INLAND EMPIRE HEALTH PLAN
COMBINED 2nd TRIMESTER REASSESSMENT

Member Name_____DOB_____EDC_____Date_____

ANTHROPOMETRIC ☐ WT. GRID PLOTTED
Wt. this visit: Weeks Gestation:
Gain Since Last Visit: Total Wt. Gain:
Comment:

BIOCHEMICAL

Blood	**Date Collected:**		
Hemoglobin:	**H L**	Hematocrit:	**H L**
MCV:	**H L**	Albumin:	**H L**
Glucose:	**H L**	GTT:	**H L**

Urine	**Date Collected:**		
Glucose:	+ -	Protein:	+ -
Ketones:	+ -		

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:

NUTRITION
5. Have your eating habits changed since your last assessment? **Y N**
   If **YES**, please explain

Dietary Assessment ☐ 24 hour recall completed
Dietary Goals/Comments:

Infant Feeding
6. How do you plan to feed your baby?
☐ Breast ☐ Bottle ☐ Both ☐ Not Sure
7. Have you breastfed a baby before? Y N
   If **YES**, how long did you breastfeed?_____

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**

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?
    _____

Labor and Delivery
15. Have you had a hospital tour ☐ Y ☐ N
16. Do you need information about what will happen during labor and delivery? ☐ Y ☐ N

Health Education Goals:

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: ☐ electricity ☐ hot water ☐ telephone ☐ transportation ☐ heating ☐ refrigerator ☐ 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)
☐ trouble sleeping ☐ sadness ☐ worried feelings
☐ crying ☐ depression ☐ sadness ☐ none
☐ other_____
26. Since becoming pregnant, have you been slapped, hit, or otherwise hurt by someone? If yes, by whom?_____

REFFERRALS:
☐ WIC Date enrolled _____
Appointment Date _____
☐ Car Seat Class Date Attended _____

Other referrals 1) _____ Date _____

2) _____ Date _____

MATERIALS GIVEN:
☐ Family Planning ☐ Infant Feeding
☐ Other _____ ☐ Other _____

ASSESSMENT SUMMARY:

Reviewed By:

Next Assessment Date:_____

For Provider Use Only
Number:_____

IEHP Member

Prenatal Care Provider:_____

IEHP Provider Number:_____