Healthy Beats Enrollment Questionnaire

Please answer the following questions:

1.	**Is this your first pregnancy?**	**Yes**	**No**	**If no, how many times have you been pregnant?**
2.	**Is this a planned pregnancy?**	**Yes**	**No**	
3.	**Do you have access to birth control?**	**Yes**	**No**	**If no, are you interested in birth control? Yes No**

4.	**Do you currently have an OB doctor?** **OB Name: _____ OB Clinic: _____** **Last OB appointment: ____/____/____ Next OB appointment: ____/____/____** **Expected due date? _____/_____/_____**	**Yes**	**No**
5.	**What is the child's father's name? _____** **Date of birth: ____/____/____ Age: _____ Cell Phone: _____** **Address: _____** **Place of employment: _____**		
6.	**Do you have a steady source of income?**	**Yes**	**No**
7.	**If yes, does it meet your basic needs? (*clothing, groceries, housing)***	**Yes**	**No**
8.	**Do you currently use tobacco products of any kind?**	**Yes**	**No**
9.	**If yes, do you want information on how to quit tobacco use?**	**Yes**	**No**
10.	**Any current or past drug use?**	**Yes**	**No**
11.	**During your most recent pregnancy, did you feel you needed any of the following services? For each one, circle ' No' if you did not feel you needed the service or 'Yes' if you did feel you needed the service.**		
	a. Food stamps or money to buy food (SNAP)	**Yes**	**No**
	b. WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)	**Yes**	**No**
	c. Counseling for family and personal problems	**Yes**	**No**
	d. Help to quit drug or alcohol use	**Yes**	**No**
	e. Help to reduce violence in my home	**Yes**	**No**
	f. Help applying for Medicaid	**Yes**	**No**
	g. Transportation to prenatal care/OB appointments	**Yes**	**No**
	h. Help to find an OB provider	**Yes**	**No**
12.	**Do you have issues with your current housing? (*please circle*)** **Paying rent Who I live with Repairs In need of housing**	**Yes**	**No**
13.	**Do you need assistance with any of the following: (*please circle)*** **Childbirth/parenting class Breastfeeding class Baby/Maternity clothes Adoption options**	**Yes**	**No**
14.	**Is there anything else you need assistance with? Please let us know in the space below.**	**Yes**	**No**

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

Healthy Beats Consent and Enrollment

The information in this consent form is given so that you will be informed about the health care services you will receive. If you understand the information and agree to receive the service, sign this form to indicate your consent.

NOTIFICATION: The San Antonio Metropolitan Health District (SAMHD) encourages individuals to seek a personal physician or community medical clinic for examinations and treatment of health problems. The SAMHD clinic services are targeted toward prevention of health problems among those who cannot access a physician. The SAMHD cannot assume the responsibility of payment if medical care is received outside this clinic.

DISCLAIMER ON SCREENING: The SAMHD performs screening tests, which may identify individuals who are at risk for developing common medical problems which may require medical evaluation and treatment from a private physician, community medical clinic or Emergency room. Screening tests do not cover all diseases/conditions and are not diagnostic. They may not identify all the diseases they are intended to find and do not replace or constitute a complete examination. I understand that no warranty or guarantee has been made to me by the SAMHD regarding test results.

GENERAL CONSENT: I understand that I have high risk pregnancy and that I am being enrolled into the San Antonio Metropolitan Health District *Healthy Beats* program due to my pregnancy status and I agree to routine follow-up calls. I also give consent for *Healthy Beats* staff to contact my OB provider to request information regarding my pregnancy.

PRIVACY NOTIFICATION: With a few exceptions you have the right to request and are informed about information that the SAMHD collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the SAMHD to correct any information that is determined to be incorrect. You may permit or restrict the release of this information. I have received a copy of the SAMHD's HIPAA privacy notification dated 4/14/03 which further explains how medical information may be used and disclosed.

I certify this form has been fully explained to me and I understand its contents. I have been given an opportunity to ask questions about the services and risks and benefits and all my questions have been answered to my satisfaction.

☐ **YES, sign me up.** ☐ **NO, do not sign me up.**				**Code:**	
Patient Name:				**Date:**	
Patient Signature:				**Witness:**	
Date of Birth:	**Social Security#:**	**Phone #:**	**Family Size:**	**Monthly Income:**	
Address:		**Apt #:** / **City:**	**County:** **Bexar or** _____	**State:**	**Zip Code:**
Do you have health insurance? ☐ NO ☐ YES		**If Yes, please check what type of insurance you have:** ☐ Medicaid ☐ CHIP ☐ Private Insurance ☐ Other:			

Race:	**Ethnicity:**	**Sex/Gender:**	**My Sex Partners Are:**
☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Bi-Racial:_____ ☐ Other:_____	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Male ☐ Female ☐ Transgender ☐ Male to Female ☐ Female to Male	☐ Male ☐ Female ☐ Both ☐ Other:_____

Marital Status:
☐ Single ☐ Married
☐ Polyamorous ☐ Other _____

Military Status:
☐ N/A ☐ Active Duty
☐ Reserves ☐ Veteran

Highest level of education:
☐ 6th -8th Grade
☐ High School
☐ Some College
☐ Professional Certification
☐ Bachelor Degree
☐ Master's Degree
☐ Doctoral Degree

During you most recent pregnancy, did a doctor, nurse, or other health care worker tell you that you had any of the following infections? For each item, check No if you were not told that you had the infection or Yes if you were.

☐ **Genital warts (HPV)**	☐ No ☐ Yes ☐ Not sure	☐ **Hepatitis C**	☐ No ☐ Yes ☐ Not sure
☐ **Herpes**	☐ No ☐ Yes ☐ Not sure	☐ **Gonorrhea**	☐ No ☐ Yes ☐ Not sure
☐ **Chlamydia**	☐ No ☐ Yes ☐ Not sure	☐ **Syphilis**	☐ No ☐ Yes ☐ Not sure

Have you been tested for HIV before this pregnancy? ☐ No ☐ Yes ☐ Not sure

0 DATA RESULTS
0 STD MIS 0 ENTERED
0 TWOC 0 PROVIDED

Incentive provided:_____