This form is confidential. If you have any problems or questions, please call 1-866-433-6041 (TTY 711).

Are You Pregnant?* Yes ◯ No ◯ If you are pregnant, please continue to answer all the questions. Return the form in the envelope provided. When your answers are received, a gift will be mailed to you! We may call you if we find that you are at risk for problems with your pregnancy.

***Required Field**

Medicaid ID #:* ______ Today's Date: (mmddyyyy) ______

Your First Name:* ______ Your Birth Date:* (mmddyyyy) ______

Your Last Name:* ______

Mailing Address: ______

City: ______ State: ______ Zip Code: ______

Home Phone: ___ - ___ - ____ Cell Phone: ___ - ___ - ____

Would you like to receive text messages about pregnancy and newborn care? Yes ◯ No ◯

If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe.

Email Address: ______

Your OB Provider's Name: ______

Your Due Date*: (mmddyyyy) ______

Primary insurance (for mom or baby) other than Medicaid? Yes ◯ No ◯

Race/Ethnicity (fill in all that apply) White ◯ Black/African American ◯ Hispanic/Latina ◯

American Indian/Native American ◯ Asian ◯ Hawaiian/Pacific Islander ◯

Other ◯ If other ethnicity, please specify ______

Preferred Language (if other than English) ______

Planning to breastfeed? Yes ◯ No ◯ If no, what is the reason? ______

Pediatrician chosen? Yes ◯ No ◯ Pediatrician Name ______

Number of Full Term Deliveries ______ Number of Miscarriages ______ Height ___ ' ___ "

Number of Preterm Deliveries ______ Number of Stillbirths ______ Pre-Pregnancy Weight ______

Do you have any of the following?* Yes ◯ No ◯ If yes, fill in the oval for all that apply.

Your Medical History

Previous preterm delivery (<37 weeks)? ______ ◯
(A delivery more than three weeks early.)

Recent delivery within past 12 months? ______ ◯

Was delivery within past 6 months? ______ ◯

Previous C-Section? ______ ◯

Current Pregnancy History

Preterm labor this pregnancy? ______ ◯

Current gestational diabetes? ______ ◯

Current twins? ______ ◯

Current triplets? ______ ◯

Currently having severe morning sickness? ______ ◯

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Your First Name:* ____________ Your Birth Date:* (mmddyyyy) ________

Your Last Name:* ____________

Diabetes (prior to pregnancy)? ○

Sickle Cell? ○

Asthma? ○

If yes, are asthma symptoms worse during pregnancy? ○

High Blood Pressure (prior to pregnancy)? ○

Previous neonatal death or stillborn? ○

HIV positive? ○ HIV negative? ○ Testing refused? ○

AIDS? ○

Thyroid problems? ○

Seizure disorder? ○

Seizure within the last 6 months? ○

Previous alcohol or drug abuse? ○

Current mental health concerns? ○

List: ____________

Current STD? List ____________ ○

Current tobacco use? Amount ____________ ○

If yes, are you interested in quitting smoking? ○

Current alcohol use? Amount ____________ ○

Current street drug use? ○

Taking any prescription drugs (other than prenatal vitamins?) List ____________ ○

Any hospital stays this pregnancy? ○

Do you have enough food? Yes ○ No ○

Do you lack reliable phone access? Yes ○ No ○

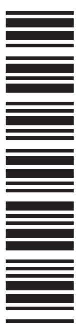
Are you enrolled in WIC? Yes ○ No ○

Are you homeless or living in a shelter? Yes ○ No ○

Do you have problems getting to your doctor visits? Yes ○ No ○

Do you feel unsafe in your home? Yes ○ No ○

Please list any other social needs you may have:



Please list anything else you would like to tell us about your health:

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