

PRECONCEPTION SCREENING CHECKLIST - PAGE of

All questions contained in this checklist are strictly confidential and will become part of your medical record.

Name (Last, First, MI.):		Date of Birth:						
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed								
Previous or referring doctor:		Date of last physical exam:						
Intent of Pregnancy:	Are you planning to get pregnant in the next 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/>							
	In the next 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>							
	Does your partner support your pregnancy plan? Yes <input type="checkbox"/> No <input type="checkbox"/>							
	Are you using any birth control methods? Yes <input type="checkbox"/> No <input type="checkbox"/>							
	If yes, what type? <input type="checkbox"/> Oral (pills) <input type="checkbox"/> Depo (shot) <input type="checkbox"/> Patch <input type="checkbox"/> Nuva Ring <input type="checkbox"/> IUD/IUS <input type="checkbox"/> Condoms <input type="checkbox"/> Other _____							
Have you ever had sex? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when was the last time? _____								
Healthcare Provider Notes								
Medical History Do you have a history of?	<input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Hepatitis							
	<input type="checkbox"/> Lupus <input type="checkbox"/> Kidney disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Sickle Cell Disease							
	<input type="checkbox"/> Active TB <input type="checkbox"/> Cancer Type _____							
Does your partner have a history of? (Check all that apply)	<input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hepatitis							
	Healthcare Provider Notes							
Immunization History	<input type="checkbox"/> Measles, Mumps, Rubella (MMR) <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Chickenpox							
	<input type="checkbox"/> Tetanus/Diphtheria/Pertussis (Tdap)							
Healthcare Provider Notes								
Genetic History Do you or your partner have a family history of? (Check all that apply)	Tay-Sachs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Sickle Cell Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
	Birth Defects	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Muscular Dystrophy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
	Gaucher's Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Downs Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
	PKU	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Cystic Fibrosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
	Hemophillia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Niemann-Pick Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
	Trisomy 18	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Other	_____		
	Healthcare Provider Notes							

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Reproductive History A	When was your last period? _____ Do you have a period every month? Yes <input type="checkbox"/> No <input type="checkbox"/> How many sanitary products do you use each cycle? _____ Have you had an abnormal pap test? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have a history/or were you treated for the following? (check all that apply) Preeclampsia/eclampsia <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Genital Warts <input type="checkbox"/> HPV <input type="checkbox"/> Chlamydia <input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas <input type="checkbox"/> Have you ever been pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Have any of your babies died at birth or during their first year of birth? Yes <input type="checkbox"/> No <input type="checkbox"/> Healthcare Provider Notes
Reproductive History B	LEEP Yes <input type="checkbox"/> No <input type="checkbox"/> Cone Biopsy Yes <input type="checkbox"/> No <input type="checkbox"/> Date of the last pregnancy outcome: _____ Surgeries on: Uterus <input type="checkbox"/> Ovaries <input type="checkbox"/> Tubes <input type="checkbox"/> Breasts <input type="checkbox"/> Cervix <input type="checkbox"/> Birth Outcomes: G _____ P _____ Prior ectopic pregnancy <input type="checkbox"/> Prior fetal deaths <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Prior preterm birth(s) <input type="checkbox"/> Birth weight _____ Healthcare Provider Notes
Medication and Supplements	Are you taking any of the following? Folic acid <input type="checkbox"/> Multivitamins <input type="checkbox"/> Calcium <input type="checkbox"/> Iron <input type="checkbox"/> Diet Pills <input type="checkbox"/> Herbal remedies <input type="checkbox"/> Over the counter medication <input type="checkbox"/> Are you taking any medications? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list: _____ Are you allergic to any medications? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list: _____ Healthcare Provider Notes
Diet and Exercise	Are you at a healthy weight? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you: Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Are you on a special diet? Yes <input type="checkbox"/> No <input type="checkbox"/> Check all that apply: Diabetic <input type="checkbox"/> Low Salt <input type="checkbox"/> Other _____ Do you eat? Raw Meat <input type="checkbox"/> Raw Fish <input type="checkbox"/> Do you eat fruits and vegetables every day? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you drink milk or juice with calcium? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have problems with your teeth or gums? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you seen a dentist in the past year? Yes <input type="checkbox"/> No <input type="checkbox"/> Healthcare Provider Notes

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Lifestyle	Do you smoke cigarettes or use other tobacco products? Yes <input type="checkbox"/> No <input type="checkbox"/> How often? _____ How much? _____ Are you exposed to second hand smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/> How often? _____ How much? _____ Do you or have you used drugs? Cocaine/crack <input type="checkbox"/> Heroin <input type="checkbox"/> Ecstasy <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Methadone <input type="checkbox"/> Other _____ Are you in a rehab program? Yes <input type="checkbox"/> No <input type="checkbox"/> Healthcare Provider Notes
Environmental Health	Do you have any pets? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, check all that apply: Cats <input type="checkbox"/> Rodents <input type="checkbox"/> Exotic Animals <input type="checkbox"/> Have you had any contact with: Contaminated Soil <input type="checkbox"/> Cat litter <input type="checkbox"/> Do you or your partner have to wear protective covering at the job? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you or your partner work with? Pesticides <input type="checkbox"/> Cleaning Fluids <input type="checkbox"/> Chemicals <input type="checkbox"/> Paint <input type="checkbox"/> Healthcare Provider Notes
Emotional Support	Do you have emotional support at home? Yes <input type="checkbox"/> No <input type="checkbox"/> Is help available from relatives or friends? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you worried about being homeless this year? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you in a stable relationship? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you physically threatened? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you feel safe at home? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you feel good about yourself? Yes <input type="checkbox"/> No <input type="checkbox"/> Have the following been diagnosed with depression? You <input type="checkbox"/> Your family <input type="checkbox"/> Your partner <input type="checkbox"/> Healthcare Provider Notes
Baby Preparations	If you are planning a pregnancy: Do you have a place for the baby to stay? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you need WIC? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you plan to breast feed? Yes <input type="checkbox"/> No <input type="checkbox"/> Healthcare Provider Notes
Demographics	Are you Hispanic or Latino? Yes <input type="checkbox"/> No <input type="checkbox"/> What is your race? (check all that apply) African American <input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Samoan <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Guamanian or Charmorro <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> What is the highest grade of education you completed? _____ Do you have a GED? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you or your partner have maternity insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have employer maternity leave? Yes <input type="checkbox"/> No <input type="checkbox"/> Healthcare Provider Notes

The Foundation for Accessing Preconception Care

The U.S. Centers for Disease Control and Prevention defines preconception care as "interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management." The most fundamental elements of preconception care include screening for medical, behavioral and social risk factors that can impact a healthy pregnancy, and then intervening through appropriate educational and community resources to deliver effective treatment and prevention plans.

Preconception care helps women think about how their behaviors, lifestyle choices and medical conditions may affect their ability to have a healthy pregnancy. Preconception evaluations allow healthcare providers to assess possible risks to pregnancy, discuss pregnancy planning, and discontinue potentially teratogenic medications prior to becoming pregnant. In Illinois, the Department of Healthcare and Family Services has supported a myriad of preconception care initiatives. Through partnership with its quality improvement organization eQHealth Solutions, a practical preconception tool was developed for the provider community. This risk assessment tool comprises the key tenets of preconception health for easy incorporation into a standard medical record. The tool includes categories related to lifestyle, reproductive, medical and genetic history, emotional support, as well as environmental and occupational risks.

As an adjunct to a woman's medical history, the preconception risk assessment begins with questions related to pregnancy intention. As learned by eQHealth's physician panels and the Michael Reese Health Trust Peer review, an essential component of preconception care is the consistent question of pregnancy intent by healthcare providers. Since women often seek care from multiple providers, it is critical that each visit be viewed as an opportunity to discuss pre-conception health. The following guidance is to be used in conjunction with the preconception risk assessment tool:

Pregnancy Intention Screen at Every Visit

Tool Section	Recommendations
Pregnancy Intention Yes	<ul style="list-style-type: none"> > Last menstrual period <ul style="list-style-type: none"> • Check UCG if negative proceed with preconception check list discuss health benefits of pregnancy planning • UCG positive schedule prenatal care prescribe prenatal vitamins discuss involvement of partner
No or Unsure	<ul style="list-style-type: none"> > Last menstrual period - if abnormal <ul style="list-style-type: none"> • Check UCG > Unprotected intercourse in the last month - if yes counsel for STI prevention and birth control options > Discuss birth control options <ul style="list-style-type: none"> • Screen for compliance • Discuss side effects > Discuss health benefits of pregnancy planning and spacing (18-24 mos) > Encourage annual health assessments

Preconception Risk Assessment Tool Reference

Tool Section	Recommendations
Medical History	Screen for diabetes, thyroid disease, hypertension, seizure disorders and asthma. Treatment and control of identified conditions. Counsel on fetal effects with appropriate specialty referral.
Infectious Diseases	Screen for HIV, Hepatitis B surface antigen, Hepatitis C, Tuberculosis
Immunizations	Check Immunization status for: <ul style="list-style-type: none"> > MMR vaccination - recommended if non-pregnant, not vaccinated or non immune. Since it is a live vaccine, women should be counseled not to become pregnant for 3 months after receiving the MMR vaccination. > Hepatitis B vaccination recommended for high risk. > If Varicella is discovered during pregnancy, the series should be initiated immediately after delivery (or termination of pregnancy) with a second vaccination in the series at the 6-week postpartum visit. > T-dap immunization status unknown women should receive one dose.
Genetic Risk Factors	<ul style="list-style-type: none"> > 3-generation family history for both members of the couple. > Screen for ethnically related genetic disorders <ul style="list-style-type: none"> • Congenital malformations • Developmental delay/mental retardation <p>If positive refer for genetic counseling.</p>
Reproductive History	<ul style="list-style-type: none"> > Screen for preterm or low birth weight infants - screen for underlying causes. > Miscarriages - structural evaluation of the uterus and work-up to determine the underlying etiology. > C-section - counsel to wait at least 18 months before the next pregnancy. > LEEP or CONE biopsy - counsel regarding increased risk of PTL.
Sexually Transmitted Infections (STI)	<ul style="list-style-type: none"> > Screen for Chlamydia, GC, Syphilis > Treat all active STIs (Including Herpes) > Prevention counseling
Medications/Supplements	<ul style="list-style-type: none"> > Folic Acid - 400 mcg daily > Calcium - 1000mg/day for pregnant and lactating women >19 years old. 1300 mg/day for pregnant and lactating women <19 years old. > Screen for iron deficiency > Screen for psychotropic medications <ul style="list-style-type: none"> • Anti-depression patient chart www.hfs.illinois.gov/mch/medchart.html > Screen for medications contraindicated to a pregnancy > IL Teratogen Information Service 1-800-252-4847 www.fetal-exposure.org
Weight assessment	<ul style="list-style-type: none"> > Calculate annual BMI > Counsel if BMI <19.8 or >26 due to risks to fertility > Refer to treatment programs for eating disorders > Suggest a well-balanced diet of fruits and vegetables
Lifestyle	<ul style="list-style-type: none"> > Screen for alcohol consumption - counsel on fetal effects of alcohol. > Screen for tobacco use - counsel on fetal effects, refer chronic smokers to QUIT line or other formal smoking cessation programs. > Screen for illicit drugs - counsel on fetal effects, refer to treatment programs. > Screen for methadone usage and enrollment in outpatient drug rehabilitation.
Environmental Health	<ul style="list-style-type: none"> > Rural residents - screen water quality, bacteria, pesticides and toxic exposure. > Screen for exposure to chemicals. Refer to occupational medicine specialist if necessary. > Counsel on effects of exposure to pet feces
Emotional Support	<ul style="list-style-type: none"> > Screen for depression <ul style="list-style-type: none"> • If present, mental health referral > Screen for domestic and partner violence <ul style="list-style-type: none"> • Refer to Crisis Centers