Prenatal Birth Plan

H-335

(Complete at enrollment)

Date Completed: ____/____/_____ Name: _____

Complications during pregnancy: (Mark all that apply)

[ ] Abdominal Pain
[ ] Headaches
[ ] Hypertension
[ ] Uterine Irritability
[ ] Sickle Cell Anemia
[ ] Stress
[ ] Swelling
[ ] Chronic Fatigue
[ ] Vaginal Bleeding
[ ] Depression
[ ] Diabetes (insulin dependent)
[ ] Pregnancy- induced hypertension
[ ] Pre-term labor
[ ] Anxiety
[ ] None of the above

Prenatal Exposure to Drugs:

[ ] Caffeine
[ ] Cigarettes/ Tobacco
[ ] Non-prescription drugs: Specify:_____
[ ] Prescription Drugs: Specify _____
[ ] Alcohol

Planned Delivery Location:

[ ] Hospital/Clinic
[ ] Birthing Center
[ ] At home
[ ] Undecided

Planned Delivery Type:

[ ] Vaginal
[ ] C-Section

Feeding Plan:

[ ] Bottle
[ ] Breast

Pediatrician:

[ ] Undecided
[ ] Dr. _____

Contraception After Birth:

[ ] Oral "pills" [ ] Injectable "Depo-Provera" [ ] Tubal ligation/Vasectomy [ ] None
[ ] Other: _____

Completed By: _____
Home Visitor Signature