Pregnancy Health History

Purpose and Procedure

Use the form to engage pregnant moms in a conversation to gather information about their confidential health history. Staff must make sure that pregnant women enrolled in Early Head Start have access to ongoing prenatal health and dental care as well as other family resources. Expectant families are supported by staff in the preparation and planning for their new baby and receive information and education on a variety of topics including but not limited to: fetal development, maternal mental health and nutrition, family planning, infant health and nutrition, parenting education and postpartum recovery. Family Support is responsible for the following:

- To gather health, education and community resources information related to the current pregnancy.
- To coordinate and link families to appropriate services and resources.
- To facilitate discussion with the parents about how they view themselves, particularly in relationship to the impending birth of their baby.
- To assist the parents in identifying their strengths, growth and goals.

It is very important that all health information be considered confidential. It must not be shared with anyone who is not involved in planning for pregnant women and/or for the child. Certain health information has even stricter requirements for confidentiality (HIV/AIDS, sexually transmitted diseases, hepatitis B), and written permission must be obtained before it can be shared with anyone when it is disclosed. Health records must be kept secure at all times, maintained for eight years, and shredded when disposed of.

Medical/Dental Insurance/Homes

- Determine whether the pregnant woman has medical and dental coverage and is receiving regular prenatal and dental care.

Pregnancy Services

- Determine current services and assess resources needed.

Nutrition

- Determine family's plan to breast or formula feed. Assess the need for more information.
- Review maternal nutritional status. Offer resources, information.

Risk Assessment

- Identify health concerns and other factors that may impact the pregnancy and birth, and offer resources, as needed.
- Consult with Health/Nutrition/Safety Coach with questions or concerns.

Pregnancy Goals

- Identify family's preparation, strengths and expectations for upcoming birth.

When: At enrollment, both the pregnant mother and staff review the form and sign and date. Attach and enter the event in ChildPlus.

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: _____