Great Expectations® FOR HEALTH

Maternity Questionnaire

Welcome to our maternity management program! As a member of this program, you will receive information about pregnancy, general guidance on your insurance benefits and support from one of our maternity counselors. All of these benefits are **FREE**. This confidential questionnaire will help us determine your special needs. If you prefer to complete the questionnaire by phone, contact us at 1-800-327-3183, ext. 25287, or in Columbia at (803) 382-5287.

Name: ______________________ BlueChoice® HealthPlan ID #: ______________________

Obstetrician : ______________________ Hospital: ______________________

Home Phone #: (___)__________ Cell Phone #: (___)__________ Work Phone #: (___)__________

Best number and time to reach you: ______________________ E-mail*: ______________________

What is your: Age _______ DOB _______ Height _______ Race (optional) _______ Marital Status _______

Pre-pregnancy Weight: __________ Current Weight: __________ Expected Due Date: __________

** Disclosing your e-mail address is optional. By providing your e-mail address on this form, you are authorizing BlueChoice HealthPlan to send information related to health and disease management programs to you via e-mail.*

Medical History

Please check any of the following that CURRENTLY apply or PREVIOUSLY applied to you.

- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Diabetes (when not pregnant)
- ☐ History of Blood Clots
- ☐ Asthma
- ☐ Uterine Fibroids
- ☐ Cancer. What kind?__________
- ☐ Seizure. How often? _______
- ☐ Hypertension or High Blood Pressure
- ☐ Nutrition-related Anemia
- ☐ Inflammation of Kidneys
- ☐ Sickle Cell Anemia or ☐ Trait
- ☐ Chronic Kidney Disease or Renal Failure
- ☐ Vaginitis
- ☐ More than one bladder/kidney infection in last 12 months.
- ☐ Mother took hormone DES while pregnant with you.
- ☐ Eating disorder. What kind?_______
- ☐ Eye problems. What kind? _______
- ☐ Dental problems. What kind?_______
- ☐ Previous surgery, including GYN. What kind? __________
- ☐ Abnormal Pap Smear. When? __________
- ☐ Any current difficulties with walking, dressing, bathing or feeding yourself? Explain: ______________________
- ☐ Other medical/mental health condition(s) that require treatment. Explain: ______________________
- ☐ Had last vision exam within a year. Date: __________
- ☐ Had last dental exam within a year. Date: __________

Pregnancy History

If this is your first pregnancy, please skip to CURRENT PREGNANCY section on the back of this page.

Not counting this one, how many times have you been pregnant? _____ How many babies have you delivered?_____

What were their birth weights? __________ What are their current ages? __________

Have you ever had any of the following with a previous pregnancy? Check all that apply.

- ☐ Abruptio Placenta
- ☐ Placenta Previa
- ☐ Incompetent Cervix/Cerclage
- ☐ Newborn with an Infection
- ☐ Gestational Diabetes
- ☐ High Blood Pressure
- ☐ Positive Group Beta Strep
- ☐ Fetal Death
- ☐ Preterm Delivery (over 3 weeks early)
- ☐ Baby Weighing Under 5 lbs. at Birth
- ☐ Postpartum Depression
- ☐ One or more C-sections. Number and reason(s): ______________________
- ☐ Miscarriage under 13 weeks. How many? __________
- ☐ Miscarriage at 13-19 weeks. How many? __________
- ☐ Stillborn at 20 weeks or more. How many? __________
- ☐ Preterm Labor. At how many weeks? __________
- ☐ Elective Abortion. How many? __________
- ☐ Bleeding after 12 weeks of pregnancy.

Please turn OVER to complete the survey

Current Pregnancy

Date of first prenatal exam for this pregnancy: ______________

Are you having: ☐ Twins? ☐ Triplets? ☐ Quadruplets? ☐ Quintuplets? or ☐ More? __________

Please check all that apply. Do you...

☐ Use tobacco products? What kind? How often? ___________ ☐ Frequently exposed to second-hand smoke?

☐ Consume caffeine? How much a day? _________ ☐ Consume alcohol? How many drinks a week? ________

☐ Currently exercise? How many times a week? _______ How long?______ What type(s) of exercise? __________

☐ Have concerns that you may currently be a victim of physical, mental or emotional abuse?

☐ Currently use any recreational or street drugs? What kind? ____

☐ Currently use any assistive devices or equipment in your daily activities (cane, walker, wheelchair, etc.)?
Please list: ____

☐ Take prenatal vitamins? List the name, dose, how often and for what you are taking any **prescribed** medications:

____

☐ Take **over-the-counter** drugs? List the name, dose, how often and for what you are taking:

____

Did you receive any fertility treatments to help you get pregnant? If so, check the treatment you used.
☐ Medications ☐ GIFT ☐ IVF ☐ Embryo Transfer ☐ IUI ☐ Other: ______________

Has your physician diagnosed you with any of the following condition(s) during this pregnancy? Check all that apply.

☐ Abruptio Placenta ☐ Placenta Previa ☐ Placenta Accreta ☐ Gestational Diabetes

☐ Vaginal Bleeding After 12th Week ☐ Preterm Labor ☐ Low or Excess Amniotic Fluid

☐ Ruptured or Leaking Membranes ☐ Birth Defect or Abnormality of Baby ☐ Poor Fetal Growth

☐ RH Factor Disease or Incompatibility ☐ Pregnancy-induced Hypertension ☐ Incompetent Cervix or Cerclage

Other pregnancy-related problems or condition(s). Explain: ____

General information questions: Check the appropriate box or answer as fully as possible.

Do you currently have? ☐ Health Care Power of Attorney ☐ Advanced Directives (Living Will) or ☐ Other: ________

What is the last level of education you completed? ☐ Completed Grade ______ ☐ High School Graduate
☐ Trade School Graduate ☐ Some College ☐ College Graduate ☐ Post College School/Degree

What type of work do you do? ____

How many hours do you work a week? ☐ Less than 10 ☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60 ☐ More than 60

Does your job require that you: ☐ Stand for long periods. ☐ Lift heavy equipment. ☐ Do anything physically.

On a scale of 0 to 10 (10 the highest), rate your daily stress level. (Circle your answer.) 0 1 2 3 4 5 6 7 8 9 10

When you need emotional, physical or any type of support, whom do you ask? (Check all that apply.) ☐ Parent
☐ Spouse or Significant Other ☐ Sibling ☐ Friend ☐ Religious Group ☐ Community ☐ Other: ____________

If you have purchased or received a book on pregnancy, what is the name of it? ____________________________

Are you enrolled in the WIC (Women, Infants and Children) food program? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No
Please call 1-800-868-0404 to learn more about these programs and eligibility criteria.

BlueChoice HealthPlan appreciates any additional comments or suggestions you may have regarding the Great Expectations ***Maternity*** program. ____

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BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.