

# SETA EARLY HEAD START PRENATAL HISTORY



Mother's name: Last: _____ First: _____		<b>1</b> Age: _____ High risk? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any medical coverage or insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of coverage insurance? <input type="checkbox"/> Geographic Managed Care Medi-Cal <input type="checkbox"/> Fee for Service Medi-Cal <input type="checkbox"/> Private <input type="checkbox"/> None	Provider's Name: _____ ID or Policy Number: _____	Is dental coverage included in this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of dental plan: _____ Date of last exam: _____
How long have you been pregnant? _____ What is your expected delivery date? _____ Have you received any prenatal care? <b>2</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, in which month of pregnancy did you first see a physician or attend a clinic for prenatal care? <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th <input type="checkbox"/> 5th <input type="checkbox"/> 6th <input type="checkbox"/> 7th <input type="checkbox"/> 8th <input type="checkbox"/> 9th <input type="checkbox"/> Don't remember	Where did you receive prenatal care? <input type="checkbox"/> Health clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Enrollee's home <input type="checkbox"/> Private Physician <input type="checkbox"/> School-based health facility <input type="checkbox"/> Other- please specify _____	Who is your primary health care provider? Name _____ Phone _____ Street _____ Suite _____ City _____ State _____ Zip _____ <input type="checkbox"/> No primary health care provider	
What is the date of your next scheduled prenatal care visit? _____ / _____ / _____ <input type="checkbox"/> None scheduled What is the date of your most recent prenatal care visit? _____ / _____ / _____ <input type="checkbox"/> No prenatal care visits <b>2</b>	Have you experienced any complications during this or any previous pregnancy? <b>3</b> <input type="checkbox"/> No complications <input type="checkbox"/> Yes If yes, explain: _____ _____ _____ _____	Who is your primary prenatal care provider? Name: _____ Phone _____ Street _____ Suite _____ City _____ State _____ Zip _____ <input type="checkbox"/> No primary prenatal care provider <input type="checkbox"/> Same as primary health care provider	
How many of your children were born prematurely? <b>4</b> (i.e. < 5 lbs or < 7 months)	How long has it been since your last pregnancy? <input type="checkbox"/> Never pregnant before <input type="checkbox"/> Less than 18 months <input type="checkbox"/> More than 18 months	How many times have you been pregnant prior to this pregnancy? _____	What was the outcome of other pregnancies? <b>3</b> <input type="checkbox"/> Miscarriage <input type="checkbox"/> Stillborn <input type="checkbox"/> Abortion <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other- please specify _____
Have you participated in any education groups for child birth or parenting during your current pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what kinds of groups have you participated in? <input type="checkbox"/> Prenatal exercise <input type="checkbox"/> Preparing for baby care <input type="checkbox"/> Personal development <input type="checkbox"/> Prenatal general discussion <input type="checkbox"/> Birth education (i.e. Lamaze) <input type="checkbox"/> Parenting education <input type="checkbox"/> Breast feeding preparation <input type="checkbox"/> Other: _____		How many sessions of these groups have you attended? <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> more than 30
Have you been visited regularly by any nurse, social worker, support person during your pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: Visitor's name: _____ <input type="checkbox"/> Don't know Agency: _____ <input type="checkbox"/> Don't know		How are you planning on feeding your baby? <input type="checkbox"/> Breast <input type="checkbox"/> Formula
Have you used any of the following substances during your pregnancy? Street drugs <input type="checkbox"/> Yes <input type="checkbox"/> No      Caffeine <input type="checkbox"/> Yes <input type="checkbox"/> No      Cigarettes/Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No Prescription drugs <input type="checkbox"/> Yes <input type="checkbox"/> No      Non-Prescription drugs <input type="checkbox"/> Yes <input type="checkbox"/> No      Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Are you exposed to second hand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No Other (please specify) <input type="checkbox"/> Yes <input type="checkbox"/> No			

**1** Refer to Health Coordinator if >35 or <18

**2** Refer to Health coordinator if no prenatal visits

**3** Refer to Health Coordinator if any miscarriages or stillborn

Staff \_\_\_\_\_ Date \_\_\_\_\_

**Distribution:**

**White: Child's File**

**Yellow: Parent**

Revised 11/07

- ④ *Refer to Health coordinator if any premature babies*
- ⑤ *Refer to Health Coordinator if Yes.*