PRENATAL QUESTIONNAIRE

TUFTS Health Plan

Congratulations on your pregnancy!

Tufts Health Plan hopes to help you stay healthy during pregnancy and childbirth. We encourage you to fill out the attached questionnaire, discuss it with your health care provider, and return it to our Health Programs Department, so that we may help to identify and support your pregnancy and health care needs during this special time. Although this information may be used to assist or refer you to a health program, always contact your health care provider if you have questions about your condition or to seek care if needed.

Your enrollment in our maternity program begins when you send your completed Prenatal Questionnaire to the Tufts Health Plan Health Programs Department. You will receive a Prenatal Care Guide book, which is your guide to the many programs we offer pregnant members, and have access to a comprehensive range of pregnancy-related benefits and resources at no additional cost. Program features include:

- Nutritional counseling
- Lactation consultation
- Childbirth classes
- Pediatrician interviews
- Smoking cessation for pregnant women
- Postpartum care
- Postpartum home visit with a nurse
- **Healthy Birthday Program** for pregnant members who are at risk for preterm labor and delivery as well as women with a medically high risk pregnancy due to a condition such as diabetes, heart disease, multiple sclerosis, pregnancy induced hypertension or gestational diabetes. Obstetrical nurse care managers work with members and their providers to support treatment and help make resources available.

Your Privacy

At Tufts Health Plan we adhere to strict guidelines with regards to confidentiality and privacy of our members' protected health information (PHI). Completing and returning the questionnaire is voluntary, as is your participation in any of our programs. The information you provide us in the questionnaire will be treated in a confidential manner. We will not share it with anyone unrelated to your health care needs, nor will it impact your health insurance coverage.

Please return your completed prenatal questionnaire to:

By Mail: Tufts Health Plan
Attn: Maternity Program Manager
Health Programs
705 Mt. Auburn Street
Watertown, MA 02472-1508

By Fax: (617) 972-9417

If you have a benefit or payment question, please contact Tufts Health Plan Member Services, at the number located on your Identification Card.

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Pregnant Member Name:______________________________

Pregnant Member ID Number:______________________________

Address 1:______________________________

Address 2: ______________________________

City:____________________ State:__________ Zip:__________

Pregnant Member Phone Number:______________________________

What is the best time and day to call you?______________________________

Obstetrical Provider Name:______________________________

What is your Due Date:______________________________

1. How tall are you without shoes? __________feet __________ inches

2. Just before you got pregnant, how much did you weigh? __________ pounds

3. How many times have you been pregnant, including this pregnancy?
❑ 1 ❑ 2 ❑ 3 ❑ 4 or more

4. Are you pregnant with more than one baby?
❑ No ❑ Yes, Two babies ❑ Yes, Three babies ❑ Yes, 4 or more babies

5. Have you ever had a miscarriage? ❑ No ❑ Yes

6. Have you had premature labor (labor before 37 weeks), with this pregnancy or a previous pregnancy?
❑ No ❑ Yes, this pregnancy ❑ Yes, previous pregnancy

Pregnant Member Name:____

Pregnant Member ID Number:___________________________________

7. Have you ever had a procedure on your cervix?
   ❏ No ❏ Yes ❏ Unsure

8. Do you have, or have you ever had, an incompetent/insufficient cervix or a cerclage?

   Cerclage: procedure that closes the cervix with strong stitches to prevent it from opening too early.
   ❏ No ❏ Yes, this pregnancy ❏ Yes, previous pregnancy

   Incompetent/insufficient cervix: a cervix that opens before 37 weeks of pregnancy.
   ❏ No ❏ Yes, this pregnancy ❏ Yes, previous pregnancy

9. Has your Doctor told you, you have a short cervix? ❏ No ❏ Yes

10. Have you ever delivered a baby 3 or more weeks before your due date? ❏ No ❏ Yes

11. Have you ever been told you have a differently shaped (not tipped) uterus? ❏ No ❏ Yes

12. Has your Doctor told you, you have too much amniotic fluid? (watery fluid surrounding the baby in the womb)
    ❏ No ❏ Yes

13. Has your Doctor told you, you have a low pregnancy weight gain? ❏ No ❏ Yes

14. Have you had any placenta problems with this pregnancy? ❏ No ❏ Yes

15. Have you had vaginal bleeding with this pregnancy?
    ❏ No ❏ Yes, 2nd Trimester (week 13 to week 28) ❏ Yes, 3rd Trimester (week 29 to week 40)

16. Did you have any treatments or medications for infertility to achieve this pregnancy? ❏ No ❏ Yes

17. Did your mother or grandmother take the medication DES? (DES: Diethylstibestrol, a medication given to many women in the 1950's and 1960's to prevent miscarriage and other pregnancy complications.)
    ❏ No ❏ Yes ❏ Unsure

18. Are you now or have you ever been treated for any of the conditions below? (check all that apply)
    ❏ Heart Conditions/High Blood Pressure
    ❏ Kidney Conditions
    ❏ Diabetes/Gestational Diabetes
    ❏ Lung/Breathing Conditions
    ❏ Thyroid Conditions
    ❏ Anemia (low number of red blood cells)
    ❏ Blood Clotting Disorder
    ❏ Lupus or other Autoimmune Conditions
    ❏ Seizures
    ❏ Digestive Conditions
    ❏ Depression/Anxiety
    ❏ Other: ______________________
    ❏ None

Pregnant Member Name:______________________________

Pregnant Member ID Number:____________________________

19. Have you used any of the following during this pregnancy?
   ❏ No   ❏ Alcohol   ❏ Tobacco   ❏ Street Drugs, such as Cocaine

Please indicate any specific questions or concerns that we may address for you.

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Additional information you would like us to know.

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