CAP AGENCY
COMMUNITY ACTION PARTNERSHIP
SERVING SCOTT CARVER & DAKOTA COUNTIES

Head Start

May return via fax at:
651-322-3555

Prenatal Visit Form

1302.80

NAME	DATE OF BIRTH	CLASSROOM

Prenatal Visit

***Date of Service:** _____ ***

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

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 whether the following complications occurred during the current or any prior pregnancies.

Complication	**Current Pregnancy**	**Prior Pregnancies**
Anemia	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Bleeding	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
C-Section	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Diabetes	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Fatigue	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Headache	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Hypertension	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Miscarriage	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Neonatal Death	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Pain	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Preterm Labor	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Pregnancy Induce Diabetes	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Pregnancy Induced Hypertension	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Sickle Cell	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**
Swelling	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No** ☐ **N/A**

Bed Rest

Current bed rest of hospitalization? ☐ **Yes** ☐ **No** **Due to:** **How long?**	Current bed rest of hospitalization? ☐ **Yes** ☐ **No** **Due to:** **How long?**

Health Provider's Contact Information and Signature

Provider Name (Print):	Clinic Name/Address (Stamp acceptable)
Provider Signature:	
Date Form Completed:	
Phone Number:	

Sign below: I hereby give my permission to the Provider/Clinic listed above to release information regarding the 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