

# Birth Expectations Survey

Name: \_\_\_\_\_ ConnectiCare ID# \_\_\_\_\_  
 Address: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 \_\_\_\_\_ OB-GYN: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ email address: \_\_\_\_\_

## Obstetrical History

Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pregnancy #	Year	Type of Delivery	Birth Weight
#1	_____	_____	_____
#2	_____	_____	_____
#3	_____	_____	_____
#4	_____	_____	_____
#5	_____	_____	_____

Pre-pregnancy Weight: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

### Have you ever had:

	Previous Pregnancy	Current Pregnancy
Premature Labor	_____	_____
Premature Delivery (between 24 and 37 weeks)	_____	N/A
Twins/Triplets	_____	_____
Incompetent Cervix/Cerclage	_____	_____
Gestational Diabetes	_____	_____
Other:	_____	_____

## Medical History

Please indicate all that apply:

\_\_\_\_\_ Hypertension/High Blood Pressure      \_\_\_\_\_ Diabetes      Other \_\_\_\_\_  
 \_\_\_\_\_ Uterine Fibroid/Tumor      \_\_\_\_\_ Asthma      Do you Smoke?  Y  N

List any medications you currently take. \_\_\_\_\_  
 \_\_\_\_\_

**Return to:** *ConnectiCare*  
 Health Management Programs  
 P.O. Box 4050  
 175 Scott Swamp Road  
 Farmington, CT 06034-4050



Coverage is provided by and services are administered as follows: **In Connecticut:** Group HMO and POS coverage, and Individual HMO is underwritten by ConnectiCare, Inc.; Individual POS is underwritten by ConnectiCare Insurance Company, Inc. **In Massachusetts:** Group HMO and POS coverage is underwritten by ConnectiCare of Massachusetts, Inc. **In New York:** HMO and POS is underwritten by ConnectiCare of New York, Inc. PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc. Voluntary products are distributed by Producer Partners, Inc., and coverage is underwritten by Boston Mutual Insurance Company.