Tri-County Head Start/Early Head Start

Prenatal Health History

Name: _____ Expected delivery date: _____

Address: _____

Home Phone _____Work phone _____Cell_____

Health Care Provider Information

Do you have health coverage? □ Yes □ No If so, what kind? ___ Medicaid ___ Private insurance ____ Other
Do you decide not to receive medical care for religious or cultural reasons? □ Yes □ No
Do you have a primary care doctor/clinic? □ Yes □ No *If yes, please complete the Request for Release of Medical Information Name of doctor/clinic ___ Date of child's last physical exam ___/___/___ Date of next appointment__/___/___
Do you have a dentist? □ Yes □ No *If yes, please complete the Request for Release of Medical Information Name of Dentist_____ Date of last dental exam ___/___/___ Date of next appointment ___/___/___
Are you getting home visits from Healthy Start? □ Yes □ No Healthy Start Visitor Name _____
Are you enrolled in a childbirth class? □ Yes □ No If so, where? _____
Are you receiving other pregnancy services? □ Yes □ No If so, where? _____

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Health History

Have you ever been tested for tuberculosis (TB)? □ Yes □ No If so, what were the results? ___Positive ___Negative Were medications taken? □ Yes □ No
Have your family members been tested for tuberculosis (TB)? □ Yes □ No If so, what were the results? ___Positive ___Negative Were medications taken? □ Yes □ No If yes, who and when?
Are you currently smoking? □ Yes □ No If so, how often? _____
Do you currently drink alcohol? □ Yes □ No If so, how often? _____
Have you used illicit substances in the past year? □ Yes □ No If so, when and what substances were used?
Are you taking prescription medications? □ Yes □ No (If yes, name of the drug(s) _____
Are you taking any non-prescription/over-the-counter medications, supplements/herbs? □ Yes □ No If yes, name of medicinal product(s) _____
Do you consume products that contain caffeine (e.g., soda, coffee, tea)? □ Yes □ No If so, how often? _____
Have you ever had any of the following illnesses or health problems (check and provide the date)?

□ Anemia/low iron	□ High blood pressure
□ Seizure disorder	□ Heart problems
□ Cancer	□ Nephropathy

□ Mental illness/depression If yes, are you currently receiving treatment? □ Yes □ No
□ Other health problems (If yes, please describe)

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History of Past Pregnancies

Is this your first pregnancy? □ Yes □ No (If yes, skip to the next section) How many live births? _____
Did you have any illnesses or complications during any of your past pregnancies? □ Yes □ No
Were there any complications during labor or delivery? □ Yes □ No
Did any of your babies weigh 10 pounds or more at birth? □ Yes □ No
Were any of your babies born before your due date (premature) or were born weighing less than 5 pounds, 5 ounces? □ Yes □ No
Did any of your children have problems immediately after birth? □ Yes □ No If yes, please describe _____

Current Pregnancy Information

Have you experienced any of the following conditions during this pregnancy? (Please check)		
□ Extreme nausea	□ Dental problems	□ Headaches
□ Cramps	□ Pain	□ Diarrhoea
□ Constipation	□ Anxiety	□ Irritability
□ Heartburn	□ Fatigue	□ Swelling
□ Diabetes/hyperglycemia	□ Other	

Have you experienced any complications that require bed rest or hospitalization? □ Yes □ No (If yes, please describe)_____
Are you expecting a cesarean delivery? □ Yes □ No
Are you expecting more than one baby? □ Yes □ No
Do you have any health problems or concerns during this pregnancy? □ Yes □ No
Are you planning to breastfeed this baby? □ Yes □ No
Want to learn more about breastfeeding? □ Yes □ No

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Nutrition

Are you getting WIC? □ Yes □ No			
Are you taking prenatal vitamins? □ Yes □ No			
Are you on a special diet? □ Yes □ No If yes, describe _____			
Do you experience a craving for non-food items (clay, dirt, laundry soap)? □ Yes □ No			
Which of the following best describes your grocery shopping?	1-2 times a month	Once a week	Several times a week
Is the TV on during dinner?	Yes	No	Occasionally
Do you make a list of necessary foods before you go shopping?	Yes	No	Occasionally
Are nutritious foods a priority for you when shopping for groceries?	Yes	No	Occasionally

Approximately how many servings do you eat of each of the following food groups in a <u>single day?</u> (Circle the nearest number)

Dairy: Milk or yogurt, cheese (1 1/2 slices), etc.	0	1	2	3	4	5	6	7	8+
Protein: 2-3 oz cooked meat/fish/poultry, 1/2 cup dried beans, peas, lentils	0	1	2	3	4	5	6	7	8+
Grains: slice of bread, 1/2 hamburger bun, 1/2 cup pasta/noodles/rice pancake, waffle, 1 oz. dry cereal, 1/2 cup hot cereal, etc.	0	1	2	3	4	5	6	7	8+
Fruits: 1 small apple, 1/2 banana, 1/2 cup canned fruit, etc.	0	1	2	3	4	5	6	7	8+
Fruit juice: 3/4 cup 100% juice only	0	1	2	3	4	5	6	7	8+
Vegetables: 1/2 cup cooked	0	1	2	3	4	5	6	7	8+
Vegetables: 1 cup raw	0	1	2	3	4	5	6	7	8+
Fat: 1 teaspoon. Oil, margarine, butter, lard, etc.	0	1	2	3	4	5	6	7	8+
Sugars: Cakes, cookies, caramel sodas, fruit drinks,	0	1	2	3	4	5	6	7	8+

Do you have these things where you live? Check everything you have

□ Tables and chairs	□ Running water	□ Running water	□ Microwave
□ Highchair	□ Stove	□ Refrigerator	□ Freezer

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Is there any additional information you think Tri-County Head Start/Early Head Start might need to know about your pregnancy? □ Yes □ No If yes, please explain.

Applicant's signature

Date