Healthy Start Pregnancy History Screening Tool | August 2016

OMB #: 0915-0338
Expiration Date: XX/XX/XXXX

Name: _____

Completed by: _____ **Date of Administration:** _____

This screening tool should be completed with all women seeking Healthy Start services.
Some key aims of this screening tool:

- **Assess woman's current pregnancy status**
- **Document previous pregnancy history**
- **Identify risks from previous pregnancy(s) which may impact future pregnancy**

The questions and answer choices were selected based on the available evidence about factors that may impact a woman's health or pregnancy outcomes. The information provided by the participant through this screening tool will help Healthy Start identify each participant's unique needs and ensure that she is connected to the appropriate support services.

Please read the questions to the participant. Only read the responses to the participant if the instructions for any question tells you to do so.

Please read the following statement to the participant: *Thank you for taking time to complete this interview. Any information you provide will be kept confidential to the extent allowed by law. You do not have to answer any question you do not want to, and you can end the interview at any time.*

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1. ***Are you pregnant now?***

   Select one only.

   € Yes (Go to question 1.1 AND **Complete the Prenatal Screening Tool)**
   € No (Go to question 2)
   € Don't know (Go to question 2)
   € Declined to answer (Go to question 2)

   1.1 How many weeks or months pregnant are you now?

   STAFF: Please enter a number of weeks or months.

   _____Weeks OR _____Months

   € Don't know
   € Declined to answer

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2. ***How many times have you been pregnant in your life? Include those that ended in live birth, miscarriage, stillbirth or fetal death, abortion, and ectopic or tubal pregnancy.***

Staff: The following information is for your reference only:

- Live Birth: a birth at which a child is born alive
- Miscarriage: a loss of pregnancy before the 20th week of pregnancy
- Stillbirth or fetal death: a loss of pregnancy after the 20th week of pregnancy
- Abortion: a procedure to end a pregnancy
- Ectopic or tubal pregnancy: when a fertilized egg implants somewhere outside of the uterus, usually in the fallopian tube

Please enter the number of pregnancies.

_____PREGNANCIES (If participant has had any pregnancies, go to question 3)

€ Don't know

€ Declined to answer

IF PARTICIPANT HAS HAD NO PREVIOUS PREGNANCIES, THIS SCREENING TOOL IS COMPLETE.

3. Please tell me how your previous pregnancies ended.

STAFF: PLEASE READ OUT LOUD the following responses: Live birth, miscarriage, ectopic or tubal pregnancy, abortion, or fetal death or stillbirth, and enter type for each pregnancy. For any live birth and fetal death / stillbirth, please indicate how many babies for each type of pregnancy, and the date of birth.

	Live Birth	Miscarriage	Ectopic or Tubal pregnancy	Abortion	Fetal Death/Stillbirth
Pregnancy 1	# ____ Date: __ / __ / ____				# ____ Date: __ / __ / ____
Pregnancy 2	# ____ Date: __ / __ / ____				# ____ Date: __ / __ / ____
Pregnancy 3	# ____ Date: __ / __ / ____				# ____ Date: __ / __ / ____
Pregnancy 4	# ____ Date: __ / __ / ____				# ____ Date: __ / __ / ____

Last updated 8/31/16 Developed by the Healthy Start CoIIN, with technical support from the Healthy Start EPIC Center, JSI, and funding from the Health Resources and Services Administration, Maternal and Child Health Bureau grant #UF5MC268450103.

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Pregnancy 5	# ____ Date: __ / __ / ____				# ____ Date: __ / __ / ____

DO NOT READ OUT LOUD:

- € Declined to answer

STAFF:
If participant has had **any live births**, continue to question 4.
If participant has had **only** miscarriage, ectopic or tubal pregnancies, or abortion (**and no live births**) the **TOOL IS COMPLETE**.

4. Did you ever have a baby by cesarean delivery or c-section (when a doctor cuts through the mother's belly to bring out the baby)?

- € Yes
- € No
- € Don't know
- € Declined to answer

5. Did you have any problems or complications with any of your past pregnancies?

Select one only.

- € Yes (Go to question 5.1)
- € No (Go to question 6)
- € Don't know (Go to question 6)
- € Declined to answer (Go to question 6)

5.1 Which of the following problems did you have during your most recent pregnancy?

Select all that apply.

- € Vaginal bleeding
- € Kidney or bladder (urinary tract) infection (UTI)
- € Severe nausea, vomiting, or dehydration that sent me to the doctor or hospital
- € Cervix had to be sewn shut (cerclage for incompetent cervix)
- € High blood pressure, hypertension (including pregnancy-induced hypertension [PIH]), preeclampsia, or toxemia
- € Problems with the placenta (such as abruptio placentae or placenta previa)
- € HIV, Herpes, or HPV
- € Labor pains more than 3 weeks before my baby was due (preterm or early labor)
- € Water broke more than 3 weeks before my baby was due (premature rupture of membranes [PROM])
- € I had to have a blood transfusion
- € I was hurt in a car accident

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€ Other: please specify:_____

€ Declined to answer

6. Were any of your babies born more than 3 weeks before his or her due date?

Select one only.

€ Yes, please specify how many: _____
€ No
€ Don't know
€ Declined to answer

7. Did any of your babies weigh less than 5 pounds, 8 ounces at birth?

Select one only.

€ Yes, please specify how many: _____
€ No
€ Don't know
€ Declined to answer

8. Did any of your babies stay in the hospital after you came home?

Select one only.

€ Yes, Please specify reason:_____
€ No
€ Declined to answer

9. Are all of your children living with you?

Select one only.

€ Yes
€ No
€ Declined to answer

The Healthy Start Pregnancy History Screening Tool is Complete

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