State of Illinois
Illinois Department of Healthcare and Family Services

PRECONCEPTION RISK ASSESSMENT TOOL (PAGE 1 OF 2)

All questions contained in this checklist are strictly confidential and will become part of your medical record.

Name *(Last, First, MI.):*	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

Intent of Pregnancy:	Are you planning to get pregnant in the next 6 months? ☐ Yes ☐ No In the next 12 months? ☐ Yes ☐ No Does your partner support your pregnancy plan? ☐ Yes ☐ No
	Are you using any birth control methods? ☐ Yes ☐ No If yes, what type? ☐ Oral (pills) ☐ Depo (shot) ☐ Patch ☐ Nuva Ring ☐ IUD/IUS ☐ Condoms ☐ Other _____
	Have you ever had sex? ☐ Yes ☐ No If yes, when was the last time? _____
	Healthcare Provider Notes:
Medical History Do **you** have a history of? Does **your partner** have a history of? (Check all that apply)	☐ Diabetes ☐ Seizures ☐ Thyroid Disease ☐ Asthma ☐ Anemia ☐Hepatitis ☐ Lupus ☐ Kidney disease ☐ Hemophilia ☐ High Blood Pressure ☐ Sickle Cell Disease ☐ Active TB ☐ Cancer Type_____
	☐ Sickle Cell Disease ☐ HIV/AIDS ☐ Hepatitis
	Healthcare Provider Notes:
Immunization History	☐ Measles, Mumps, Rubella (MMR) ☐ Hepatitis B ☐ Chickenpox ☐ Tetanus/Diphtheria/Pertussis (Tdap)
	Healthcare Provider Notes:
Genetic History Do you or your partner have a family history of? (Check all that apply)	Tay-Sachs ☐ Yes ☐ No ☐ Don't Know Sickle Cell Disease ☐ Yes ☐ No ☐ Don't Know
	Birth Defects ☐ Yes ☐ No ☐ Don't Know Muscular Dystrophy ☐ Yes ☐ No ☐ Don't Know
	Gaucher's Disease ☐ Yes ☐ No ☐ Don't Know Downs Syndrome ☐ Yes ☐ No ☐ Don't Know
	PKU ☐ Yes ☐ No ☐ Don't Know Cystic Fibrosis ☐ Yes ☐ No ☐ Don't Know
	Hemophillia ☐ Yes ☐ No ☐ Don't Know Niemann-Pick Disease ☐ Yes ☐ No ☐ Don't Know
	Trisomy 18 ☐ Yes ☐ No ☐ Don't Know Other _____
	Healthcare Provider Notes:
Reproductive History A	When was your last period? ___/___/_____ Do you have a period every month? ☐ Yes ☐ No How many sanitary products do you use each cycle? ____ Have you had an abnormal pap test? ☐ Yes ☐ No Do you have a history/or were you treated for the following? (check all that apply)
	☐ Preeclampsia/eclampsia ☐ Gestational diabetes
	☐ Genital Herpes ☐ Gonorrhea ☐ HIV/AIDS ☐ Genital Warts ☐ Chlamydia ☐ Syphilis ☐ Trichomonas ☐ HPV
	Have you ever been pregnant? ☐ Yes ☐ No Have any of your babies died at birth or during their first year of birth? ☐ Yes ☐ No
	Healthcare Provider Notes:
Reproductive History B	LEEP: ☐ Yes ☐ No Cone Biopsy: ☐ Yes ☐ No Date of the last pregnancy outcome: ___/___/_____
	Surgeries on: ☐ Uterus ☐ Ovaries ☐ Tubes ☐ Breast ☐ Cervix
	Birth Outcomes: G__ P__ __ __ __ ☐ Prior ectopic pregnancy ☐ Prior fetal deaths ☐ Congenital anomalies
	☐ Prior preterm birth(s) Birth weight _____, _____, _____, _____.
	Healthcare Provider Notes:

PRECONCEPTION RISK ASSESSMENT TOOL (PAGE 2 OF 2)

Medication and Supplements	Are you taking any of the following? ☐ Folic acid ☐ Multivitamins ☐ Calcium ☐ Iron ☐ Diet pills ☐ Herbal remedies ☐ Over the counter medication
	Are you taking any medications? ☐ Yes ☐ No If yes list: _____
	Are you allergic to any medication? If yes list: _____
	Healthcare Provider Notes:
Diet and Exercise	Are you at a healthy weight? ☐ Yes ☐ No Are you: ☐ Overweight or ☐ Underweight Are you on a special diet? ☐ Yes ☐ No Check all that apply: ☐ Diabetic ☐ Low Salt ☐ Other _____
	Do you eat? ☐ Raw meat ☐ Raw fish Do you eat fruits and vegetables every day? ☐ Yes ☐ No
	Do you drink milk or juice with calcium? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No
	Do you have problems with your teeth or gums? ☐ Yes ☐ No Have you seen a dentist in the past year? ☐ Yes ☐ No
	Healthcare Provider Notes:
Lifestyle	Do you smoke cigarettes or use other tobacco products? ☐ Yes ☐ No How often? _____ How much? _____
	Are you exposed to second hand smoke? ☐ Yes ☐ No
	Do you drink alcohol? ☐ Yes ☐ No How often? _____ How much? _____
	Do you or have you used drugs? ☐ Cocaine/crack ☐ Heroin ☐ Ecstasy ☐ Marijuana ☐ Methamphetamines ☐ Methadone ☐ Other _____ Are you in a rehab program? ☐ Yes ☐ No
	Healthcare Provider Notes:
Environmental Health	Do you have any pets? ☐ Yes ☐ No If yes, check all that apply: ☐ Cats ☐ Rodents ☐ Exotic Animals Have you had contact with: ☐ Contaminated soil ☐ Cat litter
	Do you or your partner have to wear protective coverings at the job? ☐ Yes ☐ No Do you or your partner work with? ☐ Pesticides ☐ Cleaning fluids ☐ Chemicals ☐ Paint
	Healthcare Provider Notes:
Emotional Support	Do you have emotional support at home? ☐ Yes ☐ No | Is help available from relatives or friends? ☐ Yes ☐ No
	Are you worried about being homeless this year? ☐ Yes ☐ No
	Are you in a stable relationship? ☐ Yes ☐ No Do you feel safe at home? ☐ Yes ☐ No | Are you physically threatened? ☐ Yes ☐ No Do you feel good about yourself? ☐ Yes ☐ No
	Have the following been diagnosed with depression? ☐ You ☐ Your family ☐ Your partner
	Healthcare Provider Notes:
Baby Preparations	If you are planning a pregnancy: Do you have a place for the baby to stay? ☐ Yes ☐ No
	Do you need WIC? ☐ Yes ☐ No | Do you plan to breast feed? ☐ Yes ☐ No
	Healthcare Provider Notes:
Demographics	Are you Hispanic or Latino? ☐ Yes ☐ No
	What is your race? (check all that apply): ☐ African American ☐ White ☐ Asian Indian ☐ Japanese ☐ Korean ☐ Chinese ☐ Samoan ☐ Filipino ☐ Hmong ☐ Other Asian ☐ Native Hawaiian ☐ Native American/Alaska Native ☐ Guamanian or Chamorro ☐ Other Pacific Islander
	What is the highest grade of education you completed? _____ Do you have a GED? ☐ Yes ☐ No Do you or your partner have maternity insurance? ☐ Yes ☐ No Do you have employer maternity leave? ☐ Yes ☐ No
	Healthcare Provider Notes:

The Foundation for Accessing Preconception Care

The U.S. Centers for Disease Control and Prevention defines preconception care as "interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management." The most fundamental elements of preconception care include screening for medical, behavioral and social risk factors that can impact a healthy pregnancy, and then intervening through appropriate educational and community resources to deliver effective treatment and prevention plans.

Preconception care helps women think about how their behaviors, lifestyle choices and medical conditions may affect their ability to have a healthy pregnancy. Preconception evaluations allow healthcare providers to assess possible risks to pregnancy, discuss pregnancy planning, and discontinue potentially teratogenic medications prior to becoming pregnant.

In Illinois, the Department of Healthcare and Family Services has supported a myriad of preconception care initiatives. Through partnership with its quality improvement organization eQHealth Solutions, a practical preconception tool was developed for the provider community. This risk assessment tool comprises the key tenets of preconception health for easy incorporation into a standard medical record. The tool includes categories related to lifestyle, reproductive, medical and genetic history, emotional support, as well as environmental and occupational risks.

As an adjunct to a woman's medical history, the preconception risk assessment begins with questions related to pregnancy intention. As learned by eQHealth's physician panels and the Michael Reese Health Trust Peer review, an essential component of preconception care is the consistent question of pregnancy intent by healthcare providers. Since women often seek care from multiple providers, it is critical that each visit be viewed as an opportunity to discuss pre-conception health.

The following guidance is to be used in conjunction with the preconception risk assessment tool:

Pregnancy Intention Screen at Every Visit

Tool Section	Recommendations
Pregnancy Intention Yes	▸ Last menstrual period ▪ Check UCG if negative o proceed with preconception check list o discuss health benefits of pregnancy planning ▪ UCG positive o schedule prenatal care o prescribe prenatal vitamins o discuss involvement of partner
No or Unsure	▸ Last menstrual period- if abnormal ▪ Check UCG ▸ Unprotected intercourse in the last month – if yes counsel for STI prevention and birth control options ▸ Discuss birth control options ▪ Screen for compliance ▪ Discuss side effects ▸ Discuss health benefits of pregnancy planning and spacing (18-24 mos) ▸ Encourage annual health assessments

Preconception Risk Assessment Tool Reference

Tool Section	Recommendations
Medical History	Screen for diabetes, thyroid disease, hypertension, seizure disorders and asthma. Treatment and control of identified conditions. Counsel on fetal effects with appropriate specialty referral.
Infectious Diseases	Screen for HIV, Hepatitis B surface antigen, Hepatitis C, Tuberculosis
Immunizations	Check Immunization status for: ▸ MMR vaccination – recommended if non-pregnant, not vaccinated or non immune. Since it is a live vaccine, women should be counseled not to become pregnant for 3 months after receiving the MMR vaccination. ▸ Hepatitis B vaccination recommended for high-risk. ▸ If Varicella is discovered during pregnancy, the series be initiated immediately after delivery (or termination of pregnancy) with a second vaccination in the series at the 6-week postpartum visit. ▸ Tdap immunization status unknown women should receive one dose.
Genetic Risk Factors	▸ 3-generation family history for both members of the couple. ▸ Screen for ethnically related genetic disorders ▪ Congenital malformations ▪ Developmental delay/mental retardation If positive refer for genetic counseling.
Reproductive History	▸ Screen for preterm or low birth weight infants – screen for underlying causes. ▸ Miscarriages - structural evaluation of the uterus and work-up to determine the underlying etiology. ▸ C-section - counsel to wait at least 18 months before the next pregnancy. ▸ LEEP or CONE biopsy – counsel regarding increased risk of PTL.
Sexually Transmitted Infections (STI)	▸ Screen for Chlamydia, GC, Syphilis ▸ Treat all active STIs (Including Herpes) ▸ Prevention counseling
Medications/ Supplements	▸ Folic Acid - 400 µg daily ▸ Calcium - 1000 mg/day for pregnant and lactating women > 19 years old 1300 mg/day for pregnant and lactating women < 19 years old. ▸ Screen for iron deficiency ▸ Screen for psychotropic medications ▪ Anti-depression patient chart www.hfs.illinois.gov/mch/medchart.html ▸ Screen for medications contraindicated to a pregnancy ▸ IL Teratogen Information Service 1-800-252-4847 www.fetal-exposure.org
Weight assessment	▸ Calculate annual BMI ▸ Counsel if BMI ≤ 19.8 or ≥ 26 due to risks to fertility ▸ Refer to treatment programs for eating disorders ▸ Suggest well-balanced diet of fruits and vegetables
Lifestyle	▸ Screen for alcohol consumption – counsel on fetal effects of alcohol. ▸ Screen for tobacco use – counsel on fetal effects, refer chronic smokers to QUIT line or other formal smoking cessation programs. ▸ Screen for illicit drugs - counsel on fetal effects, refer to treatment programs. ▸ Screen for methadone usage and enrollment in outpatient drug rehabilitation.
Environmental Health	▸ Rural residents - screen water quality, bacteria, pesticides and toxic exposure. ▸ Screen for exposure to chemicals. Refer to occupational medicine specialist if necessary. ▸ Counsel on effects of exposure to pet feces
Emotional Support	▸ Screen for depression ▪ If present, mental health referral ▸ Screen for domestic and partner violence ▪ Refer to Crisis Centers