Pregnancy Intake Form

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| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** |  | **Due Date:**  |  |
| **Primary Payer:** |  | **Primary Payer No:** |  | **Signify ID:** |  |
| **Referral Date:** |  | **G** |  | **P** |  | **Father of baby involved?**  | *Yes**No* |

# Pregnancy Intake Survey

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| --- | --- | --- | --- |
| **Has the client been seen at any other agency with this pregnancy?***e.g. Home Visiting, other pregnancy support services, prenatal care* | *Yes**No**Unknown* | **Was this a planned pregnancy?** | *Yes**No**Unknown* |
|  |  |  |  |
| **Was client using birth control?** | *Yes**No**Unknown* | **Birth control type?** | * *Birth Control Pills*
 | * *Condom*
 | * *Contraceptive Implant*
 | * *Contraceptive Ring*
 |
| * *Injections*
 | * *IUD*
 | * *Natural Family Planning*
 | * *Patch*
 |
| * *Tubal Ligation*
 | * *Vasectomy*
 | * *Other (specify)*
 |  |
|  |
| **Date of last menses:***Not in Signify, needed for charting*  |  | **Is client receiving prenatal care?** | *Yes* | *No* | *Unknown* |
|  |  |  |  |  |  |
| **When was first care received?** | * *Pre-Conception*
 | * *1st Trimester*
 | * *2nd Trimester*
 | **Is client taking prenatal vitamins, including folic acid?** | *Yes**No**Unknown* |
| * *3rd Trimester*
 | * *No Care*
 |
|  |  |  |
| **Is the client on a known Teratogenic drug?**  | *Yes – refer to OB or PCP immediately* | *No* |
| Teratogenic drugs include: *Thalidomide, Methotrexate, Androgenic steroids (e.g. testosterone), Diethylstilbestrol (e.g. DES), Anticonvulsants (e.g. Dilantin), Tetracycline (e.g. Doxycycline), Oral Anticoagulants (e.g. Warfarin), Isotretinoin, Vitamin A derivatives (e.g. Accutane), ACE Inhibitors (e.g. Lotensin), Mycophenolate mofetil (e.g. Cellcyst)* |
|  |  |  |
| **Has client used tobacco or nicotine products in the 3 months prior to pregnancy?**  | *Yes**No**Unknown* | **Does client currently use tobacco or nicotine products?**  | *Yes**No**Unknown* |
| **If yes, which products?** | * *Cigarettes*
* *E-Cigarettes (vaping)*
* *Smokeless Tobacco*
* *Other*
 | **How many cigarettes per day?** | * *<1*
 | * *5-10*
 | * *1 pack*
 | * *> 2 packs*
 |
| * *1-5*
 | * *10-20*
 | * *1-2 packs*
 | * *Unknown*
 |
| **Referred to Quitline?**  | *Yes* | *No* | *N/A* |
| **Has the client used alcohol in the 3 months prior to pregnancy?** | *Yes**No**Unknown* | **Does client currently use alcohol?**  | *Yes**No**Unknown* |
| **If yes, how often does client use alcohol?** | * *< 1 Drink/week*
 | * *2-6 drinks/week*
 | * *1 drink/day*
 | * *> 1 drink/day*
 |
| **Has the client used illicit drugs in the 3 months prior to pregnancy?** | *Yes**No**Unknown**Declined* | **Does client currently use illicit drugs?**  | *Yes**No**Unknown* |
| **If yes, what illicit drugs does the client use?**  | * Cocaine
 | * Crank
 | * Marijuana
 | * Unknown
 |
| * Crack
 | * Heroin
 | * Methamphetamine
 |  |
| * Other (*specify*)
 |  |
| **Does client have known exposure to CMV?**  | *Yes**No**Unknown* | **Does the client have STDs or a history of STDs?** | *Yes**No**Unknown**Declined* |
| **If yes, What STDs?** | * *Chlamydia*
 | * *Gonorrhea*
 | * *Cytomegalovirus*
 | * *Hepatitis*
 | * *Herpes*
 |
| * *HPV*
 | * *Syphilis*
 | * *Trichomonas*
 | * *Unknown*
 | * *Other (specify)*
 |
|  |
| **Is client being treated for STDs?** | *Yes**No**Unknown**Declined* | **Is partner being treated for STDs?** | *Yes**No**Unknown**Declined* | **Is client attending childbirth education classes?** | *Yes**No**Unknown*  |
|  |  |  |  |  |  |
| **Provider:** |  | **Signature:** |  | **Date:** |  |