	Child Abuse and Neglect Services		ESL		Nutritionist		township trustee
	Child Birth Education		Family Support		Parenting Education		Transportation
	Child Support Assistance		Family Planning		Pediatrician		WIC
	Clothing		Food		Rent/Utility Assistance		
	Crisis Assistance		Health Education		Prenatal Care		

EDUCATION TOPICS

Date	Education Topics	Date	Education Topics	Date	Education Topics	Date	Education Topics
	Activity/Exercise		Dental Health		Normal Discomforts		Seat belt
	Adoption		Domestic Violence		Nutrition		Secondhand Smoke
	Birth Plan		Drug/alcohol cessation		Parenting Education		Shaken Baby Syndrome
	Breastfeeding and Formula Feeding		Immunizations/well baby		Personal Care		Signs of Infection
	Car Seat Safety		ESL		Post partum care		Smoking cessation
	Child Birth Education		Family Planning		Post partum depression		Stress Reduction
	Child care options		Fetal Movement		Prenatal Weight Gain		Vitamins/Folic Acid/Iron
	Circumcision		Labor and Delivery		Prenatal Care		When to call the doctor
	Community Resources		Marriage Education		Preterm Labor		
	Coping Skills		Infant Care and Safety		Safe sleep		

Additional Notes and Follow Up

Prenatal Signature________________ Staff Signature________________

Initial Date: ________ Second:________ Third: ________