

# COMPREHENSIVE PERINATAL SERVICES PROGRAM

## Prenatal Combined Assessment / Reassessment Tool

Initial \_\_\_\_\_ / \_\_\_\_\_  
(1st OB) Date Weeks

2nd Trimester \_\_\_\_\_ / \_\_\_\_\_  
(14-27 weeks) Date Weeks

3rd Trimester \_\_\_\_\_ / \_\_\_\_\_  
(28 weeks-Delivery) Date Weeks

This Prenatal Combined Assessment /Reassessment Tool has received California State Department of Health Services approval and **MAY NOT BE ALTERED** except to be printed on your logo stationery.

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Health Plan: \_\_\_\_\_ Identification No.: \_\_\_\_\_

Provider: \_\_\_\_\_ Hospital: \_\_\_\_\_ Location: \_\_\_\_\_

Case Coordinator/Manager: \_\_\_\_\_ EDC: \_\_\_\_\_

Dx. OB High Risk Condition: \_\_\_\_\_

### Personal Information

- Patient age:  Less than 12 years  12-17 years  18-34 years  35 years or older
- Are you:  Married  Single  Divorced/Separated  Widowed  Other: \_\_\_\_\_
- How long have you lived in this area? \_\_\_\_\_ yrs./mos. Place of birth: \_\_\_\_\_
- Do you plan to stay in this area for the rest of your pregnancy?  Yes  No
- Years of education completed:  0-8 years  9-11 years  12-16 years  16+ years
- What language do you prefer to speak:  English  Spanish  Other: \_\_\_\_\_
- What language do you prefer to read:  English  Spanish  Other: \_\_\_\_\_
- Which of the following best describes how you read:  
 Like to read and read often  Can read, but read slowly or not very often  Do not read
- Father of baby: (name) \_\_\_\_\_ His preferred language: \_\_\_\_\_ Education: \_\_\_\_\_ Age: \_\_\_\_\_
- Was this a planned pregnancy?  Yes  No
- How do you feel about being pregnant now?  
0-13 wks:  Good  Troubled, please explain: \_\_\_\_\_  
14-27 wks:  Good  Troubled, please explain: \_\_\_\_\_  
28-40 wks:  Good  Troubled, please explain: \_\_\_\_\_
- Are you considering (circle)adoption/abortion?  No  If Yes, Do you need information/referrals?  No  Yes
- How does the father of the baby feel about this pregnancy? \_\_\_\_\_  
Your family? \_\_\_\_\_  
Your friends? \_\_\_\_\_

## Economic Resources

14. a) Are you currently working or going to school?  Yes - type & hr/week: \_\_\_\_\_ Cal Learn?  Yes  No  
 b) Do you plan to work or go to school while you are pregnant?  Yes - type: \_\_\_\_\_ How long? \_\_\_\_\_  No  
 c) Do you plan to return to work or go to school after the baby is born?  Yes type: \_\_\_\_\_  No
15. Will the father of the baby provide financial support to you and/or the baby?  Yes  No  
 Other sources of financial help? \_\_\_\_\_

16. Are you receiving any of the following? (check all that apply)

	0-13 wks:		14-27 wks:		28-40 wks:		Referral Date
	Yes	No	Yes	No	Yes	No	
a. WIC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b. Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. AFDC/TANF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Emergency Food Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Pregnancy-related disability insurance benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

17. Do you have enough of the following for yourself and your family?

	0-13 wks:		14-27 wks:		28-40 wks:	
	Yes	No	Yes	No	Yes	No
Clothes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Food	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

## Housing

18. What type of housing do you currently live in?  House  Apartment  Trailer Park  Public Housing  
 Hotel/Motel  Farm Worker Camp  Emergency Shelter  Car  Other: \_\_\_\_\_  
 Any Changes?  No  Yes 14-27 wks: \_\_\_\_\_  No  Yes 28-40 wks: \_\_\_\_\_

19. Do you have the following where you live?  Yes 0-13 wks  Yes 14-27 wks  Yes 28-40 wks

0-13 wks:	<input checked="" type="checkbox"/> No:	<input type="checkbox"/> toilet	<input checked="" type="checkbox"/> stove/place to cook	<input type="checkbox"/> tub/shower	<input type="checkbox"/> electricity	<input checked="" type="checkbox"/> refrig.	<input type="checkbox"/> hot/cold water	<input type="checkbox"/> phone
14-27 wks:	<input checked="" type="checkbox"/> No:	<input type="checkbox"/> toilet	<input checked="" type="checkbox"/> stove/place to cook	<input type="checkbox"/> tub/shower	<input type="checkbox"/> electricity	<input checked="" type="checkbox"/> refrig.	<input type="checkbox"/> hot/cold water	<input type="checkbox"/> phone
28-40 wks:	<input checked="" type="checkbox"/> No:	<input type="checkbox"/> toilet	<input checked="" type="checkbox"/> stove/place to cook	<input type="checkbox"/> tub/shower	<input type="checkbox"/> electricity	<input checked="" type="checkbox"/> refrig.	<input type="checkbox"/> hot/cold water	<input type="checkbox"/> phone

20. Do you feel your current housing is adequate for you?  Yes  No, please explain: \_\_\_\_\_

21. Do you feel your home is safe for you and your children?  Yes 0-13 wks  Yes 14-27 wks  Yes 28-40 wks  
 No 0-13 wks, please explain: \_\_\_\_\_  
 No 14-27 wks, please explain: \_\_\_\_\_  
 No 28-40 wks, please explain: \_\_\_\_\_

22. If there are guns in your home, how are they stored? \_\_\_\_\_  N/A

23. Do any of your children or your partner's children live with someone else?  N/A  No  
 If Yes, please explain: \_\_\_\_\_

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## Transportation

24. Will you have problems keeping your appointments/attending classes?  No 0-13 wks:  No 14-27 wks:  No 28-40 wks:
- Yes 0-13 wks:  Transportation  Child care  Work  School  Other: \_\_\_\_\_
- Yes 14-27 wks:  Transportation  Child care  Work  School  Other: \_\_\_\_\_
- Yes 28-40 wks:  Transportation  Child care  Work  School  Other: \_\_\_\_\_
25. When you ride in a car, do you use seatbelts?  Never  Sometimes  Always
26. Do you have a car seat for the new baby?  
0-13 weeks:  Yes  No 14-27 weeks:  Yes  No 28-40 weeks:  Yes  No
27. How will you get to the hospital? 14-27 weeks: \_\_\_\_\_ 28-40 weeks: \_\_\_\_\_

## Current Health Practices

28. Do you know how to find a doctor for you and your family?  Yes  No, explain: \_\_\_\_\_
29. Do you have a doctor for your baby? 14-27 wks:  Yes  No 28-40 wks:  Yes  No Who? \_\_\_\_\_
30. Have you been to a dentist in the last year?  Yes  No Any dental problems?  No  Yes, please describe: \_\_\_\_\_
31. On average, how many total hours at night do you sleep? 0-13 wks: \_\_\_\_\_ 14-27 wks: \_\_\_\_\_ 28-40 wks: \_\_\_\_\_  
 On average, how many total hours do you nap in the day? 0-13 wks: \_\_\_\_\_ 14-27 wks: \_\_\_\_\_ 28-40 wks: \_\_\_\_\_
32. Do you exercise?  No  Yes, what kind? \_\_\_\_\_ how often? \_\_\_\_\_ minutes/day \_\_\_\_\_ days/week \_\_\_\_\_
33. Are you smoking/using chewing tobacco now?  No 0-13 wks  No 14-27 wks  No 28-40 wks
- 0-13 wks:  If Yes, for how many years? \_\_\_\_\_ how much per day? \_\_\_\_\_ Have you tried to quit?  Yes  No
- 14-27 wks:  If Yes, how much per day? \_\_\_\_\_ have you tried to quit during this pregnancy?  Yes  No
- 28-40 wks:  If Yes, how much per day? \_\_\_\_\_ have you tried to quit during this pregnancy?  Yes  No
34. Are you exposed to second-hand smoke?  No  Yes at home?  No  Yes at work?  No  Yes
35. Do you handle or have exposure to chemicals? (examples: glue, bleach, ammonia, pesticides, fertilizers, cleaning solvents, etc.)
- 0-13 wks: (circle) At work - home - hobbies?  No  Yes, \_\_\_\_\_
- 14-27 wks: (circle) At work - home - hobbies?  No  Yes, \_\_\_\_\_
- 28-40 wks: (circle) At work - home - hobbies?  No  Yes, \_\_\_\_\_
36. In your home, how do you store the following?  
 Medications: \_\_\_\_\_  Vitamins: \_\_\_\_\_  
 Cleaning agents: \_\_\_\_\_

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37. Are you taking any prescription, over-the-counter, herbal or street drugs?

None 0-13 weeks     None 14-27 weeks     None 29-40 weeks

**Examples:** Tylenol®, Tums®, Sudafed®, laxatives, appetite suppressants, aspirin, prenatal vitamins, iron, allergy medications, Aldomet®, Prozac®, ginseng, manzanilla, greta, magnesium, yerba buena, marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other?

Yes, 0-13 weeks: \_\_\_\_\_

Yes, 14-27 weeks: \_\_\_\_\_

Yes, 28-40 weeks: \_\_\_\_\_

38. How much of the following do you drink per day?

	<u>Water</u>	<u>Milk</u>	<u>Juice</u>	<u>Decaf Coffee</u>
<u>Coffee</u>	<u>Punch, Kool-Aid, Tang</u>	<u>Soda</u>	<u>Diet Soda</u>	<u>Herb tea</u>
<u>Beer</u>	<u>Wine</u>	<u>Wine Coolers</u>	<u>Hard Liquor</u>	<u>Mixed Drinks</u>

14-27 wks: Has this changed?     No     Yes, how? \_\_\_\_\_

28-40 wks: Has this changed?     No     Yes, how? \_\_\_\_\_

39. If you use drugs and/or alcohol, are you interested in quitting?     Yes     No

Have you tried to quit?     Yes     No    comments: \_\_\_\_\_

## Pregnancy Care

40. Besides having a healthy baby, what are your goals for this pregnancy? \_\_\_\_\_

41. Do you plan to have someone with you:

	<u>14-27 weeks:</u>			<u>28-40 weeks:</u>		
During labor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
When you first come home with the baby?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

42. If you had a baby before, where was that baby(ies) delivered?     N/A     Hospital     Clinic     Home  
 Other: \_\_\_\_\_ Were there any problems?     No     Yes, please explain: \_\_\_\_\_

43. Have you lost any children?     No     If Yes, please explain: \_\_\_\_\_

44. Do you have any traditions, customs or religious beliefs about pregnancy?     No     If Yes, please explain: \_\_\_\_\_

45. Does the doctor say there are any problems with this pregnancy?

14-27 wks:     No     Yes    please describe: \_\_\_\_\_

28-40 wks:     No     Yes    please describe: \_\_\_\_\_

46. Are you scheduled for any tests?

14-27 wks:     No     If Yes, what: \_\_\_\_\_

28-40 wks:     No     If Yes, what: \_\_\_\_\_

Do you have any questions?     No     If Yes, what: \_\_\_\_\_

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47. Have you experienced any of the following discomforts during this pregnancy?

If Yes, check box:

0-13 wks:

14-27 wks:

28-40 wks:

- Edema (swelling of hands or feet) ☒
- Diarrhea ☒
- Constipation ☒
- Nausea/vomiting ☒
- Leg cramps ☒
- Hemorrhoids ☒
- Heartburn ☒
- Vaginal Bleeding ☒
- Varicose veins ☒
- Headaches ☒
- Backaches ☒
- Abdominal cramping/contractions ☒

Other: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

48. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive this time?

N/A     No     If Yes, please explain: \_\_\_\_\_

49. Who has given you the most advice about your pregnancy? \_\_\_\_\_

50. What are the most important things they have told you? \_\_\_\_\_

51. Are you planning to use birth control after this pregnancy?

14-27 wks:

No     Undecided

If Yes,  what method?

- (circle)    Birth control pills    Diaphragm    Norplant    IUD    Abstinence  
Foam and/or condoms    Natural family planning    Tubal/Vasectomy    Depoprovera

28-40 wks:

No     Undecided

If Yes,  what method?

- (circle)    Birth control pills    Diaphragm    Norplant    IUD    Abstinence  
Foam and/or condoms    Natural family planning    Tubal/Vasectomy    Depoprovera

52. Your current or past behaviors, or the current or past behaviors of your sexual partner(s) may place you at risk for being / becoming infected with HIV, the virus which causes AIDS. Since 1979 have you or any of your sexual partner(s):

(check all that apply)

self    partner(s)    unknown    no

	self	partner(s)	unknown	no
Had sex with more than one partner?				
Had sex with someone you/they didn't know well?				
Been treated for trichomonas, chlamydia, genital warts, syphilis, gonorrhea, or other sexually transmitted infections?				
Had sex with someone who used drugs?				
Had hepatitis B?				
Shared needles?				
Had a blood transfusion since 1979?				

Is there any other reason you think you might be at risk for HIV/AIDS?  No     If Yes, please explain: \_\_\_\_\_

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Change in HIV risk status? 14-27 weeks:  No  Yes, what? \_\_\_\_\_  
28-40 weeks:  No  Yes, what? \_\_\_\_\_

53. Have you been offered counseling/information on the benefits of HIV testing and been offered a blood test for HIV?

0-13 wks:  No (Refer to OB provider)  
14-27 wks:  No (Not applicable if previous Yes answer)  
28-40 wks:  No (Not applicable if previous Yes answer)  
 If Yes, do you have any questions? \_\_\_\_\_

## Educational Interests

54. If you have had experience or received education/information in any of the following topics check Column A. If would you like more information check Column B.

TOPIC	0-13 WKS		14-27 WKS		28-40 WKS		Educational Materials Provided		
	A	B	A	B	A	B	Date	Code*	Initials
How your baby grows (fetal development)									
How your body changes during pregnancy									
Healthy habits for a healthy pregnancy/baby									
Assistance with cutting down/quitting smoking									
Assistance with cutting down/quitting alcohol or drugs									
What happens during labor and delivery									
Hospital Tour									
Helping your child(ren) get ready for a new baby									
How to take care of yourself after the baby comes									
Breastfeeding									
How to take care of your baby/infant safety									
Infant development									
How to avoid sexually transmitted infections/HIV									
Circumcision									

\* Teaching Codes: A = Answered questions E = Explained verbally V = Video shown  
W = Written material provided S = Visual aids shown I = Interpreter used

55. Is there anything special you would like to learn?  No  Yes, what? \_\_\_\_\_

56. How do you like to learn new things?  Read  Talk one-on-one  Group education/classes  
 Watch a Video  Pictures and diagrams  Being shown how to do it  
 Other: \_\_\_\_\_

57. Will someone be able to attend classes with you?  No  Yes, who? \_\_\_\_\_

58. Do you have any physical, mental, or emotional conditions, such as learning disabilities, Attention Deficit Disorder, depression, hearing or vision problems that may affect the way you learn?  No  Yes: \_\_\_\_\_

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**Anthropometric:** EDC: \_\_\_\_\_ WKS GA: \_\_\_\_\_ Height: \_\_\_\_\_ Current weight : \_\_\_\_\_

59. Weight gain in previous pregnancies: 1st: \_\_\_\_\_  Unknown 2nd: \_\_\_\_\_  Unknown  N/A

**Recommended weight gain during pregnancy (check one)**

60. Prepregnant weight: \_\_\_\_\_ lbs.  for underweight women 28-40 lbs.  for normal weight women 25-35 lbs.  
 61. Net weight gain: \_\_\_\_\_ lbs.  for overweight women 15-25 lbs  for very overweight women 15-20 lbs  
 Adequate  Inadequate  Excessive  Weight loss  Weight grid plotted

**Biochemical Data:**

62. Urine-Date: \_\_\_\_\_ (circle + or -) Glucose:  +  - Ketones:  +  - Protein:  +  -  
 63. Blood-Date drawn: \_\_\_\_\_ Hgb: \_\_\_\_\_ (<10.5) Hct: \_\_\_\_\_ (<32) MCV: \_\_\_\_\_ Glucose: \_\_\_\_\_

**Clinical Data:**

64.  None relevant 65.  Age 17 or less (#1) 66.  Pregnancy interval < 1 yr.  
 67.  High Parity (≥4 births) 68.  Multiple Gestation 69.  Currently Breastfeeding  
 70.  Dental Problems (#30) 71.  Serious Infections 72.  Anemia  
 73.  Diabetes (circle) Prepreg Past preg Current preg comments: \_\_\_\_\_  
 74.  Hypertension (circle) Prepreg Past preg Current preg comments: \_\_\_\_\_  
 75.  Hx. of poor pregnancy outcome (e.g., preterm delivery, fetal/neonatal loss): \_\_\_\_\_  
 76.  Other medical/obstetrical problems (low birth weight, large for gest. age, PIH): \_\_\_\_\_ Past: \_\_\_\_\_

Present: \_\_\_\_\_

77. Psychosocial or Health Education Problems:  Eating disorder  Psychiatric illness (#99)  Abuse (# 102-106)  
 Homelessness (#18)  Dev. disability (#58)  Low education (#5)  Other: \_\_\_\_\_

**Dietary:**

78. Any discomforts? (#47)  No  If Yes, please check:  Nausea  Vomiting  Swelling  Diarrhea  
 Constipation  Leg cramps  Other: \_\_\_\_\_  
 79. Do you ever crave/eat any of the following?  No,  If Yes, please check  Dirt  Paint chips  Clay  
 Ice  Paste  Freezer Frost  Cornstarch  Laundry starch  Plaster  Other: \_\_\_\_\_  
 80. a) Number of meals/day : \_\_\_\_\_ b) meals often skipped?  No  Yes c) Number of snacks/day : \_\_\_\_\_  
 81. Who does the following in your home: a) buys food: \_\_\_\_\_ b) prepares food : \_\_\_\_\_  
 82. Do you have the following in your home: (#19) a) stove/place to cook?  No  Yes b) refrigerator?  No  Yes  
 83. Are you on any special diet?  No  If yes, please explain: \_\_\_\_\_  
 84. a) Any food allergies?  No  If yes, please explain: \_\_\_\_\_  
 b) Any foods/beverages you avoid?  No  If yes, please explain: \_\_\_\_\_  
 85. Are you a vegetarian?  No  If Yes, do you eat:  Milk Products  Eggs  Nuts  Dried Beans  Chicken/Fish  
 86. Substance use?  No  Alcohol (#38)  Drugs (#37)  Tobacco (#33)  Secondhand smoke (# 34)  
 Present: \_\_\_\_\_  Past: \_\_\_\_\_  
 87. Currently use? (#37)  None  Prenatal vitamins  Iron pills  Other vitamins/minerals: \_\_\_\_\_  
 Herbal remedies: \_\_\_\_\_  Antacids  Laxatives  Other medicines: \_\_\_\_\_  
 88. Any previous breastfeeding experience?  N/A  No  If Yes, how long? \_\_\_\_\_  < 1 month  
 Why did you stop? \_\_\_\_\_  
 89. Current infant feeding plans:  Breast  Breast & Formula  Formula  Undecided

90. **Nutrition Assessment Summary**  24 hour recall  Food frequency (7 days)

a) Food Group	Servings/Points	Suggested_Changes	Food Group	Servings/Points	Suggested Changes
Protein		+ -	Vit A-rich fruit/veg		+ -
Milk products		+ -	Other fruit/veg		+ -
Breads/cereals/grains		+ -	Fats/Sweets		+ -
Vit. C-rich fruit/veg		+ -			

Referred to Registered Dietitian

b) Diet adequate as assessed:  Yes  No c) Excessive  Caffeine (#38)

Completed by: \_\_\_\_\_  
 Title: \_\_\_\_\_ Minutes: \_\_\_\_\_  
 Facility: \_\_\_\_\_ Telephone: \_\_\_\_\_

Pt. Name \_\_\_\_\_  
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**DIETARY INTAKE EVALUATION (Assessment of the Perinatal Food Frequency Questionnaire)**

GROUP	FOOD	POINTS NEEDED	SERVINGS/DAY	MAJOR NUTRIENTS
1	PROTEINS	21	3	PROTEIN, IRON, ZINC
2	MILK	21	3	CALCIUM, PROTEIN, VITAMIN D
3	BREADS, GRAINS	49	7	CARBOHYDRATES, B VITAMINS, IRON
4	FRUITS/VEGETABLES	7	1	VITAMIN C, FOLIC ACID
5	FRUITS/VEGETABLES	7	1	VITAMIN A, FOLIC ACID
6	FRUITS/VEGETABLES	21	3	CONTRIBUTES TO INTAKE OF VITAMINS A & C
OTHER	FATS AND SWEETS	N/A	3	VITAMIN E

**Refer to Protocols for instructions on completing the dietary assessment using the point system above.**

90. (continued)

**14-27 weeks:**

**28-40 weeks:**

a) Food Group	Servings/Points	Suggested Changes		a) Food Group	Servings/Points	Suggested Changes	
Protein		+ -		Protein		+ -	
Milk products		+ -		Milk products		+ -	
Breads/cereals/grains		+ -		Breads/cereals/grains		+ -	
Vit. C-rich fruit/veg		+ -		Vit. C-rich fruit/veg		+ -	
Vit. A-rich fruit/veg		+ -		Vit. A-rich fruit/veg		+ -	
Other fruit/veg		+ -		Other fruit/veg		+ -	
Fats/Sweets		+ -		Fats/Sweets		+ -	

b) Diet adequate as assessed:  Yes  No

c) Excessive:  Caffeine (#38)  
 Referred to Registered Dietitian

14-27 weeks:	Date: _____	28-40 weeks:	Date: _____
<b>Anthropometric:</b> BP: _____	<b>Biochemical:</b>	<b>Anthropometric:</b> BP: _____	<b>Biochemical:</b>
Weight: _____	Urine: Glucose: - +	Weight: _____	Urine: Glucose: - +
Net wt. gain: _____ (61)	Protein: - +	Net wt. _____ (61)	Protein: - +
<input type="checkbox"/> Adequate	Ketones: - +	<input type="checkbox"/> Adequate	Ketones: - +
<input type="checkbox"/> Inadequate	Blood drawn: date: _____	<input type="checkbox"/> Inadequate	Blood drawn: date: _____
<input type="checkbox"/> Excessive	Hgb: _____ Hct: _____ MCV: _____	<input type="checkbox"/> Excessive	Glucose _____ Hgb: _____ Hct: _____ MCV: _____

91.  3 Hr GTT: Fasting: \_\_\_\_\_ 1 Hr: \_\_\_\_\_ 2 Hr: \_\_\_\_\_ 3 Hr: \_\_\_\_\_  N/A (1 Hr < 140 dl/ml.)

Pt. Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

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92. Are you on any special diet? 14-27 weeks:  No  If Yes, please explain: \_\_\_\_\_  
28-40 weeks:  No  If Yes, please explain: \_\_\_\_\_

93. Have your eating habits changed since you've been pregnant?  
14-27 wks:  No  If Yes, how:  Eat more:  Vegetables  Fruit  Protein  Milk  Bread  Other: \_\_\_\_\_  
 Eat less:  Vegetables  Fruit  Protein  Milk  Bread  Other: \_\_\_\_\_  
28-40 wks:  No  If Yes, how:  Eat more:  Vegetables  Fruit  Protein  Milk  Bread  Other: \_\_\_\_\_  
 Eat less:  Vegetables  Fruit  Protein  Milk  Bread  Other: \_\_\_\_\_

## Coping Skills

94. Are you currently having problems/concerns with any of the following? (check all that apply)

	<u>0-13 wks:</u>	<u>14-27 wks:</u>	<u>28-40 wks:</u>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Divorce/separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illness (TB, cancer, abn. pap smear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immigration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Probation/parole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Protective Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	Other: _____	Other: _____	Other: _____

95. What things in your life do you feel good about? \_\_\_\_\_  
 \_\_\_\_\_

96. What things in your life would you like to change? \_\_\_\_\_  
 \_\_\_\_\_

97. What do you do when you are upset? \_\_\_\_\_  
 \_\_\_\_\_

98. In the past month, how often have you felt that you could not control the important things in your life?

Very often  Often  Sometimes  Rarely  Never

99. Have you ever attended group or individual meetings for emotional support or counseling?  No

If Yes, when and why? \_\_\_\_\_

Yes Have you ever been prescribed drugs for emotional problems?  What? \_\_\_\_\_  No

Yes Have you ever been hospitalized for emotional problems?  What year? \_\_\_\_\_  No

100. What do you do when you and your partner have disagreements? \_\_\_\_\_

101. Does your partner or other family member(s) use drugs and/or alcohol?  No  If Yes, does this create problems for you?

No  If Yes, Please explain: \_\_\_\_\_

102. Do you ever feel afraid of, or threatened by your partner?  No  If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

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103. Within the last year have you been hit, slapped, kicked, choked or physically hurt by someone?  No  
 If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple  
 Total Number of Times: \_\_\_\_\_

104. Since you have been pregnant, have you been hit, slapped, kicked, choked or physically hurt by someone?  No

0-13 wks:  No  If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple  
 Total Number of Times: \_\_\_\_\_

14-27 wks:  No  If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple  
 Total Number of Times: \_\_\_\_\_

28-40 wks:  No  If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple  
 Total Number of Times: \_\_\_\_\_

105. Within the last year has anyone forced you to have sexual activities?  No  If Yes, by whom (circle all that apply)

0-13 wks:  No  If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple  
 Total Number of Times: \_\_\_\_\_

14-27 wks:  No  If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple  
 Total Number of Times: \_\_\_\_\_

28-40 wks:  No  If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple  
 Total Number of Times: \_\_\_\_\_

106. Are your children, or have your children ever been, a victim of violence or sexual abuse?  No

If Yes, please explain: \_\_\_\_\_

107. Would you feel comfortable talking to a counselor if you had a problem?  No  Yes

**Initial Assessment Completed by:**

Name and Title	Initials	Date	Minutes
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**Second Trimester Reassessment Completed by:**

Name and Title	Initials	Date	Minutes
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**Third Trimester Reassessment Completed by:**

Name and Title	Initials	Date	Minutes
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Pt. Name _____
Date of Birth _____
Health Plan: _____
Identification No.: _____