nh healthy families Pregnancy Form

This form is confidential. If you have any problems or questions, please call **1-866-769-3085** (TDD/TTY 1-855-742-0123).

Are You Pregnant?* Yes ☐ No ☐ If you are pregnant, please continue to answer all the questions. Return the form in the envelope provided. We may call you if we find that you are at risk for problems with your pregnancy.

***Required Field**

Medicaid ID #:* Today's Date: (mmddyyyy)

Your First Name:* Your Birth Date:* (mmddyyyy)

Your Last Name:*

Mailing Address:

City: State: Zip Code:

Home Phone: - - Cell Phone: - -

Would you like to receive text messages about pregnancy and newborn care? Yes ☐ No ☐
If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe.

Email Address:

Your OB Provider's Name:

Your Due Date*: (mmddyyyy)

Primary insurance (for mom or baby) other than Medicaid? Yes ☐ No ☐

Race/Ethnicity (place a thick X in each box that applies) White ☐ Black/African American ☐

Hispanic/Latina ☐ American Indian/Native American ☐ Asian ☐ Hawaiian/Pacific Islander ☐

Other ☐ If other ethnicity, please specify

Preferred Language (if other than English)

Planning to breastfeed? Yes ☐ No ☐ If no, what is the reason?

Pediatrician chosen? Yes ☐ No ☐ Pediatrician Name

Number of Full Term Deliveries Number of Miscarriages Height ' "

Number of Preterm Deliveries Number of Stillbirths Pre-Pregnancy Weight

Do you have any of the following?* Yes ☐ No ☐ If yes, place a thick X in each box that applies.

Your Medical History

Previous preterm delivery (<37 weeks)? ☐
(A delivery more than three weeks early.)

Recent delivery within past 12 months? ☐

Was delivery within past 6 months? ☐

Previous C-Section? ☐

Current Pregnancy History

Preterm labor this pregnancy? ☐

Current gestational diabetes? ☐

Current twins? ☐

Current triplets? ☐

Currently having severe morning sickness? ☐

Your First Name:*

Your Birth Date:* (mmddyyyy)

Your Last Name:*

Diabetes (prior to pregnancy)? _____

Sickle Cell? _____

Asthma? _____

If yes, are asthma symptoms worse during pregnancy? _____

High Blood Pressure (prior to pregnancy)? _____

Previous neonatal death or stillborn? _____

HIV positive? HIV negative? Testing refused?

AIDS? _____

Thyroid problems? _____

Seizure disorder? _____

Seizure within the last 6 months? _____

Previous alcohol or drug abuse? _____

Current mental health concerns? _____

List:

Current STD? List

Current tobacco use? Amount

If yes, are you interested in quitting smoking? _____

Current alcohol use? Amount

Current street drug use? _____

Taking any prescription drugs (other than prenatal vitamins?) List

Any hospital stays this pregnancy? _____

Do you have enough food? Yes No

Do you lack reliable phone access? Yes No

Are you enrolled in WIC? Yes No

Are you homeless or living in a shelter? Yes No

Do you have problems getting to your doctor visits? Yes No

Do you feel unsafe in your home? Yes No

Please list any other social needs you may have:

Please list anything else you would like to tell us about your health: