absolute total care | Healthy Connections

Member Notice of Pregnancy

Start Smart for Your Baby®

My Own Info

First and Last Name: _____

Date of Birth: _____ Gender Identification: _____ Phone Number: _____

Full Mailing Address: _____

Email Address: _____

Race/Ethnicity (Please check all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Wish to not disclose

What Provider or Clinic is Helping Me During My Pregnancy

Last Name: _____ First Name: _____

Phone Number: _____ Clinic Name (if applicable): _____

My Current Situation

☐ Please check this box if you would answer no to any of the below statements:

- I have a phone
- I feel safe at home and with the people in my life
- I have enough food for me and my family each day
- I feel good about where I live
- I have transportation for my daily needs
- I am able to pay my utility bills (gas, water, electric, etc.)

My Current Pregnancy Information

I have been to my first prenatal visit (yes/no): _____ If yes, how many weeks pregnant were you at your first visit: _____

My due date is (If you do not know your due date, when was the first day of your last period): _____

This is my first pregnancy (yes/no): _____

Where will I give birth to my baby (Hospital or birthing center): _____

(Continued)

My Current Pregnancy Information Continued (Please check all that apply)

- ☐ Multiples (twins, triplets)
- ☐ High blood pressure or heart problems
- ☐ Diabetes (high blood sugar; type I, type II, during pregnancy only)
- ☐ Very bad nausea and vomiting
- ☐ Asthma or other breathing problems
- ☐ Sickle cell
- ☐ Kidney disease
- ☐ Seizures/epilepsy
- ☐ Depression (feeling blue)
- ☐ Bipolar disorder
- ☐ Anxiety (feeling worried or stressed)
- ☐ Substance use (fentanyl, opiates, heroin, crack, cocaine, alcohol, marijuana, methamphetamine)
- ☐ Tobacco use (smoking cigarettes, chewing tobacco, or vaping)
- ☐ I do not have any of these
- ☐ Other health needs (Please tell us about it) _____

_____

My Past Pregnancy History (Please check all that apply)

- ☐ Previous delivery before 37 weeks
- ☐ Gestational diabetes (high blood sugar while pregnant)
- ☐ Delivery less than 18 months ago
- ☐ Previous c-section
- ☐ I did not have any of these or this is my first pregnancy
- ☐ High blood pressure in pregnancy/preeclampsia or heart problems
- ☐ Taken any form of progesterone
- ☐ Other (Please tell us about it) _____

_____