Pregnancy Health History

Please fill out and bring to your initial prenatal visit. This is information that we use to guide us in providing your care. If you are unsure about the questions, fill out as best you can and we can clarify your history at the time of your visit.

Identifying and Contact Information

Name_____ Birth Date _____

Address _____

Phone: Home _____ Work_____ Cell_____

E-mail_____

How would you like us to contact you? _____ What is the best time?_____

Education/Highest grade completed: _____ Occupation: _____

Ethnic Background: _____ Religious Affiliation: _____

Marital Status:

	Single		Living Together		Married		Divorced
	Engaged		Civil Union		Separated		Widowed

Name of Partner: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Name of Primary Care Provider: _____

How did you learn about our practice? Ad_____ Friends/Family _____ PCP _____ Other _____

Menstrual History/Contraceptive History

What was the FIRST day of your last period? _____ Was it normal? _____

What was the date of your first positive pregnancy test? _____

Do your periods come monthly? _____ every how many days? _____

Were you using birth control or any method to try and keep from getting pregnant? _____

Is this a planned pregnancy? _____ How many months have you been attempting pregnancy?_____

Have you had difficulty getting pregnant or a history of infertility? _____

Menstrual History/Contraceptive History (continued)

Did you use fertility treatment or medication to achieve this pregnancy?

Interval History

What pregnancy symptoms are you experiencing?

Since your last menstrual period have you been exposed to anything (e.g., medicines, alcohol, recreational drugs, chemicals, infections, x-rays) that you are concerned about?

Medications

Please list any prescription or over the counter medications, including vitamins or supplements.

Were you on any medications or supplements not listed above, before pregnancy?

Allergies

Are you allergic to any medications, foods, or latex?

Are you allergic to any substance not mentioned?

Describe the reaction and how severe. (e.g. upset stomach, rash, trouble breathing, etc.)

Past Pregnancy History

Please list total number of prior:

_____Pregnancies _____Full term births _____Preterm births (< 37 weeks) _____Elective abortion

_____Miscarriages (before 13 weeks) _____Miscarriages (between 13 and 24 weeks)

_____Tubal pregnancy _____Twin or multiple pregnancies _____Stillbirths

	Date of Birth	Weeks Pregnant	Length of labor	Birth weight	Sex of baby	Type of Birth e.g. vaginal vacuum cesarean	Anesthesia pain relief	Place of birth	Childs name	Premature labor? Comments Complications
1										
2										
3										
4										
5										
6										

With any of your pregnancies have you had?

	Severe nausea and vomiting		Problems with the placenta such as Placenta previa, or abruption
	Premature labor or threatened premature labor		Heavy bleeding at the birth or up to month after the birth
	Premature rupture of membranes		Placenta removed by the doctor or midwife
	Cervix open too early in pregnancy		Difficult tears or lacerations of the perineum, vagina or rectum
	Breech, transverse, posterior or other unusual position of the baby		Infection (episiotomy, breast, bladder, uterus) after the birth
	High blood pressure, preeclampsia		Postpartum depression, anxiety or difficulty with adjustment postpartum?
	Seizure or eclampsia		Any hospitalization other than for the birth and routine postpartum stay?
	Bleeding during the pregnancy		Serious or significant problems during pregnancy, labor, and birth or in the postpartum period

Comment on checked items

_____

_____

_____

Medical and Surgical History

Do you have now or have you ever had any of the following problems?

	Diabetes or hypoglycemia		Varicosities, phlebitis, blood clots or clotting disorder
	Psychiatric: anxiety, panic, post-traumatic stress disorder, bipolar, ADHD		Heart disease, murmurs that require medication
	Depression/postpartum depression		Hypertension, high blood pressure
	Hepatitis, liver disease, jaundice, Hepatitis B or C		Migraine headaches
	Breast disease or treatment		Autoimmune (e.g. Lupus, Rheumatoid Arthritis)
	History of abnormal pap smears *When was your last pap smear?* _____		Kidney disease, urinary tract or bladder infections, kidney stones
	Neurological disease, epilepsy, seizures, black-out spells		Pulmonary or Respiratory disease (Tuberculosis, Asthma)
	Neuropathy		Anemia
	Thyroid disease, Graves, Hashimoto's		Gynecological surgery, any treatment to cervix, uterus, ovaries, fallopian tubes
	Accident/trauma/violence		Operations/Hospitalizations. Note year and reason below. Any complications from anesthesia?
	Blood transfusion		Received medical treatment for any condition not mentioned above?
	Have you ever been told that you have a uterine anomaly? Did your mother take a medication called DES when she was pregnant with you?		Use complementary or alternative medicine.

Comment on checked items

_____

_____

Family History

For the questions below, please check those conditions that have occurred in YOUR first degree or blood relatives such as mother, father, brother, sister, grandparents, or your other children. ***Note the relatives affected.***

	Heart disease		Cancer
	Hypertension, high blood pressure		Epilepsy
	Stroke		Neurological disease
	Clotting disorder, thrombosis		Anesthesia complications

	Diabetes		Complicated pregnancies
	Mental Health or behavioral problems e.g. ADD/ADHD, autism, Bipolar disorder, schizophrenia, substance abuse, anxiety, depression, suicide		Severe allergies or asthma

Comment on checked items and note any other family medical history that you feel is important:

_____

_____

_____

What is the age of the father of the baby? _____

What is his occupation?

_____

Does he or his family have any medical history that you feel is important to share?

_____

Genetic Screening

Where did you and the father of the baby's ancestors come from before the United States? Check all that apply.

You	Partner		You	Partner	
		Hispanic (e.g., Puerto Rican, Dominican, Mexican)			Southeast Asian (e.g., Laotian, Chinese, Vietnamese)
		European Caucasian (e.g., Irish, English, German)			Middle Eastern (e.g., Lebanese, Iranian, Egyptian)
		African or African American			Mediterranean (e.g., Italian, Greek)
		Ashkenazi Jewish			Native American
		Indian (from India)			Other
		Cajun or French Canadian			

For the questions below, please check those conditions that have occurred in your or the father of the baby's family. Include you, the baby's father, as well as your and his siblings (full and half), parents, children, grandparents, aunts, uncles, nieces, nephews, and first cousins. Note the relatives affected.

	Eclampsia, seizures in labor		Neural tube or open spine defect, anencephaly
	Premature birth		Tay-Sachs
	Down syndrome		Canavan disease
	Sickle cell disease/trait		Familial dysautonomia
	Clotting disorder		Muscular dystrophy
	Cystic fibrosis		Huntington's chorea
	Intellectual disability, autism		Other inherited genetic or chromosomal disorder
	Congenital heart defect		Maternal metabolic disorder (e.g., PKU, Type 1 diabetes)
	Birth defects		Repeated pregnancy loss or stillbirth
	Thalassemia		Any birth defect not listed

Is there any other history in your family or the father of the baby's family that will influence your pregnancy or the baby?

_____

_____

_____

___

Substance History/Exposure

Describe your smoking status:

____ I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.

____ I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.

____ I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.

____ I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.

____ I smoke regularly now, about the same as BEFORE I found out I was pregnant.

What age did you start? _____ Are you interested in quitting? _____

Does anyone in your household smoke? _____

Have you had any alcohol in the last two years?

_____

If yes, have you had ≥ 4 drinks in one day? _____Have you used alcohol during this pregnancy? _____

Have you ever used street drugs, recreational drugs or drugs other than those required for medical reasons? (e.g., Marijuana, heroin, cocaine, speed, hallucinogens, narcotics, inhalants)?

_____

Have you used drugs during this pregnancy?

_____

Have you ever been concerned about your use of or had a problem with drugs or alcohol in the past? ____

Does your partner have a problem with drugs or alcohol?

_____

Do you consider one of your parents to be an addict or alcoholic? _____

Do you have any concerns about substance use or exposure and your pregnancy?

_____

_____

Infection History and Risk Assessment

Do you have pet cats, birds, turtles, rodents, exotic animals?

_____

Have you had chicken pox or the immunization?

_____

Have you had the vaccine for measles, mumps and rubella? _____

Have you had the Tdap vaccine (Tetanus, Diphtheria, and Pertussis)? _____

When?_____

Have you had Fifth's disease or human Parvovirus?

_____

Have you had Tuberculosis or exposure to someone who has it? _____

Have you had the Hepatitis B or the vaccine?

_____

Have you had Hepatitis C, exposure to someone who has it, a recent tattoo or piercing? _____

Do you have a past history of any sexually transmitted diseases?

_____

Chlamydia ___ Gonorrhea _____ HPV: human papilloma virus _____ HIV/AIDS _____ Syphilis _____

Do you or your partner have genital herpes?

_____

Have you ever been treated for MRSA (methicillin resistant staph aureus)? _____

Any other infections or exposures that you are concerned about at work or at home? _____

Have you had a rash or a viral illness since your last period?

_____

Nutritional Assessment and Exercise History

Height: _____ Weight at last menstrual period: _____

Do you have any dietary restrictions, or food intolerances?

_____

Do you avoid milk or milk products? _____

Follow a vegetarian diet? _____ Ovo-lacto_____ Vegan _____

Are you on a special diet? _____

Are you satisfied with your eating patterns?

_____

Exercise amount and type: _____

Nutritional Assessment and Exercise History (continued)

Do you skip meals?

_____

To lose weight, have you ever dieted? _____

Used laxatives or purged? _____

Ever been diagnosed with or treated for an eating disorder?

_____

How often do you exercise 30 minutes or more?

_____

Social, Safety, and Stress History and Assessment

How many members are in your household? _____

Are you responsible for the care of any family member other than your own children?

_____

How does your partner feel about this pregnancy?

_____

Do you have concerns about a past or current experience with physical or emotional violence in a dating or family relationship?

_____

Do you feel safe in your current relationship?

_____

Who is available to help you if a problem comes up?

_____

Do you have smoke alarms and carbon monoxide detectors in your home? _____

Do you wear seat belts? _____

In the past year, have you experienced any of the following stressful life events?

_____Family member illness or hospitalization _____Death of someone close to you

_____Separation or divorce _____Moved _____Homeless

_____Close family member with substance abuse problem

_____Partner didn't want me to be pregnant _____Argued more with partner

_____Job loss partner _____Job loss self even though you wanted to keep working

_____Too many bills to pay _____Physical fight _____Jail _____Other

Is there anything else that you would like to discuss or share with your health care providers?

_____

_____

_____

3-Day Journal

Instructions: Write down everything you eat and drink on 3 typical days. Note the time and the size of the serving consumed as well as a description of the food or beverage, (e.g., 8am—8oz skim milk, 1-1/2 cup Raisin Bran, 1/2 medium banana, 6 almonds)

Day 1	Day 2	Day 3

Please list any comments or concerns you have: