DATE\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EDC: \_\_\_\_\_\_\_\_\_\_\_ IEHP MEMBER NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Note: Medical history and anthropometric information is available on OB-Medical History forms.)

(Note: Complete Diet Recall at this time if not already completed.)

# Please answer the following questions by marking a √ in the or by writing in the blank space STATUS

1. What languages do you speak?  English  Spanish Other\_\_\_\_\_\_\_\_ 1. L  M  H
2. What languages do you read?  English  Spanish Other\_\_\_\_\_\_\_\_ 2. L  M  H
3. How many years of school have you finished? \_\_\_\_\_\_\_\_\_\_years 3. L  M  H
4. Do you have a job? Yes No What kind of work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. L  M  H
5. Does your partner have a job? Yes No What kind of work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. L  M  H
6. Are you on a special diet? Yes No If you are on a special diet, what kind? 6. L  M  H Weight loss  low fat /low cholesterol  low salt  diabetic

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you a vegetarian?  Yes  No 7. L M  H

 If yes, do you use milk products (milk, cheese, yogurt) and /or eggs? Yes  No

1. Are you allergic to any foods, or do you try not to eat any foods?

  Yes  No If yes, what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. L M  H

1. How many cups, glasses or cans of these do you drink every day? 9. L M  H

 water\_\_\_\_\_ milk\_\_\_\_\_ juice\_\_\_\_\_ diet soda\_\_\_\_\_ punch/kool aid\_\_\_\_\_

 coffee\_\_\_\_\_ tea \_\_\_\_\_ soda \_\_\_\_\_

1. How many times a day do you usually eat (including snacks)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. L M  H
2. Do you have 11. L M  H

 nausea  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 vomiting  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 poor appetite  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 weight loss  Yes  No How many pounds?\_\_\_\_\_\_\_\_\_\_

 diarrhea  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 constipation  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 heartburn  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What home remedies, food supplements, or herbs are you taking? 12. L M  H

 Ginseng  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ma Huang (Ephedra)  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Manzanilla (Chamomile)  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hierba buena (Peppermint) Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During this pregnancy, have you eaten 13. L M  H

 maicena (cornstarch)  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 laundry starch  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 dirt or clay  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 paste or plaster  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 freezer frost  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During this pregnancy, are you taking 14. L M  H

 aspirin  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 cold medicine  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 allergy/sinus medicine  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 diet pills  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 prenatal vitamins  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 other vitamins  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 iron pills  Yes  No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROVIDER INFORMATION**:

Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IEHP Provider Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **STATUS**

15. How do you plan to feed your new baby? Breast Bottle Both not sure 15.  L  M  H

1. Have you breastfed a baby before? Yes No 16.  L  M  H
2. a. Where are you living right now?  House  Apartment  Motel

  in a friend’s house or apartment  Car Street other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 17.  L  M  H

How long have you lived there?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. How many people live with you? 18.  L  M  H  no one 1-3 others  4-6 others  7 or more others

 Who lives with you?

 live alone husband/partner  parents  in-laws

 your children other’s children friends  other family

 How many children are in your household?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you are worried about something, who do you talk to ? 19.  L  M  H

  partner/husband parents  grandparents  other relatives

 friend  other person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have (√if yes) 20.  L  M  H

  electricity  hot water refrigerator  stove or oven

 transportation  telephone heating

1. Are you usually able to (√if yes) 21.  L  M  H

buy enough food pay rent  pay other bills

1. Have you ever had trouble finding a doctor, or getting medical help for yourself or your

 family? Yes  No 22.  L  M  H

 If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you on the WIC (Women, Infants & Children) Program? Yes  No 23.  L  M  H
2. Do you have an infant car seat? Yes  No 24.  L  M  H
3. Do you use you car seat belt? Yes  No 25.  L  M  H
4. Was your pregnancy planned? Yes  No 26.  L  M  H
5. How does the baby’s father feel about this pregnancy? 27.  L  M  H

doesn’t care  doesn’t know  angry  happy sad other\_\_\_\_\_\_\_\_\_\_

1. How do you feel about this pregnancy? 28.  L  M  H

don’t care  angry  happy sad other\_\_\_\_\_\_\_\_\_\_

1. Have you ever had any of the following? 29.  L  M  H Miscarriage abortion stillbirth  fetal demise

 neonatal death premature birth  none

When did it happen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What/who helped you get through this?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any traditional, cultural, or religious customs about pregnancy or 30.  L  M  H

childbirth you would like supported? Yes  No

1. Since becoming pregnant, which of the following have you had? (√if yes) 31.  L  M  H

 problem sleeping  excessive worrying  crying  depression

 sadness  none  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you taking medicine for your nerves?

Yes No Name of Medicine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 32.  L  M  H

33. What two problems in your life cause you the most trouble? 33.  L  M  H 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever thought about, planned, or tried to hurt yourself? Yes No 34.  L  M  H
2. Have you ever thought about, planned, or tried to hurt someone else?  Yes  No 35.  L  M  H
3. In the past year, have you been slapped, hit, kicked, or otherwise physically hurt be someone? 36.  L  M  H

 Yes No

 By whom? (Check all that apply)

 partner/husband  ex-husband  parent

 step-parent  stranger  brother/sister

 other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # times hurt\_\_\_\_\_\_\_\_\_\_\_\_\_



 **STATUS**

37. On this picture mark the area of the body where you have been hurt.

 37.  L  M 

38 .For how many months or years have you been hurt by this person?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 38.  L  M  H

 Not applicable

1. How many cigarettes do you smoke each day? 39.  L  M  H don’t smoke less than pack  pack  to 1 pack

 1-2 packs 2-3 packs more than 3 packs

1. Do you live with anyone who smokes?  Yes No 40.  L  M  H
2. Check all that apply:

 a. Does the father of your baby use drugs or drink alcohol? Yes  No 41a.  L  M  H

 Do/did your parents use drugs or drink alcohol? Yes  No

 Do/did you have friends who use drugs or drink alcohol?Yes  No

b. What drugs did you use before this pregnancy? 41b.  L  M  H

 cocaine  marijuana  speed, methamphetamines  PCP

 heroin  none  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. How often do you drink beer, wine, or liquor? 41c.  L  M  H

 daily  weekends 1-2 times a month  rarely or never

 Have your alcohol habits changed since you became pregnant?

 Yes  No If yes, how?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

42. Have you received counseling on HIV (AIDS) in pregnancy? Yes  No 42.  L  M  H

43. Tell us what you know about and want to learn about: 43.  L  M  H

 Already Like to Already Like to

 Know Know Know Know

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Child Care |  |  | Breastfeeding |
|  |  | Hospital Tour |  |  | Infant Feeding |
|  |  | Labor & Delivery |  |  | Baby Care |
|  |  | Sexual Abuse |  |  | Exercise |
|  |  | Circumcision |  |  | Stop Smoking |
|  |  | Substance Abuse |  |  | Domestic Violence |
|  |  | How Your Baby Grows |  |  | Sexually Transmitted Disease |
|  |  | Making Children Behave |  |  | Body Changes During Pregnancy |
|  |  | Car Seat Safety |  |  | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Signs of Preterm Labor |  |  |  |

44. a. How do you learn new things best? (Please check all that apply) 44a.  L  M  H

 \_\_\_\_\_\_read \_\_\_\_\_\_\_watch video \_\_\_\_\_\_talk one-to-one

 \_\_\_\_\_\_go to class \_\_\_\_\_\_\_Pictures or diagrams \_\_\_\_\_\_Demonstration

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any problems with hearing, seeing, or depression that will make it hard for you 44b.  L  M  H

 to learn new things? Yes  No

 If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. a. Will you have any problems coming to prenatal classes?  Yes  No 45a.  L  M  H  H If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Who can come to prenatal classes with you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 45b.  L  M  H things (goals) you would like to work on during this pregnancy.

46. List one or two things (goals) you would like to work on during this pregnancy 46.  L  M  H

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If patient assisted by staff to complete assessment tool**

**Assessment Tool Completed by:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment Reviewed by:

Name (OB)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (H.E.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Nut.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Psych. Soc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Trimester reassessment completed by:

Name (OB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (H.E.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Nut.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Psych. Soc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

3rd Trimester assessment completed by:

Name (OB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (H.E.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Nut.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Psych. Soc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postpartum assessment completed by:

Name (OB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (H.E.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Nut.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Psych. Soc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy Permission:

Riverside/San Bernardino County DOPH-CPSP Program