Help Me Grow Home Visiting
Prenatal Screen

Family Name_____ OCHIDS # _____

Instructions: Complete at enrollment or prior to the due date, if the family is enrolled prenatally. If a caregiver other than the mother completes, some of the responses may be unknown.

Prenatal Health

Has the mother attended her first prenatal care appointment? ☐ Yes ☐ No If yes, when: _____ Provider name: _____ If no: ☐ Scheduled ☐ Not scheduled	Does the mother have any barriers to attending her prenatal care appointments? ☐ Yes ☐ No If yes, what? (check all that apply) ☐ Transportation ☐ Childcare ☐ Work schedule ☐ Financial/Insurance
What is the mother's delivery/birth plan? (check all that apply) ☐ Transportation during labor ☐ Home delivery ☐ Doula ☐ Midwife ☐ Birthing coach ☐ Hospital birthing center ☐ None	Does the mother plan to have someone with her: During labor: ☐Yes ☐ No When she comes home? ☐ Yes ☐ No
If the mother has had a pregnancy before, were there any problems? (check all that apply) ☐ Miscarriage ☐ Still Birth ☐ Preterm birth ☐ Infant death ☐ Low birth weight ☐ I have not had a pregnancy before	If the mother identified any of the previous birth problems, was information provided about Progesterone provided by their medical provider during this pregnancy? ☐ Yes ☐ No
Has the mother been offered information about the benefits of testing for HIV and other STI's? ☐ Yes ☐ No	Has the mother ever breastfed before? ☐ Yes ☐ No
How does she plan to feed the baby? (select one) ☐Breastfeeding only ☐Formula only ☐ Breastfeeding and formula	Does the mother have a dental provider? ☐ Yes ☐No
Does the mother take folic acid daily? ☐ Yes ☐ No	Does the mother take vitamins? ☐ Yes ☐No
In the month before the mother knew she was pregnant, how much beer, wine, liquor did she drink? (select one) ☐ None ☐ Unknown ☐ Any	Has the mother had a problem with drugs or alcohol in the past? ☐ Yes ☐ No
Did the mother consider one of her parents to be an addict or alcoholic? ☐ Yes ☐ No	Did the mother's partner have a problem with drugs or alcohol? ☐ Yes ☐ No

Has the mother ever been treated by a health care provider for any of the following?

Condition	Outside of Pregnancy	Previous Pregnancy	Current Pregnancy	None	Unknown (if not completed by the mother)
Anxiety	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes (Type 1)	☐	☐	☐	☐	☐
Diabetes (Type 2)	☐	☐	☐	☐	☐
Gestational Diabetes	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Sexually Transmitted	☐	☐	☐	☐	☐
Substance Abuse (AOD)	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐