Better Beginnings
A PROGRAM FOR EXPECTING MOTHERS

Health Risk Assessment questionnaire

General information

MEMBER ID NUMBER

NAME

DATE OF BIRTH CELL PHONE

HOME PHONE BUSINESS/WORK PHONE

PRE-PREGNANCY WEIGHT HEIGHT

DUE DATE

PRIMARY LANGUAGE

SECONDARY LANGUAGE

Would you like the use of our translator services?

☐ yes ☐ no

Delivery plans

CURRENT OB DOCTOR/MIDWIFE/PRACTICE

PHONE

Where do you plan to deliver?

Do you plan to:

☐ breastfeed ☐ formula ☐ both

The Better Beginnings case managers are available Monday through Friday, 8 a.m. to 4:30 p.m. Please list the best day and time to reach you and the number we should call.

DAY OF WEEK TIME OF DAY

PHONE NUMBER

Pregnancy/obstetrical history

		yes	no
1	Is this your first pregnancy?	☐	☐
2	How many babies are you currently expecting? ☐ one ☐ two ☐ three ☐ unknown		

Please answer the following: Check all that apply.		yes	no
3	Have you ever had a miscarriage?	☐	☐
4	Have you ever had an abortion?	☐	☐
5	Have you ever experienced preterm labor?	☐	☐
6	Did you deliver your baby four or more weeks before your due date?	☐	☐
7	Have you ever delivered a baby by Cesarean section?	☐	☐
8	Have you ever been told there may be a problem with your cervix (e.g., shortened or incompetent)?	☐	☐
9	Have you needed a cerclage (stitch around cervix) with this or a previous pregnancy?	☐	☐
10	Have you had any vaginal bleeding or spotting in this pregnancy?	☐	☐
11	Have you been told you have an abnormally shaped uterus? (Do not check yes if your uterus is merely tipped)	☐	☐
12	Do you have any health issues or concerns you think may impact your pregnancy?		
13	Please indicate if you are currently being treated, have been treated in the past or have a family history for the following conditions:		

	Please respond for family history only for immediate family—your mother, father, brother or sister. (Check all that apply)	current or history of	family history
	Poorly controlled asthma	☐	☐
	Anxiety/depression/mood disorder	☐	☐
	Cardiac problems/heart disease	☐	☐
	Diabetes/gestational diabetes	☐	☐
	Genetic disorder/disease	☐	☐
	High blood pressure/pre-eclampsia	☐	☐
	Seizures/neurological disorder	☐	☐
	Sexually transmitted disease	☐	☐
	Blood clots/bleeding disorder	☐	☐
	Any chronic health problems not addressed in this form?	☐	☐

		yes	no
14	Have you had a dental appointment in the last 6 months?	☐	☐

Health habits

15	Your smoking status:
	☐ I do not smoke
	☐ I have quit smoking since I became pregnant
	If smoking, how many cigarettes per day? _____
16	Your substance use status:
	How many times in the past year have you had four or more drinks in a day? ☐ none ☐ 1 or more
	Are you currently drinking alcohol? ☐ yes ☐ no
	How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? ☐ none ☐ 1 or more
	Are you currently using recreational drugs or prescription medication not prescribed for you? ☐ yes ☐ no If so, please specify:
17	Psychosocial demands that you are experiencing: (Please check all that apply.)
	☐ frequent moves
	☐ difficulty getting to doctor appointments
	☐ hunger or food insecurity
	☐ violence at my home or work
	☐ significant stress at my home or work
18	Do you feel well-supported by family and friends? ☐ yes ☐ no
19	Please list all medication, vitamins, minerals or supplements you are currently taking:
20	Allergies (please list):

PRINT

BlueCross BlueShield of Vermont

Member's Rights and Responsibilities

Members have:

1. The right to be treated with respect and dignity.
2. The right to self-determination, including participation in developing one's own plan of care.
3. The right to privacy and confidentiality.
4. The right to have access to needed health and social services.
5. The right to be notified in writing of any changes in benefit determination related to services provided.
6. The right to refuse any portion of the care plan or case management services.
7. The right to withdraw from the process at any time.
8. The right to a grievance procedure in the event a member feels his or her rights have been violated, or he or she has been improperly treated without services being diminished or discontinued.
9. The right to end of life and advance care directive information when appropriate.
10. The right to receive notification, with explanation, when case management services are changed or terminated.
11. The right to obtain information regarding the criteria for case closure.
12. The right to receive a description of the rationale regarding selection for case management.

You have the responsibility to:

1. Provide honest, complete and accurate medical, social history and other pertinent information needed in order to provide a concise plan of treatment.
2. Comply with your primary care physician's plan of treatment.
3. Request additional information necessary to understand one's own plan of treatment and participate as much as one feels comfortable for self- determination.
4. Keep the case manager informed of any acute changes in the plan of treatment including physical, medical and social changes.
5. Adhere to the plan of treatment to the best of one's ability and voice difficulties so that the plan of treatment may be revised to meet one's individual needs.
6. Provide advance directive information if available.

**Please keep this page for your records.*