Special Beginnings®

Helping hands for healthy babies

Enrollment Questionnaire

The information you provide is confidential and will not affect your health benefits.
Please answer as accurately as you can so we can help support you during your pregnancy.
Please return the questionnaire, even if you choose to leave some questions unanswered.

_________________________ _________________________ _________________________

First Name Last Name Member ID#

1. Today's date _____ /_____ /_____
2. What is your date of birth? _____ /_____ /_____
3. When is your baby due? _____ /_____ /_____
4. OB Provider ____ Phone__________________

   Address ____

   City ____________________________________ State _____ Zip _______________
5. When was (or will be) your first prenatal visit? _____ /_____ /_____
6. You are expecting: ☐ One Baby ☐ Twins ☐ Triplets
7. Have you had problems with any of the following during your current or previous pregnancy(ies)?

Please check the appropriate box(es)	Current Pregnancy	Previous Pregnancy
Cerclage (cervix was stitched closed)		
Gestational diabetes (diabetes only during your pregnancy)		
Group B Strep infection		
High blood pressure (toxemia, pre-eclampsia, or pregnancy induced hypertension)		
Kidney or bladder infections		
Oligohydramnios (too little fluid surrounding the baby)		
Persistent vomiting		
Placenta previa (placenta lies low in the uterus, partially or completely covering the cervix)		
Polyhydramnios (too much fluid surrounding the baby)		
Premature rupture of membranes		
Preterm labor (labor starts before the 37th week of pregnancy)		
Vaginal bleeding		
Other medical conditions		

8. List all of your previous pregnancies (please attach additional sheet if necessary):

No.	Date	No. of weeks pregnancy lasted	Pregnancy ended by vaginal delivery, cesarean, miscarriage or termination?	Baby's weight	Boy or Girl
	2/15/89	9	Miscarriage (SAMPLE)	Unknown	Unknown
	6/15/93	40	Vaginal delivery (SAMPLE)	6 lbs 2	Boy
1					
2					
3					
4					

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Together, we can take charge.℠

9. List any medications you commonly use (including prescriptions, herbal/homeopathictreatments, over the counter medications such as pain relievers, antihistamines, and vitamins including prenatal vitamins): ______________________________________

____

____

10. Is your blood type Rh negative? ☐ Yes ☐ No

11. What is your height? _______ Pre-pregnancy weight? _______
Weight now? _______

12. How many servings of each food group do you eat during an average day? Breads/Cereals______ Meat/Protein______
Vegetables______ Fats/Oils______ Fruits______
Fluids (8 oz cups)______ Milk/Dairy______

13. Do you exercise on a regular basis? ☐ No ☐ Yes
How many hours per week?______________________________
Which days of the week?______________________________

14. Do you, the father of your baby, or any of your children have a history of any genetic diseases (including, but not limited to, Down Syndrome, spinal cord defects, hemophilia, muscular dystrophy, etc.)? ☐ No ☐ Yes (list condition) ______________

____

Who?
☐ You ☐ Baby's father ☐ Your Child(ren) ☐ I don't know

15. Did your mother take DES (Diethylstilbestrol; was used until 1971 to prevent miscarriages) while she was pregnant with you?
☐ Yes ☐ No ☐ I don't know

16. Do you have a history of any of the following when you're not pregnant (check all that apply):
- ☐ Allergies ______________________________________
  ____
- ☐ Anemia (needing treatment) ______________________
- ☐ Anxiety
- ☐ Asthma
- ☐ Depression
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Eating disorder______________________________
- ☐ Heart disease (treatment) ______________________
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Herpes ☐ Mouth ☐ Genitals
- ☐ High blood pressure What is normal for you? _________
- ☐ HIV Positive
- ☐ Hospitalized for mental health condition______________
- ☐ Infertility ______________________________________
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Seizure disorder (treatment)
- ☐ Sexually transmitted disease ___________________
- ☐ Surgery (list) ______________________________________
  ____
- ☐ Thrombophlebitis (blood clots in your legs)
- ☐ Uterine fibroids and or abnormalities
- ☐ Other______________________________________
- ☐ None of the above

17. Have you had chickenpox or the vaccine for chickenpox?
☐ Yes ☐ No

18. Do you smoke? ☐ Yes ☐ Less than 1 pack per day
☐ More than 1 pack per day ☐ No
☐ Someone else in my household smokes

19. Since you've known you are pregnant, how many alcoholic beverages do you drink each week, if any?
☐ None ☐ 1 to 2 drinks ☐ more than 2 drinks

20. Since you've known you are pregnant, have you used any recreational drugs (e.g. cocaine, marijuana, etc.)?
☐ No ☐ Yes (please list) ______________________________

21. Abuse during pregnancy carries a higher risk of prematurity and is more common than most people realize. Abuse is defined as being hit, slapped, kicked, forced to have sex, or otherwise physically hurt by anyone. During the past year have you suffered any type of abuse? ☐ Yes ☐ No

22. Rate your overall stress level on a scale of 1-10 (1 Low – 10 High)
____

23. Which of the following best describes your current support system (check all that apply)? ☐ Spouse/Partner ☐ Family ☐ Friends
☐ Club/Organization ☐ Church ☐ None ☐ Other______

24. What is your marital status? ______________________

25. What is your ethnic origin?
☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Native American ☐ Other ______________________

26. What is the highest grade level you have completed? _________

27. Are you currently employed? ☐ No ☐ Yes
How many hours per week? ________________

28. What is the best way for us to reach you during the day?
☐ By phone__________________________ work/home/cell (circle)
☐ By e-mail _________________________@__________________

To protect your privacy, we will not share your personal information with anyone else when calling the number listed above unless you return the signed **Authorization to disclose protected health information** form included in this mailing that indicates who we have permission to talk to. Thank you for taking the time to respond to our questionnaire. We encourage your questions and concerns, and look forward to working with you throughout your pregnancy.

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