

Pregnancy Form

This form is confidential.
If you have any problems or questions,
please call 1-877-658-0305
(TDD/TTY 1-866-274-6083).



Are You Pregnant?* Yes No If you are pregnant, please continue to answer all the questions.
Return the form in the envelope provided. We may call you if we find that you are at risk for problems
with your pregnancy.

***Required Field**

Medi-Cal ID #:* Today's Date: (mmddyyyy)

Your First Name:* Your Birth Date:* (mmddyyyy)

Your Last Name:*

Mailing Address:

City: State: Zip Code:

Home Phone: - - Cell Phone: - -

Would you like to receive text messages about pregnancy and newborn care? Yes No
If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe.

Email Address:

Your OB Provider's Name:

Your Due Date*: (mmddyyyy)

Primary insurance (for mom or baby) other than Medi-Cal? Yes No

Race/Ethnicity (fill in all that apply) White Black/African American Hispanic/Latina

American Indian/Native American Asian Hawaiian/Pacific Islander

Other If other ethnicity, please specify

Preferred Language (if other than English)

Planning to breastfeed? Yes No If no, what is the reason?

Pediatrician chosen? Yes No Pediatrician Name

Number of Full Term Deliveries Number of Miscarriages Height ', ''

Number of Preterm Deliveries Number of Stillbirths Pre-Pregnancy Weight

Do you have any of the following?* Yes No If yes, fill in the oval for all that apply.

Your Medical History

Current Pregnancy History

Previous preterm delivery (<37 weeks)? _____ <input type="radio"/>	Preterm labor this pregnancy? _____ <input type="radio"/>
(A delivery more than three weeks early.)	Current gestational diabetes? _____ <input type="radio"/>
Recent delivery within past 12 months? _____ <input type="radio"/>	Current twins? _____ <input type="radio"/>
Was delivery within past 6 months? _____ <input type="radio"/>	Current triplets? _____ <input type="radio"/>
Previous C-Section? _____ <input type="radio"/>	Currently having severe morning sickness? _____ <input type="radio"/>



Your First Name:*

Your Birth Date:* (mmddyyyy)

Your Last Name:*

Diabetes (prior to pregnancy)? Current mental health concerns?

Sickle Cell? List:

Asthma? Current STD? List

If yes, are asthma symptoms worse during pregnancy? Current tobacco use? Amount

High Blood Pressure (prior to pregnancy)? If yes, are you interested in quitting smoking?

Previous neonatal death or stillborn? Current alcohol use? Amount

HIV positive? HIV negative? Testing refused? Current street drug use?

AIDS? Taking any prescription drugs (other than prenatal

Thyroid problems? vitamins?) List

Seizure disorder? Any hospital stays this pregnancy?

Seizure within the last 6 months?

Previous alcohol or drug abuse?

Do you have enough food? Yes No

Are you homeless or living in a shelter? Yes No

Do you lack reliable phone access? Yes No Do you have problems getting to your doctor visits? Yes No

Are you enrolled in WIC? Yes No Do you feel unsafe in your home? Yes No

Please list any other social needs you may have:

Please list anything else you would like to tell us about your health:

