Healthy Start Prenatal Outcomes

Mother's Name: _____ DOB: _____
(First, Last)

Mother's Medicaid #:_____ **Mother's Social Security #**:_____

Race/Ethnicity: ____ Black ____White ____ Hispanic ____Other (specify) _____

Address: _____ City _____ State _____ Zip Code _____

Estimated Date of Delivery: ___ month ___day ___year

*** Child with a Permanent Medical Home:** ___Undecided ___Yes ___No

*** Healthy Start Woman Post-Partum Visit/Exam:** ___Unknown ___Yes ___No

*** Post Partum Contraception:** ___Unknown ___Yes ___No

*** With Primary Care Provider:** ___Unknown ___None ___Primary HealthCare Provider ____HealthCare Provider Specialist

***Prenatal Care Entry:** ___ Unknown ___ None ___ 1st trimester ___2nd trimester ___3rd trimester

***Alcohol Use Status During Pregnancy:** ___ Unknown ___Never ___ Continued ___Reduced ___Discontinued

***Schedule I or II Drug During Pregnancy:** ___ Unknown ___Never ___ Continued ___Reduced ___Discontinued

***Tobacco Use Status During Pregnancy:** ___ Unknown ___Never ___ Continued ___Reduced ___Discontinued

* **Second Hand Smoke Exposure During Pregnancy:** ___ Unknown ___Never ___ Continued ___Reduced ___Discontinued

* **Breastfeeding:** ___ Unknown ___Did not breastfeed ___ Exclusively breastfed ___Combination of breast milk and formula

* **Breastfeeding Duration:** ___ Unknown ___1 Day to 3 Weeks ___ 4 to 6 Weeks ___Still Breastfeeding

Health Insurance? ___Medicaid ___ Private Insurance ___ No insurance

Social Support: (check all that apply) **___**Father of Baby ___Family ___Friends ___ No Support

Care Coordinator's Name: _____ Care Coordinator Signature: _____
Date Form Completed: _____ Care Service Site: _____