

Enrollment Questionnaire

The information you provide is confidential and will not affect your health benefits. Please answer as accurately as you can so we can help support you during your pregnancy. Please return the questionnaire, even if you choose to leave some questions unanswered.

 First Name Last Name Member ID#

1. Today's date ____ / ____ / ____
2. What is your date of birth? ____ / ____ / ____
3. When is your baby due? ____ / ____ / ____
4. OB Provider _____ Phone _____
 Address _____
 City _____ State ____ Zip _____
5. When was (or will be) your first prenatal visit? ____ / ____ / ____
6. You are expecting: One Baby Twins Triplets
7. Have you had problems with any of the following during your current or previous pregnancy(ies)?

Please check the appropriate box(es)	Current Pregnancy	Previous Pregnancy
Cerclage (cervix was stitched closed)		
Gestational diabetes (diabetes only during your pregnancy)		
Group B Strep infection		
High blood pressure (toxemia, pre-eclampsia, or pregnancy induced hypertension)		
Kidney or bladder infections		
Oligohydramnios (too little fluid surrounding the baby)		
Persistent vomiting		
Placenta previa (placenta lies low in the uterus, partially or completely covering the cervix)		
Polyhydramnios (too much fluid surrounding the baby)		
Premature rupture of membranes		
Preterm labor (labor starts before the 37th week of pregnancy)		
Vaginal bleeding		
Other medical conditions		

8. List all of your previous pregnancies (please attach additional sheet if necessary):

No.	Date	No. of weeks pregnancy lasted	Pregnancy ended by vaginal delivery, cesarean, miscarriage or termination?	Baby's weight	Boy or Girl
	2/15/89	9	Miscarriage (SAMPLE)	Unknown	Unknown
	6/15/93	40	Vaginal delivery (SAMPLE)	6 lbs 2	Boy
1					
2					
3					
4					

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9. List any medications you commonly use (including prescriptions, herbal/homeopathic treatments, over the counter medications such as pain relievers, antihistamines, and vitamins including prenatal vitamins): _____

10. Is your blood type Rh negative? Yes No

11. What is your height? _____ Pre-pregnancy weight? _____
Weight now? _____

12. How many servings of each food group do you eat during an average day? Breads/Cereals _____ Meat/Protein _____
Vegetables _____ Fats/Oils _____ Fruits _____
Fluids (8 oz cups) _____ Milk/Dairy _____

13. Do you exercise on a regular basis? No Yes
How many hours per week? _____
Which days of the week? _____

14. Do you, the father of your baby, or any of your children have a history of any genetic diseases (including, but not limited to, Down Syndrome, spinal cord defects, hemophilia, muscular dystrophy, etc.)? No Yes (list condition) _____

Who?

You Baby's father Your Child(ren) I don't know

15. Did your mother take DES (Diethylstilbestrol; was used until 1971 to prevent miscarriages) while she was pregnant with you?
 Yes No I don't know

16. Do you have a history of any of the following when you're not pregnant (check all that apply):
 Allergies _____

Anemia (needing treatment) _____

Anxiety

Asthma

Depression

Diabetes Type I Type II

Eating disorder _____

Heart disease (treatment) _____

Hepatitis A B C

Herpes Mouth Genitals

High blood pressure What is normal for you? _____

HIV Positive

Hospitalized for mental health condition _____

Infertility _____

Lupus

Multiple Sclerosis

Seizure disorder (treatment)

Sexually transmitted disease _____

Surgery (list) _____

Thrombophlebitis (blood clots in your legs)

Uterine fibroids and or abnormalities

Other _____

None of the above

17. Have you had chickenpox or the vaccine for chickenpox?

Yes No

18. Do you smoke? Yes Less than 1 pack per day

More than 1 pack per day No

Someone else in my household smokes

19. Since you've known you are pregnant, how many alcoholic beverages do you drink each week, if any?

None 1 to 2 drinks more than 2 drinks

20. Since you've known you are pregnant, have you used any recreational drugs (e.g. cocaine, marijuana, etc.)?

No Yes (please list) _____

21. Abuse during pregnancy carries a higher risk of prematurity and is more common than most people realize. Abuse is defined as being hit, slapped, kicked, forced to have sex, or otherwise physically hurt by anyone. During the past year have you suffered any type of abuse? Yes No

22. Rate your overall stress level on a scale of 1-10 (1 Low – 10 High)

23. Which of the following best describes your current support system (check all that apply)? Spouse/Partner Family Friends
 Club/Organization Church None Other _____

24. What is your marital status? _____

25. What is your ethnic origin?

African American Asian Caucasian Hispanic

Native American Other _____

26. What is the highest grade level you have completed? _____

27. Are you currently employed? No Yes

How many hours per week? _____

28. What is the best way for us to reach you during the day?

By phone _____ work/home/cell (circle)

By e-mail _____ @ _____

To protect your privacy, we will not share your personal information with anyone else when calling the number listed above unless you return the signed **Authorization to disclose protected health information** form included in this mailing that indicates who we have permission to talk to. Thank you for taking the time to respond to our questionnaire. We encourage your questions and concerns, and look forward to working with you throughout your pregnancy.



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