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* | | |
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| **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)* | | | | | | | | | | | | | | |  | | | | | | |
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| **Date of last menses:**  *Not in Signify, needed for charting* | | | | | | |  | | | | | | | | | | | | | **Is client receiving prenatal care?** | | | | | | | | | | | | | | | | | | | | | | | | | | | *Yes* | | | | | | | | *No* | | | | | | | | *Unknown* | |
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| **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* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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)* | | | | | | | | | | | | | | | | |
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| **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* | | | | | | | | |
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| **Provider:** | |  | | | | | | | | | | **Signature:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | | |  | | | | | | | | |