



Health Risk Assessment Questionnaire

Congratulations on your decision to participate in the *Better Beginnings* program. We have designed this program to give women personal support and attention throughout their pregnancy and early postpartum period. Please note that this is a prenatal program and late enrollment (after 34 weeks) will result in a decrease in benefits through this program. Please see Option Choices page for benefit descriptions.

The questions in the accompanying Health Risk Assessment questionnaire will help us to identify any risk factors that might affect or complicate your pregnancy. We'll work together with you and your physician on an as-needed basis towards the goals of a trouble-free pregnancy and a happy, healthy baby. Should you develop complications during your pregnancy or postpartum phase, we'll be there to work with you to develop a plan that is customized to meet your changing needs.

Please remember that your responses will be held in strict confidence and will not affect your coverage or premiums.

Once you have completed this Health Risk Assessment (HRA) please return to us via:

Mail—BCBSVT, P.O. Box 186, Montpelier, VT 05601-0186

Fax— (802) 371-3491

Some Questions You May Be Asking:

Some of these questions seem very personal. Are they really necessary?

Every question in the assessment relates to established risk criteria. By answering the questions on this HRA we will be better able to address your specific needs.

Who will have access to my answers?

A copy of your answers will be sent to your obstetrician. Otherwise, no one apart from our *Better Beginnings* staff will have access to your answers.

What happens once I have sent in my HRA?

A *Better Beginnings* Nurse Case Manager will be assigned to you and she will send you an appointment to review, over the phone, your HRA and to discuss our program benefits and how to obtain. We normally schedule calls between 8 a.m. and 4 p.m., Monday thru Friday only. If you are unable to make this appointment please call your nurse case manager to reschedule your call at (800) 922-8778, Option 1. We do our best to try and accommodate any special needs. Please let us know ahead of time if an interpreter (TTY

(800) 535-2227) or other helpful assistance will be required so that we can make arrangements.

Once we've reviewed your information, explained our program and answered any questions you may have about our program, we will send you a packet of educational materials and a letter with Vouchers, coupons and other forms. These are designed to help you obtain your *Better Beginnings* benefits. Your active participation is important so that we can be certain that you get all your benefits through our program and have a chance to advocate for you throughout your pregnancy and early postpartum period.

What if I have questions?

If you have questions about our program or would like to speak to one of our *Better Beginnings* case managers before you send in your HRA, please call us at (800) 922-8778. You can reach our *Better Beginnings* case managers Monday through Friday, from 8 a.m. to 4:30 p.m.

General Information

Member ID number: _____
(from your ID card, please include two digits at end of number)

Name: _____

Address: _____

Date of birth: _____

Pre-pregnancy weight: _____

Height _____

Home phone: _____

Business/work phone: _____

Due date: _____

Education (highest grade or degree completed): _____

Occupation/Place of Employment: _____

Are you: Married__Divorced__Widowed__Separated__Single__

Living with Partner__Civil Union__

Number of children in household: ___ None Ages _____

What is your primary language? _____

secondary language? _____

Would you like the use of our translator services? Yes No

Race? (optional): _____

Do you have any family or cultural traditions for pregnancy, birth or infant care that are important to you and your spouse?

Yes No If yes, please explain: _____

Do you have a Living Will or Durable Power of Attorney (DPOA) for health care? (May also be known as an Advance Directive.)

If yes, who have you appointed as your DPOA? _____

If no, are you interested in receiving information? Yes No

Pregnancy/ Obstetrical History

1. **Is this your first pregnancy?** Yes No

2. **How many babies are you currently expecting?**

One Two Three Unknown

3. **Did you seek prenatal care before the 14th week of this pregnancy?** Yes No

Date of your first prenatal visit: _____

Provider you saw for your first visit: _____

Please answer the following:

Check all that apply.

	Yes	No
4. Have you had any vaginal bleeding or spotting after the 14th week of this pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>

5. Have you been told that you have have an abnormally shaped uterus? (Not tipped)	<input type="checkbox"/>	<input type="checkbox"/>
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6. Have you ever been told that there may be a problem with your cervix? (e.g., shortened or incompetent)	<input type="checkbox"/>	<input type="checkbox"/>
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7. Have you ever:		
had a miscarriage before 14 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
How many? _____		

had a miscarriage after 14 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
How many? _____		

had a abortion before 14 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
How many? _____		

had a abortion after 14 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
How many? _____		

8. Have you ever experienced preterm labor?		
If yes: (please circle) this pregnancy / past pregnancy		
If yes, was it treated by: bedrest / medication		

	Yes	No
Did you deliver your baby four or more weeks before your due date?	<input type="checkbox"/>	<input type="checkbox"/>

If you've been pregnant before:

9. Have you ever delivered a baby by Caesarean section?	<input type="checkbox"/>	<input type="checkbox"/>
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10. Have you delivered a baby who weighed less than 5 pounds?	<input type="checkbox"/>	<input type="checkbox"/>
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11. Have you needed a cerclage (stitch around cervix) with a previous pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
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12. Have you had a hospital admission or an emergency room (ER) visit in the past year?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain: _____

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Health History

Continued from previous page...

13. Do you have any health issues or concerns that you feel may impact your pregnancy?

14. **Please indicate if you are currently being treated, have been treated in the past or have a family history for the following conditions:**

*Please respond with family history **only** for blood relatives such as your mother, father, brother or sister.*

(Check all that apply.)

	Current	History of	Family History
a. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety/mood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Cardiac problems/heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes/gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Genetic disorder/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Infertility problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Preeclampsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Seizures/neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Blood clots/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Any chronic health problem not addressed in this form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please explain: _____

15. **Have you had a dental appointment in the last six months?**

Yes No

Delivery Plans

Your current OB doctor/midwife/practice:

 Phone: _____

Where do you plan to deliver? _____

Do you plan to: (circle) breastfeed / bottle feed / both

Health Habits

16. **On a typical day, how many times do you eat the following foods:**

- a. Milk or milk products _____ times a day
- b. Meat or meat substitutes _____ times a day
- c. Fruit _____ times a day
- d. Grains _____ times a day
- e. Vegetables _____ times a day

17. **You exercise _____ days per week.**

18. **Types of exercise:** _____

19. **Your smoking status:**

- I do **not** smoke
- I have **quit** smoking since I became pregnant
- I am smoking **less** now that I am pregnant
- I am smoking the **same number** as I did before becoming pregnant
- If smoking, how many cigarettes per day? _____

20. **Your substance use status:**

In the month prior to my pregnancy, how many drinks did you consume in one week: _____

How many times did you have more than three drinks? _____

Are you currently drinking alcohol? Yes No

If so, how much or how many? _____

In the past year, have you used "street drugs?"

Yes No If so, please specify? _____

Are you currently using "street drugs?"

Yes No If so, please specify? _____

21. **Occupational demands:**

I am: Sedentary Active

I spend _____ hours on my feet or standing.

I am required to perform frequent lifting or pulling of more than 25 pounds Yes No

22. **Psychosocial demands that you are experiencing:**
(Please check all that apply.)

- Frequent moves
- Difficulty getting to doctor appointments
- Hunger or food insecurity
- Violence at my home or work
- Significant stress at my home or work
- I feel well supported by family and friends
- I can count on this many people when I really need help: _____

23. **Please list all medication, vitamins, minerals or supplements that you are currently taking:**

24. **Allergies** (please list):

