WCMCA, INC. HEAD START
411 Industrial Park Blvd, Elbow Lake MN 56531
218-685-4486/Fax: 218-685-6747

PRENATAL HEALTH HISTORY

Name: _____ D.O.B: _____ FES: _____

What is your expected delivery date?
Is this a high-risk pregnancy?
Date of last dental exam?
Date you first received prenatal care?
Date of last prenatal visit?
When is your postpartum visit scheduled?
Who is your prenatal care provider?

Have you received?

Prenatal Health Care? Yes No	Education on the Importance of Nutrition? Yes No
Postpartum Health Care? Yes No	Education on Infant Care and Safe Sleep Practices? Yes No
Professional Oral Assessment, Exam and/or Treatment? Yes No	Education on Risks of Alcohol, Drugs, and/or Smoking? Yes No
Mental Health Interventions and Follow up? Yes No	Facilitating Access to Substance Abuse Treatment? Yes No
Prenatal Education of Fetal Development? Yes No	Receiving Early Head Start Services at Time of Birth? Yes No
Information on the Benefits of Breastfeeding? Yes No	Will your infant be enrolled in our program after birth? Yes No

Have you had any of the following complications?	**Current Pregnancy**	**Previous Pregnancy**
Anemia		
Bleeding		
C-section		
Diabetes		
Fatigue		
Headache		
Hypertension		
Miscarriage		
Neonatal Death		
Pain		
Pre-Term Labor		
Pregnancy Induced Diabetes		
Pregnancy Induced Hypertension		
Sickle Cell		
Swelling		

Are you currently on bed rest? Yes No

If yes, why? _____ **For how long?** _____

Have you been on bed rest for previous pregnancies? Yes No

If yes, why? _____ **For how long?** _____

Signature: _____ **Date:** _____