INLAND EMPIRE HEALTH PLAN
INITIAL PERINATAL RISK ASSESSMENT

DATE_____ MEMBER NAME_____

AGE_____ EDC: _____ IEHP MEMBER NUMBER_____

(Note: Medical history and anthropometric information is available on OB-Medical History forms.)
(Note: Complete Diet Recall at this time if not already completed.)

Please answer the following questions by marking a √ in the ☐or by writing in the blank space

STATUS

1. What languages do you speak? ☐ English ☐ Spanish Other_____ — 1. ☐L ☐ M ☐ H
2. What languages do you read? ☐ English ☐ Spanish Other_____ — 2. ☐L ☐ M ☐ H
3. How many years of school have you finished? _____years — 3. ☐L ☐ M ☐ H
4. Do you have a job? ☐ Yes ☐ No What kind of work?_____ — 4. ☐L ☐ M ☐ H
5. Does your partner have a job? ☐ Yes ☐ No What kind of work?_____ — 5. ☐L ☐ M ☐ H
6. Are you on a special diet? ☐ Yes ☐ No If you are on a special diet, what kind? — 6. ☐L ☐ M ☐ H
   Weight loss ☐ low fat /low cholesterol ☐ low salt ☐ diabetic
   Other_____
7. Are you a vegetarian? ☐ Yes ☐ No — 7. ☐L ☐M ☐ H
   If yes, do you use milk products (milk, cheese, yogurt) and /or eggs? ☐ Yes ☐ No
8. Are you allergic to any foods, or do you try not to eat any foods?
   ☐ Yes ☐ No If yes, what_____ — 8. ☐L ☐M ☐ H
9. How many cups, glasses or cans of these do you drink every day? — 9. ☐L ☐M ☐ H
   water_____ milk_____ juice_____ diet soda_____ punch/kool aid_____
   coffee_____ tea _____ soda _____
10. How many times a day do you usually eat (including snacks)?_____ — 10. ☐L ☐M ☐ H
11. Do you have — 11. ☐L ☐M ☐ H
    - nausea ☐ Yes ☐ No How often?_____
    - vomiting ☐ Yes ☐ No How often?_____
    - poor appetite ☐ Yes ☐ No How often?_____
    - weight loss ☐ Yes ☐ No How many pounds?_____
    - diarrhea ☐ Yes ☐ No How often?_____
    - constipation ☐ Yes ☐ No How often?_____
    - heartburn ☐ Yes ☐ No How often?_____
    - ☐ other _____
12. What home remedies, food supplements, or herbs are you taking? — 12. ☐L ☐M ☐ H
    - Ginseng ☐ Yes ☐ No How often?_____
    - Ma Huang (Ephedra) ☐ Yes ☐ No How often?_____
    - Manzanilla (Chamomile) ☐ Yes ☐ No How often?_____
    - Hierba buena (Peppermint)☐ Yes ☐ No How often?_____
    - ☐ other _____
13. During this pregnancy, have you eaten — 13. ☐L ☐M ☐ H
    - maicena (cornstarch) ☐ Yes ☐ No How often?_____
    - laundry starch ☐ Yes ☐ No How often?_____
    - dirt or clay ☐ Yes ☐ No How often?_____
    - paste or plaster ☐ Yes ☐ No How often?_____
    - freezer frost ☐ Yes ☐ No How often?_____
    - ☐ other _____
14. During this pregnancy, are you taking — 14. ☐L ☐M ☐ H
    - aspirin ☐ Yes ☐ No How often?_____
    - cold medicine ☐ Yes ☐ No How often?_____
    - allergy/sinus medicine ☐ Yes ☐ No How often?_____
    - diet pills ☐ Yes ☐ No How often?_____
    - prenatal vitamins ☐ Yes ☐ No How often?_____
    - other vitamins ☐ Yes ☐ No How often?_____
    - iron pills ☐ Yes ☐ No How often?_____
    - ☐ other _____

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PROVIDER INFORMATION:

Provider Name:_____ IEHP Provider Number:_____

STATUS

15. How do you plan to feed your new baby? ☐ Breast ☐ Bottle ☐ Both ☐ not sure — 15. ☐ L ☐ M ☐ H
16. Have you breastfed a baby before? ☐ Yes ☐ No — 16. ☐ L ☐ M ☐ H
17. a. Where are you living right now? ☐ House ☐ Apartment ☐ Motel
☐ in a friend's house or apartment ☐ Car ☐ Street ☐ other_____ — 17. ☐ L ☐ M ☐ H
How long have you lived there?_____

18. How many people live with you? — 18. ☐ L ☐ M ☐ H
☐ no one ☐ 1-3 others ☐ 4-6 others ☐ 7 or more others
Who lives with you?
☐ live alone ☐ husband/partner ☐ parents ☐ in-laws
☐ your children ☐ other's children ☐ friends ☐ other family
How many children are in your household?_____

19. If you are worried about something, who do you talk to ? — 19. ☐ L ☐ M ☐ H
☐ partner/husband ☐ parents ☐ grandparents ☐ other relatives
☐ friend ☐ other person_____

20. Do you have (√☐if yes) — 20. ☐ L ☐ M ☐ H
☐ electricity ☐ hot water ☐ refrigerator ☐ stove or oven
☐ transportation ☐ telephone ☐ heating

21. Are you usually able to (√☐if yes) — 21. ☐ L ☐ M ☐ H
☐ buy enough food ☐ pay rent ☐ pay other bills

22. Have you ever had trouble finding a doctor, or getting medical help for yourself or your family? ☐ Yes ☐ No — 22. ☐ L ☐ M ☐ H
If yes, please explain_____

23. Are you on the WIC (Women, Infants & Children) Program? ☐ Yes ☐ No — 23. ☐ L ☐ M ☐ H
24. Do you have an infant car seat? ☐ Yes ☐ No — 24. ☐ L ☐ M ☐ H
25. Do you use you car seat belt? ☐ Yes ☐ No — 25. ☐ L ☐ M ☐ H
26. Was your pregnancy planned? ☐ Yes ☐ No — 26. ☐ L ☐ M ☐ H
27. How does the baby's father feel about this pregnancy? — 27. ☐ L ☐ M ☐ H
☐ doesn't care ☐ doesn't know ☐ angry ☐ happy ☐ sad ☐ other_____
28. How do you feel about this pregnancy? — 28. ☐ L ☐ M ☐ H
☐ don't care ☐ angry ☐ happy ☐ sad ☐ other_____
29. Have you ever had any of the following? — 29. ☐ L ☐ M ☐ H
☐ Miscarriage ☐ abortion ☐ stillbirth ☐ fetal demise
☐ neonatal death ☐ premature birth ☐ none
When did it happen?_____

What/who helped you get through this?_____

30. Do you have any traditional, cultural, or religious customs about pregnancy or childbirth you would like supported? ☐ Yes ☐ No — 30. ☐ L ☐ M ☐ H
31. Since becoming pregnant, which of the following have you had? (√☐if yes) — 31. ☐ L ☐ M ☐ H
☐ problem sleeping ☐ excessive worrying ☐ crying ☐ depression
☐ sadness ☐ none ☐ other_____
32. Are you taking medicine for your nerves?
☐ Yes ☐ No Name of Medicine_____ — 32. ☐ L ☐ M ☐ H
33. What two problems in your life cause you the most trouble? — 33. ☐ L ☐ M ☐ H
1. _____ 2._____

34. Have you ever thought about, planned, or tried to hurt yourself? ☐ Yes ☐ No — 34. ☐ L ☐ M ☐ H

35. Have you ever thought about, planned, or tried to hurt someone else? ☐ Yes ☐ No — 35. ☐ L ☐ M ☐ H
36. In the past year, have you been slapped, hit, kicked, or otherwise physically hurt be someone? — 36. ☐ L ☐ M ☐ H
☐ Yes ☐ No
By whom? (Check all that apply)
☐ partner/husband ☐ ex-husband ☐ parent
☐ step-parent ☐ stranger ☐ brother/sister

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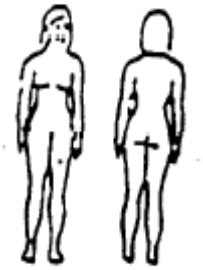
☐ other_____ # times hurt_____



STATUS

37. On this picture mark the area of the body where you have been hurt. — 37. ☐ L ☐ M ☐

38 .For how many months or years have you been hurt by this person?_____ — 38. ☐ L ☐ M ☐ H
☐ Not applicable

39. How many cigarettes do you smoke each day? — 39. ☐ L ☐ M ☐ H
☐ don't smoke ☐ less than ½ pack ☐ ½ pack ☐ ½ to 1 pack
☐ 1-2 packs ☐ 2-3 packs more than 3 packs

40. Do you live with anyone who smokes? ☐ Yes ☐ No — 40. ☐ L ☐ M ☐ H

41. Check all that apply:
a. Does the father of your baby use drugs or drink alcohol? ☐ Yes ☐ No — 41a. ☐ L ☐ M ☐ H
Do/did your parents use drugs or drink alcohol? ☐ Yes ☐ No
Do/did you have friends who use drugs or drink alcohol? ☐ Yes ☐ No

b. What drugs did you use before this pregnancy? — 41b. ☐ L ☐ M ☐ H
☐ cocaine ☐ marijuana ☐ speed, methamphetamines ☐ PCP
☐ heroin ☐ none ☐ other_____

c. How often do you drink beer, wine, or liquor? — 41c. ☐ L ☐ M ☐ H
☐ daily ☐ weekends ☐ 1-2 times a month ☐ rarely or never
Have your alcohol habits changed since you became pregnant?
☐ Yes ☐ No If yes, how?_____

42. Have you received counseling on HIV (AIDS) in pregnancy? ☐ Yes ☐ No — 42. ☐ L ☐ M ☐ H

43. Tell us what you know about and want to learn about: — 43. ☐ L ☐ M ☐ H

Already Know	Like to Know		Already Know	Like to Know	
☐	☐	Child Care	☐	☐	Breastfeeding
☐	☐	Hospital Tour	☐	☐	Infant Feeding
☐	☐	Labor & Delivery	☐	☐	Baby Care
☐	☐	Sexual Abuse	☐	☐	Exercise
☐	☐	Circumcision	☐	☐	Stop Smoking
☐	☐	Substance Abuse	☐	☐	Domestic Violence
☐	☐	How Your Baby Grows	☐	☐	Sexually Transmitted Disease
☐	☐	Making Children Behave	☐	☐	Body Changes During Pregnancy
☐	☐	Car Seat Safety	☐	☐	Other_____
☐	☐	Signs of Preterm Labor			

44. a. How do you learn new things best? (Please check all that apply) — 44a. ☐ L ☐ M ☐ H
_____read _____watch video _____talk one-to-one
_____go to class _____Pictures or diagrams _____Demonstration
Other _____

b. Do you have any problems with hearing, seeing, or depression that will make it hard for you to learn new things? ☐ Yes ☐ No — 44b. ☐ L ☐ M ☐ H
If yes, please explain_____

45. a. Will you have any problems coming to prenatal classes? ☐ Yes ☐ No — 45a. ☐ L ☐ M ☐ H
☐ H If yes, please explain_____

b. Who can come to prenatal classes with you?_____ — 45b. ☐ L ☐ M ☐ H
things (goals) you would like to work on during this pregnancy.

46. List one or two things (goals) you would like to work on during this pregnancy — 46. ☐ L ☐ M ☐ H
1. _____
2. _____

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If patient assisted by staff to complete assessment tool
Assessment Tool Completed by:

Name_____ Title_____ Date_____

Assessment Reviewed by:

Name (OB)_____ Title_____ Date_____

Name (H.E.)_____ Title_____ Date_____

Name (Nut.)_____ Title_____ Date_____

Name (Psych. Soc.)_____ Title_____ Date_____

2nd Trimester reassessment completed by:

Name (OB) _____ Title _____ Date _____

Name (H.E.) _____ Title _____ Date _____

Name (Nut.) _____ Title _____ Date _____

Name (Psych. Soc.) _____ Title _____ Date _____

3rd Trimester assessment completed by:

Name (OB) _____ Title _____ Date _____

Name (H.E.) _____ Title _____ Date _____

Name (Nut.) _____ Title _____ Date _____

Name (Psych. Soc.) _____ Title _____ Date _____

Postpartum assessment completed by:

Name (OB) _____ Title _____ Date _____

Name (H.E.) _____ Title _____ Date _____

Name (Nut.) _____ Title _____ Date _____

Name (Psych. Soc.) _____ Title _____ Date _____