

National Birth Defects Prevention Month 2006 Preconceptional Health Checklists

Becoming a Parent

This comprehensive checklist was developed by the Wisconsin Association for Perinatal Care and is designed for use by women of childbearing age (and their partners) who are contemplating pregnancy. The checklist was created to assist women with: planning and preparing for becoming a parent; preparing for a healthy pregnancy and birth; and beginning prenatal care early. Health care providers are encouraged to share the checklist with clients and review their responses to checklist items. The checklist should assist providers in identifying potential risks related to pregnancy. In addition, use of this resource will help professionals provide counseling, treatment or referrals appropriate to the client's risks and plans for pregnancy.

The revised checklist will become available in early 2006. For ordering information please contact:

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Preconception Screening and Counseling Checklist (see attached)

This resource was developed by the March of Dimes in collaboration with the Upper Hudson Prenatal Services Network of New York State as a mechanism to assess health needs and risks prior to conception. Use of the checklist will assist health care providers in their practice of preconceptional assessment, treatment and referral as means of improving pregnancy outcomes for women and children. The *Preconception Screening and Counseling Checklist* is a one page tool that asks specific questions of women of childbearing age. The elements of preconceptional health assessed are: diet and exercise (including questions on folic acid use); medication/drug use; women's health; home environment; lifestyle; medical/family history; and genetics.

The checklist is available as a .pdf file at:

<http://www.albany.edu/sph/coned/preconceptool.pdf>

PRECONCEPTION SCREENING AND COUNSELING CHECKLIST

NAME	BIRTHPLACE	AGE
DATE: / / __N		ARE YOU PLANNING TO GET PREGNANT IN THE NEXT SIX MONTHS? __ Y
IF YOUR ANSWER TO A QUESTION IS YES, PUT A CHECK MARK ON THE LINE IN FRONT OF THE QUESTION. FILL IN OTHER INFORMATION THAT APPLIES TO YOU		

DIET & EXERCISE

What do you consider a healthy weight for you? _____

___ Do you eat three meals a day?

___ Do you follow a special diet (vegetarian, diabetic, other)?

___ Which do you drink (___ coffee ___ tea ___ cola ___ milk ___ water ___ other soda/pop other _____)?

___ Do you eat raw or undercooked food (meat, other)?

___ Do you take folic acid?

___ Do you take other vitamins daily (___ multivitamin ___ vitamin A ___ other)?

___ Do you take dietary supplements (___ black cohosh ___ pennyroyal ___ other)?

___ Do you have current/past problems with eating disorders?

___ Do you exercise? Type/frequency: _____

Notes:

LIFESTYLE

___ Do you smoke cigarettes or use other tobacco products?

How many cigarettes/packs a day? _____

___ Are you exposed to second-hand smoke?

___ Do you drink alcohol?

What kind? _____ How often? _____ How much? _____

___ Do you use recreational drugs (cocaine, heroin, ecstasy, meth/ice, other)?

List: _____

___ Do you see a dentist regularly?

What kind of work do you do? _____

___ Do you work or live near possible hazards (chemicals, x-ray or other radiation, lead)? List: _____

___ Do you use saunas or hot tubs?

NOTES:

MEDICATION/DRUGS

___ Are you taking prescribed drugs (Accutane, valproic acid, blood thinners)? List them: _____

___ Are you taking non-prescribed drugs?

List them: _____

___ Are you using birth control pills?

___ Do you get injectable contraceptives or shots for birth control?

___ Do you use any herbal remedies or alternative medicine?

List: _____

NOTES:

MEDICAL/FAMILY HISTORY

Do you have or have you ever had:

___ Epilepsy?

___ Diabetes?

___ Asthma?

___ High blood pressure?

___ Heart disease?

___ Anemia?

___ Kidney or bladder disorders?

___ Thyroid disease?

___ Chickenpox?

___ Hepatitis C?

___ Digestive problems?

___ Depression or other mental health problem?

___ Surgeries?

___ Lupus?

___ Scleroderma?

___ Other conditions?

Have you ever been vaccinated for:

___ Measles, mumps, rubella?

___ Hepatitis B?

___ Chickenpox?

NOTES:

WOMEN'S HEALTH

___ Do you have any problems with your menstrual cycle?

___ How many times have you been pregnant?

What was/were the outcomes(s)? _____

___ Did you have difficulty getting pregnant last time?

___ Have you been treated for infertility?

___ Have you had surgery on your uterus, cervix, ovaries or tubes?

___ Did your mother take the hormone DES during pregnancy?

___ Have you ever had HPV, genital warts or chlamydia?

___ Have you ever been treated for a sexually transmitted infection (genital herpes, gonorrhea, syphilis, HIV/AIDS, other)? List: _____

NOTES:

GENETICS

Does your family have a history of	or	your partner's family
___ Hemophilia?		___
___ Other bleeding disorders?		___
___ Tay-Sachs disease?		___
___ Blood diseases (sickle cell, thalassemia, other)?		___
___ Muscular dystrophy?		___
___ Down syndrome/Mental retardation?		___
___ Cystic fibrosis?		___
___ Birth defects (spine/heart/kidney)?		___

Your ethnic background is: _____

Your partner's ethnic background is: _____

NOTES:

HOME ENVIRONMENT

___ Do you feel emotionally supported at home?

___ Do you have help from relatives or friends if needed?

___ Do you feel you have serious money/financial worries?

___ Are you in a stable relationship?

___ Do you feel safe at home?

___ Does anyone threaten or physically hurt you?

___ Do you have pets (cats, rodents, exotic animals)? List: _____

___ Do you have any contact with soil, cat litter or sandboxes?

Baby preparation (if planning pregnancy):

___ Do you have a place for a baby to sleep?

___ Do you need any baby items?

NOTES:

OTHER

IS THERE ANYTHING ELSE YOU'D LIKE ME TO KNOW?

ARE THERE ANY QUESTIONS YOU'D LIKE TO ASK ME?