EHS Prenatal Visit Form

Name ______________________________
DOB ______________________________
Classroom ______________________________

Appointment Date:

Expected Delivery Date: ____________________ **First Received Prenatal Care:** ____________________

Please briefly describe visit below, including any results AND attach appointment notes:

Next Appointment is Scheduled for: ____________________

Is this a high risk Pregnancy?	**Yes**	**No**

Please indicate the status of the following Complications during:	**Current Pregnancy**		**Prior Pregnancies**	
Anemia	Yes	No	Yes	No
Bleeding	Yes	No	Yes	No
C-Section	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Hypertension	Yes	No	Yes	No
Miscarriage	Yes	No	Yes	No
Neonatal Death	Yes	No	Yes	No
Pain	Yes	No	Yes	No
Preterm Labor	Yes	No	Yes	No
Pregnancy Induce Diabetes	Yes	No	Yes	No
Pregnancy Induced Hypertension	Yes	No	Yes	No
Sickle Cell	Yes	No	Yes	No
Swelling	Yes	No	Yes	No

Bed Rest

Current bed rest or hospitalization? Yes No	Previous bed rest or hospitalization? Yes No
Due to:	Due to:
How long:	How long:

Health Care Provider Name:	Clinic Name/Address (Stamp):
Provider Signature:	
Date Form Completed:	
Phone Number:	

I hereby give my permission to the Health Care Provider listed above to release information regarding this medical care provided to CAP Agency Head Start. I reserve the right to revoke my permission at any time and this release will automatically expire one year after the date of my signature.

______________________________ ____________________
Signature **Date**

*****FOR OFFICE USE ONLY*****

FE ____________________ Class ____________________ Entered ______________________________