KTF HEALTHY BEGINNINGS PROGRAM

Date: _____ Physician: _____ Hospital: _____

Name: _____	Insured Name: _____
Address: _____	Address: _____
_____	_____
Date of Birth: _____	Date of Birth: _____
Phone #: _____	Phone #: _____
Work Phone #: _____	Work Phone #: _____

PRENATAL ASSESSMENT

1. Is this your first pregnancy? ☐ Yes ☐ No If no, number of previous pregnancies: _____
   Deliveries: ____ Miscarriages: ____ (Trimester: 1st___ 2nd ____ 3rd _____)
   Abortions: _____ Tubal Pregnancy: _____
2. Number of living children _____ Age of youngest child _____
3. What gestation (weeks) did you deliver previous pregnancies? _____
4. Did any of your babies weigh less than 5 ½ pounds? ☐ Yes ☐ No ☐ Weight: _____
5. Have you had any cesarean sections in the past? ☐ Yes ☐ No
   If so, dates: _____
6. Have you ever had an emergency delivery due to a placental abruption? ☐ Yes ☐ No
7. Have you ever had gestational diabetes? ☐ Yes ☐ No
8. Have you ever had toxemia? ☐ Yes ☐ No

MEDICAL HISTORY

1. Have you ever been told you have, or are you currently under treatment for?

	Yes	No		Yes	No
High blood pressure	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Seizure Disorder	☐	☐
If yes, insulin dependent?	☐	☐	Lupus	☐	☐
Heart disease	☐	☐	Sickle Cell Disease	☐	☐
Tested positive for HIV?	☐	☐	Multiple Sclerosis	☐	☐
Sexually transmitted disease	☐	☐	Ulcerative Colitis	☐	☐
Uterine fibroids	☐	☐	Crohn's Disease	☐	☐
Cervical surgeries	☐	☐	Kidney problems	☐	☐

2. Have you had a Pap smear within the past 12 months? ☐ Yes ☐ No Results? _____
3. Are you currently taking any medications (including herbal supplements)? ☐ Yes ☐ No
   Meds/Supplements: _____
4. Do you have any allergies? ☐ Yes ☐ No

CURRENT PREGNANCY

1. What date have you been told is your due date? _____
2. Have you had an ultrasound? ☐ Yes ☐ No
3. Have you been told you are expecting more than one baby? ☐ Yes ☐ No
4. Did the doctor tell you your amniotic fluid level was unusually low or high? ☐ Yes ☐ No
5. Have you been told you have a placenta previa? ☐ Yes ☐ No
6. Have you been told your blood pressure has been above normal on at least two separate occasions during this pregnancy? ☐ Yes ☐ No
7. Have you had any kidney infection during this pregnancy? ☐ Yes ☐ No
8. Has the doctor told you that you have protein in your urine? ☐ Yes ☐ No
9. Have you had a low blood count (anemia) during this pregnancy? ☐ Yes ☐ No
10. Have you had any bleeding (more than spotting) during your first trimester? ☐ Yes ☐ No
11. During this pregnancy, have you been told you have an elevated CMV titer? ☐ Yes ☐ No
12. Have you been treated for a venereal disease since you have been pregnant? ☐ Yes ☐ No
13. How much do you weigh presently? _____ Before this pregnancy? _____
14. Have you been placed on any activity restrictions by the doctor? ☐ Yes ☐ No
    If yes, explain _____
15. Do you plan to attend childbirth class? ☐ Yes ☐ No

Answer next 3 questions if beyond 1st trimester:

1. If you are between 20-34 weeks gestation, has the doctor told you the cervix is dilated or effaced? ☐ Yes ☐ No
2. Have you experienced preterm labor with this pregnancy? ☐ Yes ☐ No
3. If you are less than 34 weeks, have you had cramps or contractions on a regular basis or been told you have an irritable uterus? ☐ Yes ☐ No

DEMOGRAPHICS

1. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
2. What is your highest level of education? ☐ 8th grade or less ☐ Grade 9-12 ☐ 12+

HOME SITUATION

1. Are you currently caring for any children at home? ☐ Yes ☐ No
2. Is there a high amount of stress at home? ☐ Yes ☐ No
3. Are you fearful of being harmed by anyone at home? ☐ Yes ☐ No

HEALTH HABITS

1. Do you currently smoke? ☐ Yes ☐ No
   If yes, how much? ☐ Less than ½ pack/day ☐ ½ -1 pack/day ☐ 1 ½ -2 packs/day

2. Prior to becoming pregnant, did you use any recreational drugs such as cocaine, LSD, or marijuana? ☐ Yes ☐ No
3. Since you became pregnant have you used any of those drugs? ☐ Yes ☐ No
4. Prior to becoming pregnant, how many alcoholic drinks did you have in a week (average)?
   ☐ None ☐ 6 or less ☐ More than 6 a week
5. Since becoming pregnant, how many alcoholic drinks do you have in a week?
   ☐ None ☐ 6 or less ☐ More than 6 a week
6. Do you eat three meals a day?
   ☐ Almost always ☐ Usually ☐ Occasionally ☐ Never
7. How often do you eat foods that are high in sugar content or add sugar to the foods that you eat or drink?
   ☐ Several times a day ☐ Once a day ☐ Several times a week ☐ Seldom
8. How often do you eat fruits, vegetables, whole grain cereals/breads and other fiber foods?
   ☐ Almost every meal ☐ 1-2 meals a day ☐ 3-4 meals a week ☐ Less than twice a week
9. Do you drink more than five beverages containing caffeine in a day? ☐ Yes ☐ No
10. How many servings of dairy products do you have each day (milk, cheese, etc.)?
    ☐ One or less ☐ 2-4 servings ☐ More than 4 servings
11. Are you currently taking your prenatal vitamins? ☐ Yes ☐ No

WORK ENVIRONMENT

1. Currently how would you describe the amount of stress at work?
   ☐ Mild ☐ Moderate ☐ High
2. Do you have a job that requires heavy physical work, such as lifting or standing in one position?
   ☐ Yes ☐ No
3. Describe the physical work: _____

REMINDER: Enroll the baby within 30 days of the delivery!