Pregnancy Health History Form

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Name: _____ Due Date: _____

Do you have medical coverage for this pregnancy? ☐ Yes ☐No

If yes what type of coverage? ☐Medicaid/Provider One ☐Private Insurance

Have you received any prenatal care? ☐ Yes ☐No

Healthcare Provider: _____ Phone: _____

Date of first prenatal visit: _____ Date of your last prenatal visit: _____

Date of next scheduled prenatal visit: _____

Have you chosen a healthcare provider for your baby? ☐ Yes ☐No Resources given: ☐ Yes ☐No

Do you have dental coverage? ☐ Yes ☐No Date of last dental exam: _____

Do you currently need dental treatment? ☐ Yes ☐No

Will you receive this treatment? ☐ Yes ☐No If yes, when? _____

Dental Provider: _____

What services are you currently receiving? List Provider:

☐ Maternity Support Services (MSS) _____Name:_____

☐ Infant Case Management (ICM) _____Name:_____

☐ Nurse/Family Partnership _____Name:_____

☐ WIC _____

☐ Mental Health/Counseling _____

☐ Chemical Dependency Treatment _____

☐ Doula /Midwife:_____Name:_____

Is this a planned pregnancy? ☐ Yes ☐No

Have you been told by your provider that your current pregnancy is high risk? ☐ Yes ☐No

If yes, why? _____

_____

_____

_____

Are you interested in information or resources for any of the following?

☐ Childbirth Education ☐ Parenting Education ☐ Car Seat Safety

☐ Basic Baby Care ☐ Childbirth Support (Doula) ☐ Breast Feeding

☐ Education/Support ☐ Other

Do you need assistance getting clothing, furniture or equipment for your baby? ☐ Yes ☐No

If yes, what can we help you with? _____

How do you plan to feed your baby? ☐Breast Feed ☐Formula Feed ☐Unsure

Do you have any questions or concerns about your nutrition? _____

_____

_____

Do you have any of the following health concerns? ☐ Yes ☐ No Please check any that apply.

☐Respiratory ☐Seizure ☐Food allergies ☐Non-food allergies ☐Other

What prescription medication do you take? _____

Are you taking a prenatal vitamin/iron supplement? ☐ Yes ☐No

What do you do for exercise and how often? _____

_____

Have you used any of the following during your pregnancy? If yes, how much did you use and have you discontinued use? (check all that apply)

☐ Caffeine _____

☐ Cigarettes/Tobacco _____

☐ Over the counter medications _____

☐ Prescription medications _____

☐ Alcohol/drugs _____

Are you interested in information on the above topics? ☐ Yes ☐No

How many times have you been pregnant? _____ How many times have you given birth? _____

How long has it been since your last pregnancy?

☐Never been pregnant before ☐Less than 18 months ☐More than 18 months

What complications have you experienced during this or any previous pregnancies?

	Current	Previous		Current	Previous
Anemia	☐	☐	Hypertension/High Blood Pressure	☐	☐
Bleeding	☐	☐	Pregnancy-induced Hypertension	☐	☐
Miscarriage	☐	☐	Neonatal Death/ Stillbirth	☐	☐
Sickle Cell	☐	☐	Anxiety/ Stress	☐	☐
C-Section	☐	☐	Swelling	☐	☐
Diabetes	☐	☐	Pain	☐	☐
Fatigue	☐	☐	Pre-term Labor	☐	☐
Headaches	☐	☐	Nausea/ Vomiting	☐	☐
Weight Loss	☐	☐	No Complications	☐	☐
Other	☐	☐	Pregnancy-induced Diabetes (gestational)	☐	☐

Is your doctor addressing these complications? ☐ Yes ☐No ☐NA

Do you have questions or concerns about this pregnancy or birth of your baby that you want addressed?

☐ Yes ☐No Please explain:_____

Have any of these complications required bed rest or hospitalizations? ☐ Yes ☐No

If yes, which complications? _____ For how many days? _____

What are you doing to prepare for your baby's birth? _____

_____

_____

Who is your support system? _____

_____

Pregnant Mother Signature: _____ Date completed: _____

Staff Signature: _____ Date completed: _____

Interpreter Signature: _____ Date completed: _____