COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START
998 Washington St. N.
PO Box 1238
Twin Falls, Idaho 83303-1238

PRENATAL PACKET

Adult General Health

Eligible Applicant:____ __________ _________________________________
First Name *MI* *Last Name*

Date:___________________ Completed by Staff:____

Food Allergies (please list):

____
____
____
____

Medications (please list):

____
____
____
____

Chronic andκ2Ŋ Acute Medical Conditions

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Insurance that covers prenatal care:

☐ Private Insurance_________________________________
☐ Medicaid____
☐ No Health Insurance
☐ Military Insurance
☐ TriCare or Champus

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? 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_____

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AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

I (name)_____authorize the mutual exchange of information concerning my prenatal care between College of Southern Idaho 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 Stndards 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 College of Southern Idaho Early Head Start at (208) 734-3832.

Thank you,

Lynndi Walker
Early Head Start Coordinator

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 Lenth 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_____