

**INLAND EMPIRE HEALTH PLAN
COMBINED 3rd TRIMESTER REASSESSMENT**

Member Name _____	DOB _____	EDC _____	Date _____
ANTHROPOMETRIC <input type="checkbox"/> WT. GRID PLOTTED Wt. this visit: _____ Weeks Gestation: _____ Gain Since Last Visit: _____ Total Wt. Gain: _____ Comment: _____		Substance Abuse: 12. Are you smoking at all? Y N If YES, how many cigarettes per day? _____ 13. How often do you drink beer, wine, or liquor? _____ 14. What drugs have you used since becoming pregnant? _____	
BIOCHEMICAL Blood Date Collected: Hemoglobin: H L Hematocrit: H L MCV: H L Albumin: H L Glucose: H L GTT: H L		Labor and Delivery 15. Have you had a hospital tour <input type="checkbox"/> Y <input type="checkbox"/> N 16. Do you need information about what will happen during labor and delivery? <input type="checkbox"/> Y <input type="checkbox"/> N	
Urine Date Collected: Glucose: + - Protein: + - Ketones: + -		Health Education Goals:	
CURRENT CLINICAL Blood Pressure: _____ Edema: _____ 1. Scheduled test or procedures? Y N If YES, please list. 2. Taking prenatal vitamins? Y N Iron? Y N 3. Taking new medications or herbs? Y N If YES, please list? 4. Significant changes since last assessment? Y N If YES, please explain. Clinical Update from previous visit: _____		PSYCHOSOCIAL 17. Where are you living right now? _____ 18. How many people are living with you? _____ 19. If you are worried about something, who do you talk to? _____ 20. Do you have: <input type="checkbox"/> electricity <input type="checkbox"/> hot water <input type="checkbox"/> telephone <input type="checkbox"/> transportation <input type="checkbox"/> heating <input type="checkbox"/> refrigerator <input type="checkbox"/> stove/oven 21. Are you able to buy enough food? Y N 22. Are you able to pay your rent? Y N 23. Are you able to pay your other bills? Y N 24. How do you feel about this pregnancy? _____ 25. Since becoming pregnant, have you had? (✓ if yes) <input type="checkbox"/> trouble sleeping <input type="checkbox"/> sadness <input type="checkbox"/> worried feelings <input type="checkbox"/> crying <input type="checkbox"/> depression <input type="checkbox"/> sadness <input type="checkbox"/> none <input type="checkbox"/> other _____ 26. Since becoming pregnant, have you been slapped, hit, or otherwise hurt by someone? If yes, by whom? _____	
NUTRITION 5. Have your eating habits changed since your last assessment? Y N If YES, please explain Dietary Assessment <input type="checkbox"/> 24 hour recall completed Dietary Goals/Comments: _____ Infant Feeding 6. How do you plan to feed your baby? <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both <input type="checkbox"/> Not Sure 7. Have you breastfed a baby before? Y N If YES, how long did you breastfeed? _____		REFERRALS: <input type="checkbox"/> WIC Date enrolled _____ Appointment Date _____ <input type="checkbox"/> Car Seat Class Date Attended _____ Other referrals 1) _____ Date _____ 2) _____ Date _____ MATERIALS GIVEN: <input type="checkbox"/> Family Planning <input type="checkbox"/> Infant Feeding <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	
HEALTH EDUCATION 8. Do you have an infant car seat? Y N 9. Do you have a doctor for the baby? Y N 10. Do you know what birth control you will use? Y N 11. Have you receive counseling on HIV (AIDS)? Y N		Reviewed By: _____ Next Assessment Date: _____	

For Provider Use Only
Number: _____

IEHP Member

Prenatal Care Provider: _____

IEHP Provider Number: _____