



PRENATAL HEALTH HISTORY

Place Label Here

To help us meet all of your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office. If you are unsure about the answer to a question, or what a question means, put a question mark by that question, and we will talk with you about it at your visit.

Today's Date: \_\_\_\_\_ Date of New OB Exam: \_\_\_\_\_

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What Language do you speak at home? \_\_\_\_\_

Phone Number: \_\_\_\_\_

Where do you work: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If you are a student, what school do you attend: \_\_\_\_\_ What grade have you completed \_\_\_\_\_

Who should we call in case of emergency: \_\_\_\_\_

What is the best phone number for us to reach them: \_\_\_\_\_

Name of father of this baby: \_\_\_\_\_ How old is father of this baby: \_\_\_\_\_

Does the father of this baby have any health problems?  Yes  No

If yes, what health problems does he have: \_\_\_\_\_

1. Menstrual History /EDC

What was the first day of your last menstrual flow: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you  Sure or  Unsure of this date?

Are your periods usually regular (every 28 – 30 days):  Yes  No

How many days does your period usually last: \_\_\_\_\_ How old were you when you got your first period: \_\_\_\_\_

Were you on birth control when you got pregnant this time:  Yes  No What kind of birth control: \_\_\_\_\_

How much did you weigh before you got pregnant: \_\_\_\_\_

Have you had an ultrasound since you got pregnant:  Yes  No

If yes, date of ultrasound: \_\_\_\_/\_\_\_\_/\_\_\_\_ Where: \_\_\_\_\_

Have you been to a hospital since you got pregnant:  Yes  No Why: \_\_\_\_\_

If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_ Which hospital: \_\_\_\_\_

## 2. Pregnancy History:

How many times have you been pregnant (including this pregnancy)? \_\_\_\_\_

How many children did you give birth? \_\_\_\_\_

Please give us information about your pregnancies in the order they happened. We would like to know about every pregnancy, including miscarriages, tubal pregnancies, babies who were born stillborn, and any abortions you had. If you have been pregnant more than 4 times, please ask for an extra form.

DELIVERY or end of Pregnancy Date (month/day/year)	Pregnancy #1 ____/____/____	Pregnancy #2 ____/____/____	Pregnancy #3 ____/____/____	Pregnancy #4 ____/____/____
What was the outcome of this pregnancy?	<input type="checkbox"/> Live Birth <input type="checkbox"/> *Miscarriage <input type="checkbox"/> *Stillbirth <input type="checkbox"/> Tubal <input type="checkbox"/> Abortion	<input type="checkbox"/> Live Birth <input type="checkbox"/> *Miscarriage <input type="checkbox"/> *Stillbirth <input type="checkbox"/> Tubal <input type="checkbox"/> Abortion	<input type="checkbox"/> Live Birth <input type="checkbox"/> *Miscarriage <input type="checkbox"/> *Stillbirth <input type="checkbox"/> Tubal <input type="checkbox"/> Abortion	<input type="checkbox"/> Live Birth <input type="checkbox"/> *Miscarriage <input type="checkbox"/> *Stillbirth <input type="checkbox"/> Tubal <input type="checkbox"/> Abortion
How pregnant were you at delivery	_____weeks	_____weeks	_____weeks	_____weeks
Sex of the Baby	<input type="checkbox"/> Male <input type="checkbox"/> Female			
How was the baby born	<input type="checkbox"/> VAGINAL <input type="checkbox"/> C-SECTION			
If you had a C/Section, do you know why.	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Where was your baby born? (City/State/Country)				
What type of Anesthesia did you have	<input type="checkbox"/> None <input type="checkbox"/> Epidural/Spinal <input type="checkbox"/> General <input type="checkbox"/> I don't know	<input type="checkbox"/> None <input type="checkbox"/> Epidural/Spinal <input type="checkbox"/> General <input type="checkbox"/> I don't know	<input type="checkbox"/> None <input type="checkbox"/> Epidural/Spinal <input type="checkbox"/> General <input type="checkbox"/> I don't know	<input type="checkbox"/> None <input type="checkbox"/> Epidural/Spinal <input type="checkbox"/> General <input type="checkbox"/> I don't know
How much did the baby weigh when it was born (Pounds or Kilos)				
Did you have:	<input type="checkbox"/> *Preterm labor <input type="checkbox"/> *Preterm delivery <input type="checkbox"/> *High Blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> An Infection <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Positive Group B Beta Strep <input type="checkbox"/> OTHER _____	<input type="checkbox"/> *Preterm labor <input type="checkbox"/> *Preterm delivery <input type="checkbox"/> *High Blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> An Infection <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Positive Group B Beta Strep <input type="checkbox"/> OTHER _____	<input type="checkbox"/> *Preterm labor <input type="checkbox"/> *Preterm delivery <input type="checkbox"/> *High Blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> An Infection <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Positive Group B Beta Strep <input type="checkbox"/> OTHER _____	<input type="checkbox"/> *Preterm labor <input type="checkbox"/> *Preterm delivery <input type="checkbox"/> *High Blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> An Infection <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Positive Group B Beta Strep <input type="checkbox"/> OTHER _____

Place Label Here

3. What medications are you taking:

Table with 3 columns: Medication, How Much, How many times a day?

4. Allergies: Please list any allergy to medications, latex, food or environment

No known allergies (Please indicate the type of reaction)

Two horizontal lines for listing allergies.

5. Have you ever had:(mark all that apply) No Previous Medical History

If you are unsure if you have had a problem on the list, put a question mark by it.

- Diabetes\*, Thyroid Problems, PCOS, Other endocrine problems, Heart Problems\*, Heart Attack\*, Rheumatic Fever, Lung problems, Tuberculosis, Positive TB skin test, Had the TB vaccine, Asthma\*, COPD\*, Pneumonia, Kidney Problems\*, Kidney Infections, Autoimmune disorder\*, Problem with anesthesia, Any chronic illness, Kidney Stones, More than 2 urinary tract infections, Seizures\*, Migraines\*, Neurologic Problem\*, Stroke\*, Liver disease\*, Hepatitis A\*, Hepatitis B\*, Hepatitis C\*, Gall Bladder Problems, Stomach Ulcer, Severe Gastric Reflux, Blood in your stool, Bone or joint problems, Blood clot in leg/arm/lung\*, Blood disease, Blood transfusion, Anemia, Difficulty getting pregnant, Abnormal pap smear, Problems with your uterus, Problems w/ your ovaries, Problems with your breasts, STDs: Chlamydia, Gonorrhea, Syphilis, Herpes, Genital Warts.

Have you seen a doctor in the past for any long term illnesses?

Are you seeing a doctor for any reason right now?

Do you have any health problems that you would like to see a doctor for but haven't been able to?

**6. List all of the surgeries you have ever had:**

No previous surgeries

Surgery	Date	Problems with Surgery

**7. Family History:** *mark all of the health problems you know a family member has had.*

*Include parents, sisters, brothers,*  No Family History

Yes	No	List Family Member(s)	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood Clots in legs, arms, or lungs
<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer
			Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental illness
<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bipolar disorder
<input type="checkbox"/>	<input type="checkbox"/>	_____	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug or Alcohol Addiction
<input type="checkbox"/>	<input type="checkbox"/>	_____	Problem that 'runs in the family'
<input type="checkbox"/>	<input type="checkbox"/>	_____	Women with heart attacks before they were 65
<input type="checkbox"/>	<input type="checkbox"/>	_____	Men with heart attacks before they were 55

## 8. Please answer these questions as best you can:

- Is your housing safe?  Y  N
- \*Do you feel safe where you live?  Y  N
- \*Are you safe with the people you live with?  Y  N
- \*Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone or forced to have any kind of sex that made you feel uncomfortable?  Y  N
  
- If you have religious practices that affect your care, please describe them (for instance, Jehovah's Witnesses do not wish to receive blood products). \_\_\_\_\_
  
- How often did you drink alcohol before you were pregnant?  
 Daily  A few nights a week  Occasionally  Rarely  Never
- On a day when you drank, how many drinks did you have? \_\_\_\_\_
- What did you drink?  beer  wine  liquor
- Have you had alcohol since you got pregnant?  Y  N
- \*Have you had alcohol since your pregnancy test was positive?  Y  N
  
- Have you ever smoked cigarettes  Y  N cigars?  Y  N used chew or snuff?  Y  N
- Do you use e-cigarettes  Y  N
- \*Are you still smoking?  Y  N
- What year did you start using tobacco? \_\_\_\_\_
- What year did you stop using tobacco? \_\_\_\_\_
- \*How many cigarettes did you smoke a day before you were pregnant? \_\_\_\_\_
- How many cigarettes do you smoke a day now? \_\_\_\_\_
- \*I stopped smoking once I found out I was pregnant and am not smoking now  Y  N
- Are you around anyone that smokes?  Y  N
- Have you used any street drugs since you became pregnant?  Y  N Type \_\_\_\_\_
- Did you use any street drugs before you became pregnant?  Y  N Type \_\_\_\_\_
- How much caffeine do you drink per day? \_\_\_\_\_
- Do you get regular exercise?  Y  N Type: \_\_\_\_\_ Times per week \_\_\_\_\_
- Seatbelt Use:  100%  75%  50%  25%  0%
- Sun Exposure:  Frequently  Occasionally  Rarely

**9. Genetic and Environmental Screening** *(Patient or Family)*

This section is about your family history and the father of the baby's family history.

I have a family member or the father of the baby has family members born with:

	Me		Father of Baby	
	Yes	No	Yes	No
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell or other blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia (bleeding disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Huntington Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fragile X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic (chromosome) Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women who've had more than 3 miscarriages	<input type="checkbox"/>	<input type="checkbox"/>		

- Any of the women in your family have a baby born not alive?  Yes  No
- Have you had any X-Rays since you got pregnant?  Yes  No
- Do you or your partner have herpes?  Yes  No
- Have you been around any harmful chemicals since you got pregnant?  Yes  No
- Do you have a cat?  Yes  No
  - If yes, do you scoop and/or change the litter yourself?  Yes  No
- Have you been exposed to TB, Hepatitis?  Yes  No
- Have you had a rash, fever or virus since the beginning of pregnancy?  Yes  No

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preloaded in GE

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by Nurse

\_\_\_\_\_  
Date