Charleston County SCHOOL DISTRICT excellence is our standard

CCSD Early Head Start

Early Head Start

Pregnancy Health History and Nutrition Screening

Date: _____

Name: _____ DOB: _____

Primary Care Physician: _____ Clinic: _____

Prenatal Care or OBGYN: _____ Clinic: _____

Dentist: _____ Clinic: _____

Insurance:

☐ None ☐ Medicaid # _____ ☐ Private/HMO: _____

Due Date: _____ **Date of last Prenatal exam**: ___/___/___ **Date of last Dental exam** ___/____/___

How many pregnancies have you had prior to this one _____ # of living children/ages: _____/_____ _____/_____

History of Miscarriage or Still-birth: ☐ Yes ☐ No How far along in your pregnancy _____weeks.

Type of complication:	Dates of pregnancy:	Bed rest needed? # of days needed?	Baby born at due date or premature?	Baby weighed?
1				
2				
3				
4				

Have you ever experienced a high-risk pregnancy ☐ Yes ☐ No

Has your Dr. shared concerns that this could be a high-risk pregnancy ☐ Yes ☐ No

Are you currently taking prenatal vitamins ☐ Yes ☐ No Are they prescribed by your Doctor ☐ Yes ☐ No

Names of prescription medications currently taking:	Names of over the counter medications currently taking:
1	1
2	2
3	3
4	4

	What:	How much/how often?	When?
Are you currently smoking?			
Are you currently drinking beer, wine or hard liquor?			
Are you being exposed to 2nd or 3rd hand smoke?			
Have you or are you using recreational or street drugs?			

Have you ever received treatment for substance abuse? ☐ Yes ☐ No

Have you, or are you experiencing any of the following health concerns?

	History of:	Currently:
Asthma	□ Yes □ No	□ Yes □ No
Depression or other Mental Health concerns	□ Yes □ No	□ Yes □ No
Diabetes	□ Yes □ No	□ Yes □ No
Heart Problems	□ Yes □ No	□ Yes □ No
High blood pressure	□ Yes □ No	□ Yes □ No
Seizures	□ Yes □ No	□ Yes □ No
Thyroid disease	□ Yes □ No	□ Yes □ No
Sexually transmitted diseases	□ Yes □ No	□ Yes □ No
Sickle Cell Trait / Disease (circle one)	□Yes □ No	□ Yes □ No

Have you ever received treatment from a Counselor or Mental Health Specialist? ☐ Yes ☐ No

. **How many servings do you eat from the following food groups each day?**

Food Group	No	Yes	If yes, # of servings
Milk, Yogurt & Cheese Group			
Vegetable Group			
Fruit Group			
Meat, Poultry, Fish, Dry Beans, Eggs & Nuts Group			
Bread, Cereal, Rice and Pasta Group			
Fats, Oils and Sweets			
Water City water? _____ Well water? _____			
My favorite food is:			

Are you currently participating in WIC _____ Do you plan to breastfeed ☐ Yes ☐ No

Have you breastfed before ☐ Yes ☐ No Did you have trouble or concerns ☐ Yes ☐ No

If yes, what were your concerns _____

Would you like information about or support with breastfeeding ☐ Yes ☐ No

What did you weigh prior to pregnancy? _____ Height: _____ Current weight: _____

How often do you eat during the day? _____ times. Is this typical? ☐ Yes ☐ No

Are you avoiding or has your Dr. recommended you avoid any foods, and if so what foods _____

Have you, or have you had the desire to eat non-food items like clay, dirt, ice _____

Have you discussed physical activity with your doctor _____

What physical activity do you currently do _____

Signature: _____ Date: _____

Staff Signature: _____ Date: _____