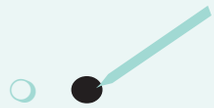
Magellan COMPLETE CARE®

Reference #:

Maternity Health Risk Assessment



- Please fill in your responses like this using ONLY A BLUE OR BLACK PEN.
- Do NOT use GREEN INK.
- Please answer as many questions as you can.

Leave blank the question(s) you cannot or choose not to answer.

Demographic Information

Name: _____

Address: _____

_____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐
MM DD YYYY

Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Welcome to Magellan Complete Care of Virginia (MCC of VA)! We are glad to have you as a member and look forward to getting to know you. We'd like you to complete this form to tell us about your health so that we can help you in the ways you need. Please complete the form and return it to us in the enclosed postage-paid envelope.

We want to make sure that you are getting all the care you need at this time, so that your baby gets the best start. As your body changes, you might need to make lifestyle changes.

All answers you provide will be kept private and only used to help us give you the best information and service possible. Please complete and return this survey in the postage-paid envelope that has been provided.

1. Are you currently pregnant?

○ Yes ○ No ○ I don't know ○ Declined

If no:

a. Have you recently experienced a pregnancy loss?
○ Yes ○ No

b. Are you planning to get pregnant in the next 12 months?

○ Yes ○ No ○ I don't know ○ Declined

If you are not currently pregnant, please skip to question 9.*

2. When is your pregnancy due date? ☐☐ ☐☐ ☐☐☐☐ MM DD YYYY ○ I don't know

3. Is this your first pregnancy?

○ Yes ○ No

4. Are you pregnant with more than one baby?

○ Yes ○ No

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5. Are you having any complications during this pregnancy or a past pregnancy? Or does your doctor have any concerns with this pregnancy?

- ❍ Yes
- ❍ No

6. In order to determine if you may be considered at high risk for this pregnancy, could you tell us if you: (mark all that apply)

- ❍ Smoke or use tobacco products
- ❍ Drink alcohol (more than a few sips)
- ❍ Smoke or use any marijuana
- ❍ Use anything else to get high (like illegal drugs, over the counter and prescription drugs or things that you sniff or huff)
- ❍ Does not apply

7. If pregnant before, did you have a sudden increase in your blood pressure after 20 weeks of pregnancy or seizures during or after pregnancy?

- ❍ Yes
- ❍ No

8. If you have chosen a doctor to deliver your baby, what is your obstetrician's name?

_____

9. How much do you weigh in pounds?

- ❍ I don't know
- ❍ Declined

Pounds	
0 10 20 30 40 50 60 70 80 90	0 1 2 3 4 5 6 7 8 9
100 200 300 400 500 600 700	

10. How tall are you?

- ❍ I don't know
- ❍ Declined

Feet	Inches
	0 1 2 3 4 5 6 7 8 9 10 11
2 3 4 5 6 7	

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11. Has a doctor or other health care professional ever told you that you have any of the following? Check all that apply.

Asthma (Lung Disorder)	❍ Yes	❍ No
Bipolar Disorder or mood swings	❍ Yes	❍ No
Cancer	❍ Yes	❍ No
Chronic Obstructive Pulmonary Disease (COPD) or other breathing problems	❍ Yes	❍ No
Diabetes or sugar in your blood	❍ Yes	❍ No
Heart Disease	❍ Yes	❍ No
High Blood Pressure	❍ Yes	❍ No
High Cholesterol	❍ Yes	❍ No
HIV or AIDS	❍ Yes	❍ No
Kidney disease/dialysis	❍ Yes	❍ No
Might need a transplant or you are on the transplant list	❍ Yes	❍ No
Obesity or that you are overweight	❍ Yes	❍ No
Schizophrenia	❍ Yes	❍ No
Sickle Cell Disease (Blood Disease)	❍ Yes	❍ No
Tuberculosis	❍ Yes	❍ No

12. Do you have a primary care physician (PCP)? If not, do you have a doctor you want to be your PCP?

❍ Yes ❍ No ❍ I don't know ❍ Declined

a. What is the doctor's name? _____

13. Are you seeing any specialists?

❍ Yes ❍ No ❍ I don't know ❍ Declined

a. If yes, what type of specialist?

❍ Cardiology ❍ Pulmonology ❍ Neurology ❍ Endocrinology
❍ Oncology ❍ Nephrology ❍ GYN/OB ❍ Other

b. Specialist Details (specialist name) _____

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14. Do you have surgery planned for the future?

❍ Yes ❍ No

a. What are the dates of the surgery planned for the future? MM DD YYYY

b. What type of surgery is that?

_____ ❍ Declined

15. Have you been in the hospital in the last 12 months?

❍ Yes ❍ No ❍ I don't know ❍ Declined

16. How many medications do you take each day? (include prescription and over-the-counter)

❍ None ❍ 1 to 3 ❍ 4 to 7 ❍ 8 to 11 ❍ 12 or more
❍ I don't know ❍ Declined

a. Can you tell us what that medicine is and what it is used for?

_____ ❍ Declined

17. Are you currently receiving any physical therapy (PT), occupational therapy (OT), or speech therapy (ST)?

❍ Yes ❍ No

18. Are you using any durable medical equipment (DME) such as a cane or walker?

❍ Yes ❍ No ❍ I don't know ❍ Declined

a. If yes, was that prescribed by a doctor?

❍ Yes ❍ No ❍ I don't know ❍ Declined

19. Are you receiving home care?

❍ Yes ❍ No

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20. Over the last 2 weeks, how often have you been bothered by any of the following?

Feeling sad, down, depressed or hopeless?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

Having little or no pleasure in doing things?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

Feeling nervous, anxious or on edge?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

Not being able to stop or control worrying?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

21. Are you currently being treated by a psychiatrist or a psychologist?

- ○ Yes
- ○ No

22. Do you have any special medical or behavioral health needs we need to discuss?

- ○ Yes
- ○ No
- ○ I don't know
- ○ Declined