Elkhart & St. Joseph Counties Head Start Consortium
EHS Prenatal Information

Name of Participant: _____

Date: ____/____/____ DOB: _____/_____/_____ Phone: _____

Early Head Start Parents: Please complete by mother of child if pregnant

Are you Pregnant? □ Yes □ No If you answered yes, please answer the following questions. Due date/Expected Delivery Date:	Is your pregnancy covered by Medical Insurance? □ Public Assistance □ Private Insurance □ None Providers Name:	Prenatal care received? □ Yes □ No
Visited regularly by nurse, social worker, school support person, etc. during current pregnancy: Visited by: _____ Agency:_____	Participating in support or educational groups for pregnancy, childbirth, or parenting during pregnancy? ☐ Yes ☐ No	Primary prenatal care provider: Primary Health Care Provider: (if different)

Substance abuse use during pregnancy (mark all that apply):
Alcohol □ Yes □ No Other drugs □ Yes □ No specify:_____

Caffeine □ Yes □ No NON-prescription drugs □ Yes □ No specify:_____

Cigarettes □ Yes □ No Prescription drugs □ Yes □ No specify: _____

Medical or Health services currently received: □ NO SERVICES CURRENTLY BEING RECEIVED

□ Medical assistance since _____/_____/_____ □ Substance abuse treatment since ____/____/____

Other services specify: _____ □ Mental Health counseling/treatment since ____/____/____

□ WIC/other nutritional services since ____/____/____ if served on WIC please provide hemoglobin or hematocrit information to the FACS.

Completed at postpartum:

Pregnancy/birth history (please explain any "yes" answers on the line provided after each question)

☐ Yes ☐ No Did mother have any health problems during this pregnancy or during delivery?
☐ Yes ☐ No Did mother visit physician fewer than two times during pregnancy?
☐ Yes ☐ No Was child born outside of hospital?
☐ Yes ☐ No What was child's birth weight? _____ lbs. _____ oz.
☐ Yes ☐ No Were there any health concerns with child at birth?
☐ Yes ☐ No Did child or mother stay in hospital for medical reasons longer than usual?
☐ Yes ☐ No Is mother pregnant now?
☐ Yes ☐ No Do you have any questions about the child's language or speech?
☐ Yes ☐ No Do you have any questions about the child's overall health and development?
☐ Yes ☐ No Is the child excepted to be experiencing a developmental delay?
☐ Yes ☐ No Is child on an IFSP (Individual Family Service Plan) or IEP (Individual Education Plan)
If yes: Where:_____ Date of beginning services: _____
☐ Yes ☐ No Has the child received any services to address special needs/disabilities?
Types of services received: _____ Provider: _____
Address: _____ Phone: _____

Prenatal:
Date of last physical exam, Pregnant: ___/___/___ Name of Physician: _____

Date of last dental exam, Pregnant: ___/___/___ Name of Dentist: _____

Postpartum:
Date of last physical exam, Infant/Toddler: ___/___/___ Name of Physician:_____

Date of last dental exam, Infant/Toddler: ___/___/___ Name of Dentist: _____