EASTCONN Early Head Start Prenatal Health History

Mother's Name: _____ DOB: _____
Expected date of delivery: _____
Health insurance: ☐ HUSKY ☐ Other: _____

Reproductive History

Number of Previous Pregnancies: _____
Number of Children: _____
Have you received regular Doctor exams since being pregnant? ☐ Yes ☐ No
Have you participated in Childbirth classes in the past? ☐ Yes ☐ No
Are you interested in Childbirth classes for this pregnancy? ☐ Yes ☐ No

Tell us about your children:

Name & Birthdate	Gender	Birth weight	Complications or Concerns
	☐ Female ☐ Male	Lbs. Oz.	
	☐ Female ☐ Male	Lbs. Oz.	
	☐ Female ☐ Male	Lbs. Oz.	
	☐ Female ☐ Male	Lbs. Oz.	

Add additional children on the bottom of this page.

Health History

Any critical health concerns: ☐ Yes ☐ No If yes, describe: _____
Allergies: ☐ Yes ☐ No If yes, describe: _____
Medications: ☐ Yes ☐ No If yes, describe: _____

Dental History

Do you receive regular dental exams? ☐ Yes ☐ No Dentist: _____
Last dental exam: _____
Dental concerns: ☐ Yes ☐ No If yes, describe: _____
If no dentist, are you interested in getting help to find a dentist? ☐ Yes ☐ No

Mental Health

Any mental health concerns? ☐ Yes ☐ No If yes, describe: _____
Any history of postpartum concerns? ☐ Yes ☐ No If yes, describe: _____
What are your feelings about this pregnancy? _____
Have you felt sad or depressed recently? ☐ Yes ☐ No
Who is your support system? _____
Is the father of the baby involved? ☐ Yes ☐ No Is he supportive? ☐ Yes ☐ No
Is your partner involved? ☐ Yes ☐ No Is he or she supportive? ☐ Yes ☐ No
Are there any safety concerns in your relationship? ☐ Yes ☐ No _____

Prenatal Exposures

Do you smoke? ☐ Yes ☐ No If yes, how often/how much?_____
Does anyone smoke inside your home/car? ☐ Yes ☐ No If yes, how often/how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much/how often?_____
Do you have a history of alcohol/substance use? ☐ Yes ☐ No _____
Have you been screened for lead? ☐ Yes ☐ No ☐ Don't Know
If not, encourage mother to follow up with her health care provider to determine whether testing is necessary.

Current Pregnancy

Last menstrual period? _____ Initial prenatal appointment _____
Consistent prenatal care? ☐ Yes ☐ No
Any health concerns during this pregnancy? ☐ Yes ☐ No If yes, describe: _____
Does your Doctor consider this pregnancy a high risk pregnancy? ☐ Yes ☐ No
Are you taking prenatal vitamins? ☐ Yes ☐ No
Do you have any: Nausea? ☐ Yes ☐ No Vomiting? ☐ Yes ☐ No Heartburn? ☐ Yes ☐ No
Constipation? ☐ Yes ☐ No
How would you describe your current health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you exercise? ☐ Yes ☐ No If yes, how much/how often?_____
Do you have a car seat? ☐ Yes ☐ No Is it installed? ☐ Yes ☐ No
Has it been checked at a car seat clinic or by a tech? ☐ Yes ☐ No

Parent Signature: _____ Date: _____