DONA ANA COUNTY HEAD START/EARLY HEAD START

2540 B El Paseo

Las Cruces, NM 88001

PRENATAL PACKET

Adult General Health

Eligible Applicant:_____ _____ _____
First Name *MI* *Last Name*

Date:_____ Completed by Staff:_____

Food Allergies (please list):

_____

_____

_____

_____

Medications (please list):

_____

_____

_____

_____

Chronic and/or Acute Medical Conditions

☐Yes ☐No ☐N/A

If Yes, please list:

_____ _____

_____ _____

Insurance that covers prenatal care:

☐Private Insurance_____ ☐Military Insurance

☐Medicaid_____ ☐TriCare or Champus

☐No Health Insurance

Date of mothers last Dental Exam:_____

Dentist _____

Address _____

City/State _____

Phone _____

Pregnancy History Form (part 1) Complete only while pregnant

Eligible Applicant:_____ Date:_____

What trimester of pregnancy enrolled?
- ☐ 1st trimester (0-3 months)
- ☐ 2nd trimester (3-6 months)
- ☐ 3rd trimester (6-9 months)

*Due Date:_____

*Has the pregnancy been medically identified as high risk? ☐ Yes ☐ No

Are you receiving Prenatal Care? ☐ Yes ☐ No

Who is your prenatal care provider?ψψψψψψψψψψψψψψψψψψψψψ Date of first prenatal visit:_____

Name _____

Address _____

City/State _____

Phone _____

Previously pregnant? ☐ Yes ☐ No ☐ N/A ☐ Unknown

Number of previous births:_____

Comments:

Complications Mother Experienced During Pregnancy (please check all that apply)

- ☐ Diabetes (insulin dependent)
- ☐ Vaginal Bleeding (after 12 weeks)
- ☐ Sickle Cell Anemia
- ☐ Past Post-partum Depression
- ☐ Hypertension
- ☐ Pre-term Labor
- ☐ Anemia
- ☐ Other_____

Is mother taking prescription or over-the-counter medications or herbal medication? ☐ Yes ☐ No

If yes, please list:

_____ _____

_____ _____

_____ _____

_____ _____

Prenatal Drug Exposure (please check all that apply and specify when applicable)

- ☐ Caffeine
- ☐ Cigarettes
- ☐ Alcohol
- ☐ Prescription Drugs_____
- ☐ Non-Prescription Drugs_____
- ☐ Other_____

DONA ANA COUNTY HEAD START/EARLY HEAD START

2540 B El Paseo

Las Cruces, NM 88001

AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

I (name)_____authorize the mutual exchange of information concerning my prenatal care between Doña Ana County Head Start/Early Head Start and _____(health care provider or agency).

Participant's Signature_____Date_____

PREGNANCY VERIFICATION

Dear Health Care Provider,

_____ is a mother participating in our Early Head Start program. Federal Performance Standards require us to verify that she is receiving regular prenatal care.

Is this mother receiving prenatal care from you? ☐ Yes ☐ No

Date of first prenatal visit_____at _____weeks gestation.

How many prenatal visits has she received up to this date?_____

Is her pregnancy considered high risk? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

Date of next scheduled prenatal visit_____

Doctor Signature_____Date_____

Please fax this form back to Olivia Seppi, Health/Nutrition Specialist at (575) 647-8734.

Pregnancy Outcome(s) Mother

Eligible Applicant:_____ Date:_____

Pregnancy Outcome (please check all that apply)

☐ Ectopic Pregnancy ☐ Fetal Death/Stillborn ☐ Induced Abortion ☐ Live Birth
☐ Multi Live Births ☐ Multiple with Stillborn ☐ Spontanious Abortion ☐ Other

Outcome Date:_____ Discharge Date:_____

Was this a premature birth? ☐ Yes ☐ No ☐ N/A

Who is your service provider?

Name _____
Address _____
City/State _____
Phone _____

Delivery Location: ☐ Hospital/Clinic ☐ Birthing Center ☐ Home ☐ N/A
Nursery Type: ☐ Intensive Care ☐ Regular ☐ Special ☐ N/A
Delivery Method: ☐ Vaginal ☐ C-Section ☐ N/A

Pluraity: ☐ Singleton ☐ Twin ☐ Triplet ☐ Quad or higher ☐ Unknown

Gestational Age (weeks)_____

Complications Associated (please check all that apply)

☐ Pre-eclampsia/Eclampsia ☐ Postpartum hemorrhage ☐ Abruptio placentae
☐ Placenta previa ☐ Pre-term labor ☐ Premature membrane rupture
☐ Fetal Distress ☐ None of the Above ☐ Other_____

Pregnancy Outcome(s) Infant

Complete for infant 0-6 months only

Child's Name:_____ DOB_____ ☐ Male ☐ Female

Admitted to NICU/SCN: ☐ Yes ☐ No

Birth Order: ☐ 1st born ☐ 2nd born ☐ 3rd born ☐ 4th born
☐ 5th born ☐ 6th born ☐ 7th born ☐ 8th born

Birth Weight: Lb_____ Oz_____ Birth Length_____ in

APGAR 1 Min:_____ APGAR 1 Min:_____ Specify:_____

Baby's Length of Hospital Stay: ☐ Routine Stay 1-2 days ☐ Non-routine, less than 1 week
☐ One Week to One Month ☐ Over 1 Month ☐ Don't Know

Birth Health: ☐ Birth Complication ☐ Normal ☐ Positive Alcohol Screen
☐ Positive Drug Screen ☐ Unknown ☐ Refused
☐ Other_____ ☐ Birth Defects_____