

MIECHV Maternal Health Form

Timeframe: Intake Pregnancy Update

♦Home Visitor: _____

♦Agency ID: _____ ♦Date Completed: _____

Participant ID#: _____ ♦Time spent on form: _____ (min.)

Completed by female caregivers at intake, new pregnancy, and updated every 6 months

♦Mother's First Name: _____

♦Mother's Last Name: _____

In order to provide you and your family with the most appropriate care and services, I'm going to ask you some questions about your health history. It can be helpful to have a relationship with a medical provider who knows our history and can meet our medical needs. People refer to this as a medical home or a primary health care provider. Do you have a...

♦Primary health care provider:

Dentist:

Yes Name: _____

Yes Name: _____

No Reason: _____

No Reason: _____

Having health insurance can be helpful when accessing medical care. What is your...

♦Health insurance status:

Medicaid Medicare SCHIP/CHIP Tri-Care CHAMPVA Private

Other _____ None → Reason no insurance: _____

♦In the past 6 months, used emergency services (ER) for self:

No Yes → Number of times: _____

Date of visit: _____ Reason for visit: _____

Date of visit: _____ Reason for visit: _____

Date of visit: _____ Reason for visit: _____

HEALTH HISTORY

Any current acute or chronic medical conditions:

No Yes → Describe: _____

♦ Current multi-vitamin or prenatal vitamin supplement use:

No Yes → ♦ Frequency (how often): 1-3 times a week 4-6 times a week every day of the week

Current Height: _____ in. Current Weight: _____ lbs. Measurement source: WIC Doctor Self-report Other

Current form of birth control: (check all that apply)

Oral Contraception Diaphragm IUD Vaginal Ring Hormonal Injection None

Hormonal Patch Sterilization Condom Withdrawal Natural Family Planning/Rhythm

Abstinence Other (describe): _____

SUBSTANCE USE

♦ Tobacco product use: Smoking cigarettes ↓ Chewing Vaping None

cigarettes/day: Current: _____ Before pregnancy: _____ Pregnancy: _____

Drink alcohol: (in past 6 months)

No Yes → # drinks per day: Current: _____ Before pregnancy: _____ Pregnancy: _____

Concerned about drinking: (self or anyone else)

No Yes → Alcohol treatment plan: No Yes → Describe plan: _____

Drug use: (current or previous)

No

Yes, in the past → Marijuana Meth Prescription drugs Other _____

Yes, using currently → Marijuana Meth Prescription drugs Other _____

If yes: Drug treatment plan: No

Yes → Describe plan: _____

Continued on back

PREGNANCY HISTORY

Number of pregnancies: _____ **Live births:** _____ **Miscarriages:** _____ **Stillbirths:** _____ **Multiple births** _____

Name of youngest child: _____ DOB (if not enrolled in MIECHV): _____

Most recent pregnancy weight gain: _____ lbs.

Planned most recent pregnancy: Yes No

Complications with most recent pregnancy:

- Gestational diabetes Anemia Headaches Low Birth Weight Pregnancy induced Hypertension
 Vaginal Bleeding Swelling C-section Pre-term Delivery High level of stress Depression
 Other: _____ None

Complications with any other pregnancy:

- Gestational diabetes Anemia Headaches Low Birth Weight Pregnancy induced Hypertension
 Vaginal Bleeding Swelling C-section Pre-term Delivery High level of stress Depression
 Other: _____ None

CURRENT PREGNANCY

♦ **Are you currently pregnant?** (No further questions if not currently pregnant)

No Yes → ♦ Estimated Due Date: _____ Current weeks gestation: _____

Start Prenatal Care (not pregnancy test appointment):

Yes → Date of first visit _____ Number of visits (to date): _____

No → Reason no prenatal care: _____

Current visit frequency: Every month Every other week Every week Other: _____

Dental exam while pregnant: Yes No

NOTES

Next Maternal Health Form due: