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WELLNESS HEALTH CARE CHECKLIST

This checklist asks for fact about your past and present health. Those facts are important. They help us provide you and your baby with the best health care while you are pregnant.

As you read, you will see "HX of". That means "History of".

PATIENT NAME (LAST, FIRST, INIT.) _____

To be filled out by provider staff

Key: Planned Done

Psychological/Parenting Risk Yes No
Interventions planned – Mark appropriate line(s)

- None
- Prenatal Classes
- Social Worker
- Parenting Counselor
- Public Health Nurse
- Community Health Worker (home visits)
- Appointment with D.S.S. / PCAP Office
- Substance Abuse Counselor
- Disability Statement
- Statement of Pregnancy
- Drug Screen
- Other _____

Nutritional Risk Yes No

Interventions planned – Mark appropriate line(s)

- None
- Dietician / Nutritionist
- WIC referral
- Breast feeding counselor
- Dental Checkup
- Anti Smoking effort
- Special Diet _____
- Other _____

Environmental Risk Yes No

Interventions planned – Mark appropriate line(s)

- None
- HIV Pretest C.
- TB Skin test
- Varicella Titer
- Toxo Titer
- Bact. Vag. Screen
- Repeat – Cx Cults for G.C., Chlam.
- Repeat – HEP – Bsa
- Repeat – VDRL
- Special Cultures _____
- Reprotox search _____
- Blood Lead test _____
- Hepatitis Vaccine _____
- Other _____

Genetic Risk Yes No

Interventions planned – Mark appropriate line(s)

- None
- MSAFP/Triple Screen Info
- Genetic Counselor
- Sonogram – Level 2
- Genetic Amnio
- Parental Karyotyping
- CVS
- PUBS
- Hemoglobin electrophoresis
- Cystic Fibrosis Counseling
- Other _____

Life Issues Put an X on the line beside each item that is true for you. Write your comments on the lines.

- | | |
|---|--|
| <input type="checkbox"/> Under 17 years old _____ | <input type="checkbox"/> Thinking about adoption _____ |
| <input type="checkbox"/> Did not finish High School _____ | <input type="checkbox"/> Want to see a social worker _____ |
| <input type="checkbox"/> On or need Medicaid or Welfare _____ | <input type="checkbox"/> Want public health nurse to visit _____ |
| <input type="checkbox"/> Unwed or baby's father not around _____ | <input type="checkbox"/> Housing problems _____ |
| <input type="checkbox"/> Under emotional stress (at home or work) _____ | <input type="checkbox"/> Problems with the legal system _____ |
| <input type="checkbox"/> Under physical stress (at home or work) _____ | <input type="checkbox"/> Problems with child care _____ |
| <input type="checkbox"/> More than 5 months (20 weeks) pregnant _____ | <input type="checkbox"/> Transportation problems _____ |
| <input type="checkbox"/> Recently felt depressed or hopeless _____ | Alcohol/Drug Use Yes No |
| <input type="checkbox"/> Mental Problems (past or present) _____ | Parents had/have drinking/drug problem _____ |
| <input type="checkbox"/> In Foster Care (you or your children, past or present) _____ | Partner with drinking/drug problem _____ |
| Safety | Alcohol/drug use in month pre-pregnancy _____ |
| Have you been hurt in the past year? Yes _____ No _____ | Alcohol/drug use since pregnancy _____ |
| Is anyone making you feel unsafe now? Yes _____ No _____ | |

Nutrition Put an X on the line beside each item that is true for you. Write your comments on the lines.

- | | |
|---|---|
| <input type="checkbox"/> Present or pre-pregnancy weight under 100lbs, or over 225lbs _____ | <input type="checkbox"/> Past or present eating disorder (anorexia or bulimia) _____ |
| <input type="checkbox"/> Smoking – how many cigarettes a day _____ | <input type="checkbox"/> A lot of vomiting while pregnant and given I.V. for it _____ |
| <input type="checkbox"/> Stomach problems (ongoing) _____ | <input type="checkbox"/> Last dental checkup was more than 2 years ago _____ |
| <input type="checkbox"/> On or need a special diet for an illness _____ | <input type="checkbox"/> Pregnant more than twice _____ |
| <input type="checkbox"/> Follow food fads or crave or eat odd things (for example, ice, starch, clay) _____ | <input type="checkbox"/> In the past 2 years _____ |
| <input type="checkbox"/> Having twins, triplets or more babies _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Plan to breast feed for first time _____ | |

Environment

- Infections** Yes No Not Sure
- Exposed to Hepatitis _____
- Hx of exposed to HIV+/AIDS _____
- Hx of or exposed to TB _____
- Have had Chicken Pox (Circle One) Yes No Not Sure
- Hx of or exposed to Genital Herpes _____
- Hx of or exposure to Syphilis _____
- Hx Chlamydia, Gonorrhea or Genital Wart _____
- Hx of Rash or Virus since last Menstrual period _____

- X rays – If pregnant** Yes No Not Sure
- Did you have one or more X-rays In the first 3 months of pregnancy _____

Chemicals

- A) General** Yes No Not Sure
- Did you take any drugs or medicines the first three months of pregnancy? List: _____
- Are you exposed to chemicals at work Or anywhere else? List: _____

Chemicals – Continued

- B) Lead** Yes No Not Sure
- Do you or others in your home have a job that involves lead exposure? (See "Lead" brochure) _____
 - Sometimes, pregnant women have the urge to eat things that are not food, such as clay, soil, plaster or paint chips? Do you ever eat lead paint chips? _____
 - Do you live in an old house that has a lot of dusty work going on inside, like sanding and scraping? _____
 - Has your home been tested for lead in the water? If so, were you told that the lead level was high? (Note: a level over 15 parts per billion [ppb], or micrograms per liter [ug/L] is considered high.) _____
 - Do you use any folk remedies or makeups that are homemade or not brought in a regular store? If so, they may contain lead. (See "Lead" brochure) _____
 - Do you or others in at your home have any hobbies or other activities that could expose people to lead? (See "Lead" brochure) _____
 - Do you use pottery or leaded crystal that was not made in a factory? _____

Genetics Put an X on the line beside each item that is true for you, the baby's father, or an older child.

- Write your comments on the lines.
- Your age is 35 years or older _____
- Hx of thalassemia (Italian, Greek, Mediterranean or Oriental background) _____
- Hx of Neural Tube defect (Meningocele, spina bifida [open spine], or anencephaly) _____
- Hx of Down's Syndrome _____
- Hx of Tay-Sachs disease (e.g., Jewish background) _____
- Hx of Sickle Cell Disease or trait / or non-white _____
- Hx of Hemophilia ("easy bleeder") _____
- Hx of Muscular Dystrophy _____
- Hx of Cystic Fibrosis _____
- Hx of Huntington's Chorea _____
- Hx of Mental Retardation if so, was the person tested for Fragile X? _____
- Other inherited genetic or chromosomal disorder if so, please describe _____
- You or your baby's father had a child with birth defects not listed above _____
- You have had 3 or more miscarriages, or a stillbirth _____
- You have taken medicine (including over the counter ones) or street drugs since your last menstrual period If so, list: _____
- Other important family health history: _____

Signature of patient _____
Date of Completion ____/____/____
Review By _____
Date of Review ____/____/____