



PRENATAL RISK SCREEN

Today's Date: _____

If you do not want to participate in the screening process, please complete the patient information section only and sign below:

Signature: _____ Date: _____

PATIENT INFORMATION	Name: First _____ Last _____ M.I. _____	Social Security Number: XXX-XX- _____	Date of Birth (mo/day/yr): _____	17. Age: <input type="checkbox"/> ₁ <18
	Street address (apartment complex name/number): _____	County: _____	City: _____ State: _____	Zip Code: _____
	Prenatal Care covered by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance _____ <input type="checkbox"/> No Insurance <input type="checkbox"/> Other _____	Best time to contact me: _____	Phone #1 _____	Phone #2 _____

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)

	YES	NO	
1. Have you graduated from high school or received a GED?	<input type="checkbox"/>	<input type="checkbox"/> ₁	11. What race are you? Check one or more. <input type="checkbox"/> White <input type="checkbox"/> ₃ Black <input type="checkbox"/> Other _____ 12. In the last month, how many alcoholic drinks did you have per week? _____ drinks ₁ <input type="checkbox"/> did not drink 13. In the last month, how many cigarettes did you smoke a day? (a pack has 20 cigarettes) _____ cigarettes ₁ <input type="checkbox"/> did not smoke 14. Thinking back to just before you got pregnant, did you want to be.....? <input type="checkbox"/> pregnant now <input type="checkbox"/> pregnant later <input type="checkbox"/> ₁ not pregnant 15. Is this your first pregnancy? <input type="checkbox"/> ₂ Yes <input type="checkbox"/> No If no, give date your last pregnancy ended: Date: (month/year) _____ 16. Please mark any of the following that have happened. <input type="checkbox"/> ₃ Had a baby that was not born alive <input type="checkbox"/> ₃ Had a baby born 3 weeks or more before due date <input type="checkbox"/> ₃ Had a baby that weighed less than 5 pounds, 8 ounces <input type="checkbox"/> None of the above
2. Are you married now?	<input type="checkbox"/>	<input type="checkbox"/> ₁	
3. Are there any children at home younger than 5 years old?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are there any children at home with medical or special needs?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is this a good time for you to be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
6. In the last month, have you felt down, depressed or hopeless?	<input type="checkbox"/> ₁	<input type="checkbox"/>	
7. In the last month, have you felt alone when facing problems?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you ever received mental health services or counseling?	<input type="checkbox"/>	<input type="checkbox"/>	
9. In the last year, has someone you know tried to hurt you or threaten you?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Do you have trouble paying your bills?	<input type="checkbox"/>	<input type="checkbox"/>	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ Date: _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

PROVIDER ONLY	LMP (mo/day/yr): _____	EDD (mo/day/yr): _____	18. Pre-Pregnancy: Wt: _____ lbs. Height: _____ ft. _____ in. BMI: _____	<input type="checkbox"/> ₁ < 19.8 <input type="checkbox"/> ₂ > 35.0
	Provider's Name: _____	Provider's ID: _____	19. Pregnancy Interval Less Than 18 Months? <input type="checkbox"/> N/A <input type="checkbox"/> No	<input type="checkbox"/> ₁ Yes
	Provider's Phone Number: _____	Provider's County: _____	20. Trimester at 1st Prenatal Visit? _____	<input type="checkbox"/> ₁ 2nd
	Healthy Start Screening Score: _____	Check One: <input type="checkbox"/> Referred to Healthy Start. If score <6, specify: _____ <input type="checkbox"/> Not Referred to Healthy Start.		
	Provider's/Interviewer's Signature and Title _____			Date (mo/day/yr) _____