**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Initiation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Completion**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Initiation** is the date in which the screening tool is first administered. **Date of Completion** is the date in which the screening tool is completed. If a screening tool is completed with a participant in one sitting, the same date should be inserted in both fields (Date of Initiation AND Date of Completion).

**This screening tool should be completed with all women seeking Healthy Start services. Some key aims of this screening tool include:**

* **Assess woman’s current pregnancy status**
* **Document previous pregnancy history**
* **Identify risks from previous pregnancy(s) which may impact future pregnancy**

*The questions and answer choices were selected based on the available evidence about factors that may impact a woman’s health or pregnancy outcomes. The information provided by the participant through this screening tool will help Healthy Start identify each participant’s unique needs and ensure that she is connected to the appropriate support services.*

*Please read the questions to the participant. Only read the responses to the participant if the instructions for any question tells you to do so.*

## Please read the following statement to the participant: Thank you for taking time to complete this interview. Any information you provide will be kept confidential to the extent allowed by law. You do not have to answer any question you do not want to, and you can end the interview at any time.

## Are you pregnant now?

*Select one only.*

* Yes (Go to question 1.1 AND **Complete the Prenatal Screening Tool)**
* No (Go to question 2)
* Don’t know (Go to question 2)
* Declined to answer (Go to question 2)

## How many weeks or months pregnant are you now?

***STAFF: Please enter a number of weeks or months.***

\_\_\_\_\_\_\_\_\_Weeks OR \_\_\_\_\_\_\_\_\_Months

* Don’t know
* Declined to answer

## How many times have you been pregnant in your life? Include those that ended in live birth, miscarriage, stillbirth or fetal death, abortion, and ectopic or tubal pregnancy.

## Staff: Do not include current pregnancy, if participant is pregnant.

**The following information is for your reference only:**

* Live Birth: a birth at which a child is born alive
* Miscarriage: a loss of pregnancy before the 20th week of pregnancy
* Stillbirth or fetal death: a loss of pregnancy after the 20th week of pregnancy
* Abortion: a procedure to end a pregnancy
* Ectopic or tubal pregnancy: when a fertilized egg implants somewhere outside of the uterus, usually in the fallopian tube

*Please enter the number of pregnancies.*

\_\_\_\_\_\_\_\_PREGNANCIES (If participant has had any pregnancies, go to question 3)

* Don’t know
* Declined to answer

IF PARTICIPANT HAS HAD NO PREVIOUS PREGNANCIES,   
THIS SCREENING TOOL IS COMPLETE.

## 3. Please tell me how your previous pregnancies ended.

## STAFF: PLEASE READ OUT LOUD the following responses: Live birth, miscarriage, ectopic or tubal pregnancy, abortion, or fetal death or stillbirth, and enter type for each of participant’s five most recent pregnancies. For any live birth and fetal death / stillbirth, please indicate how many babies for each type of pregnancy, and the date of birth. Please indicate the date of miscarriage, ectopic or tubal pregnancy, or abortion for each pregnancy. Pregnancy 1 refers to the most recent pregnancy.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Live Birth** | **Miscarriage** | **Ectopic or Tubal pregnancy** | **Abortion** | **Fetal Death/Stillbirth** |
| **Pregnancy 1** | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ |
| **Pregnancy 2** | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ |
| **Pregnancy 3** | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ |
| **Pregnancy 4** | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ |
| **Pregnancy 5** | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | Date: \_\_ / \_\_ / \_\_\_\_ | # \_\_\_\_  Date: \_\_ / \_\_ / \_\_\_\_ |

**DO NOT READ OUT LOUD:**

* Declined to answer

**STAF**F: If participant has had **any live births**, continue to question 4. If participant has had **only** miscarriage, ectopic or tubal pregnancies, or abortion (**and no live births**) this **TOOL IS COMPLETE**, and the participant should complete the **Preconception Screening Tool** (rather than the Interconception/Parenting Screening Tool), as it includes only questions related to the participant and does not include questions about child health, safety, access to care, etc.

## 4. Did you ever have a baby by cesarean delivery or c-section (when a doctor cuts through the mother’s belly to bring out the baby)?

* Yes
* No
* Don’t know
* Declined to answer

## 5. Did you have any problems or complications with any of your past pregnancies?

*Select one only.*

* Yes (Go to question 5.1)
* No (Go to question 6)
* Don’t know (Go to question 6)
* Declined to answer (Go to question 6)

## 5.1 Which of the following problems did you have during your most recent pregnancy?

***STAFF: Please read the responses out loud to participant and select all that apply.***

Vaginal bleeding

Kidney or bladder (urinary tract) infection (UTI)

Severe nausea, vomiting, or dehydration that sent me to the doctor or hospital

Cervix had to be sewn shut (cerclage for incompetent cervix)

High blood pressure, hypertension (including pregnancy-induced hypertension [PIH]), preeclampsia, or toxemia

Problems with the placenta (such as abruptio placentae or placenta previa)

HIV, Herpes, or HPV

Labor pains more than 3 weeks before my baby was due (preterm or early labor)

Water broke more than 3 weeks before my baby was due (premature rupture of membranes [PROM])

Had to have a blood transfusion

Was hurt in a car accident

* Other: please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Declined to answer

## 6. Were any of your babies born more than 3 weeks before his or her due date?

*Select one only.*

* Yes, please specify how many: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
* Don’t know
* Declined to answer

## 7. Did any of your babies weigh less than 5 pounds, 8 ounces at birth?

*Select one only.*

* Yes, please specify how many: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
* Don’t know
* Declined to answer

## 8. Did any of your babies stay in the hospital after you came home?

*Select one only.*

* Yes, Please specify reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
* Declined to answer

## STAFF: Ask Question 9 only if participant has living children.

## 9. Are all of your children living with you?

*Select one only.*

* Yes
* No
* Declined to answer

The Healthy Start Pregnancy History Screening Tool is Complete