

**CCNC Pregnancy Home Risk Screening Form – 1<sup>st</sup> OB visit**

Practice Name: \_\_\_\_\_

First name: \_\_\_\_\_ MI \_\_\_\_\_ Last name: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_ Today's date: \_\_\_/\_\_\_/\_\_\_

EDC: \_\_\_/\_\_\_/\_\_\_ By what criteria:  LMP  1<sup>st</sup> trimester U/S  2<sup>nd</sup> trimester U/S  Other: \_\_\_\_\_

Height: \_\_\_\_\_ Pre-pregnancy weight: \_\_\_\_\_ Gravidity: \_\_\_\_\_ Parity: \_\_\_\_\_

Insurance type:  Medicaid  None  Other: \_\_\_\_\_**CURRENT PREGNANCY (check all that apply)**

- \*Multifetal gestation
  - \*Fetal complications:
    - Fetal anomaly
    - Fetal chromosomal abnormality
    - Intrauterine growth restriction (IUGR)
    - Oligohydramnios
    - Polyhydramnios
    - Other: \_\_\_\_\_
  - \*Chronic condition which may complicate pregnancy:
    - Diabetes
    - Hypertension
    - Asthma
    - Mental illness
    - HIV
    - Seizure disorder
    - Renal disease
    - Systemic lupus erythematosus
    - Other(s): \_\_\_\_\_
  - \*Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)
  - \*Late entry into prenatal care (>14 weeks)
  - Cervical insufficiency
  - Gestational diabetes
  - Vaginal bleeding in 2<sup>nd</sup> trimester
  - Hypertensive disorders of pregnancy (eclampsia, preeclampsia, gestational hypertension, HELLP syndrome)
  - Short interpregnancy interval (<12 months between last live birth and current pregnancy)
  - Current sexually transmitted infection
  - Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
  - Communication barriers:
    - Literacy
    - Disability
- Explain: \_\_\_\_\_
- Non-English speaking
- Primary language: \_\_\_\_\_

**OBSTETRIC HISTORY (check all that apply)**

- \*Preterm birth (<37 completed weeks)
- Gestational age(s) of previous preterm birth(s): \_\_\_\_\_
- Were any a result of spontaneous preterm labor and/or preterm rupture of the membranes?
  - Is this a singleton pregnancy?
- If yes to both questions, this patient is eligible for 17P treatment.*
- \*Low birth weight (<2500g)
  - \*Very low birth weight (<1500g)
  - Fetal death >20 weeks
  - Neonatal death (within first 28 days of life)
  - Second trimester pregnancy loss
  - Three or more first trimester pregnancy losses
  - Cervical insufficiency
  - Gestational diabetes
  - Postpartum depression
  - Hypertensive disorders of pregnancy
    - Eclampsia
    - Preeclampsia
    - Gestational hypertension
    - HELLP syndrome

- Provider requests pregnancy care management assessment

Reason(s)/Comments: \_\_\_\_\_

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Items marked with a \* will trigger automatic follow-up by a pregnancy care manager. If you would like a care manager to assess this patient, and none of the \* conditions are marked, check the box above.

Name of person completing form: \_\_\_\_\_ Signature: \_\_\_\_\_

## CCNC Pregnancy Home Risk Screening Form – 1<sup>st</sup> OB visit

**Complete this side of the form and give it to the nurse or doctor. Please answer as honestly as possible so we can provide the best care for you and your baby. The care team will keep this information private.**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Today's date: \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_ Home phone number: \_\_\_\_\_ Work/other phone number: \_\_\_\_\_

Cell phone number: \_\_\_\_\_ Social security number: \_\_\_\_\_

Race:  American-Indian or Alaska Native  Asian  Black/African-American  
 Pacific Islander/Native Hawaiian  White  Other (specify): \_\_\_\_\_

Ethnicity:  Not Hispanic  Cuban  Mexican American  Puerto Rican  Other Hispanic

1. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
  - I wanted to be pregnant sooner.
  - I wanted to be pregnant now.
  - I wanted to be pregnant later.
  - I did not want to be pregnant then or any time in the future.
  - I don't know.
2. \*Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?  Yes  No
3. \*Are you in a relationship with a person who threatens or physically hurts you?  Yes  No
4. \*Has anyone forced you to have sexual activities that made you feel uncomfortable?  Yes  No
5. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food?  Yes  No
6. \*Do you have a safe and stable place to live?  Yes  No
7. \*Which statement best describes your smoking status? Check one answer.
  - A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
  - B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
  - C. I stopped smoking AFTER I found out I was pregnant and am not smoking now.
  - D. I smoke now but have cut down some since I found out I was pregnant.
  - E. I smoke about the same amount now as I did before I found out I was pregnant.
8. Did any of your parents have a problem with alcohol or other drug use?  Yes  No
9. Do any of your friends have a problem with alcohol or other drug use?  Yes  No
10. Does your partner have a problem with alcohol or other drug use?  Yes  No
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?  Yes  No
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?  Not at all  Rarely  Sometimes  Frequently
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?  Not at all  Rarely  Sometimes  Frequently