Providence Medical Group
Women's Services
Obstetrics/Midwifery

Midwife/OB Doctor_____Date_____
RN NOB Nurse_____

Pregnancy History

Demographics

Patient Name:_____Date of Birth:_____ Age:_____

Primary Language:_____Race:_____ Ethnicity:_____Religion:_____

Would you accept a blood transfusion in a life threatening emergency?_____
(If you will not accept a blood transfusion, please see receptionist prior to completing form)

Employer_____Occupation:_____Work Phone_____Years Educated_____

Home Phone:_____Cell Phone:_____Emergency Phone:_____

Email:_____

Status:_____ Father of Baby:_____Fathers Phone:_____

Street Address:_____City:_____State:_____Zip:_____

Primary Care Provider:_____Referred by:_____

Current Pregnancy History:

Age at first period:_____Regular (Monthly)/Irregular? Period comes every_____days and lasts for _____ days.
What was the first day of your last menstrual period (LMP)_____was it normal/lighter/heavier? (Please circle one)
Date of pregnancy test:_____ Type of test: Urine / Blood (Please circle one) Pre pregnancy weight_____Ht_____
Were you using birth control at conception? Yes / No_ If yes, type of birth control?_____Date stopped_____
Was this a planned pregnancy? Yes / No If not planned is this ok? Yes / No Is the father supportive? Yes / No
Do you plan on breastfeeding? Yes / No /Undecided. (Please circle one)
Have you had any x-rays during this pregnancy? Yes / No If yes, what type of x-ray?_____
Have you been seen by another doctor or ER in this pregnancy? Yes/No If yes, was an ultrasound done?_____
In what facility were you seen?_____
Are you currently experiencing any of the following?

Yes	No		Yes	No	
☐	☐	Nausea?	☐	☐	Vomiting? How many times a day?_____
☐	☐	Headaches?	☐	☐	Vision changes?
☐	☐	Cramping?	☐	☐	Vaginal Bleeding? If yes, Please describe:_____
☐	☐	Swelling?			_____
☐	☐	Contractions/Braxton Hicks?	☐	☐	Other concerns?_____

Medications

Please list all medications you are currently taking including over-the-counter medications and herbal supplements:

Medication	Dose	Frequency/Directions

Allergies

Please describe any allergies you have (medications, iodine, shellfish, tape and seasonal allergies) and the reaction to the substance (rash, itching, nausea/vomiting, breathing problems, etc.)

Allergy	Reaction

Medical/Infection History

Do you have any of the following or have you ever been told you have any of the following? Please explain.

Yes	No	
☐	☐	Abnormal pap? Last pap smear_____. (Normal/Abnormal)
☐	☐	Cryo/Leep/Conization of the Cervix? Date:_____Procedure:_____
☐	☐	GYN disorders (Endometriosis, Polycystic Ovarian Syndrome, etc.)?_____
☐	☐	Anemia?_____
☐	☐	Problems with anesthesia?_____
☐	☐	Asthma? Date last used inhaler:_____
☐	☐	Bleeding Disorder/Blood Clots/ Varicose veins?_____
☐	☐	Blood transfusion? When?_____What for?_____
☐	☐	Breast problems (Implants/Fibrocystic Disease/Lumpectomy/Reduction)?_____
☐	☐	Diabetes mellitus? Diabetes in previous pregnancy? Are you on medication for this?_____
☐	☐	Heart problems/High blood pressure?_____Cardiologist:_____
☐	☐	Genital Herpes? Self / Partner Last Outbreak:_____
☐	☐	Gonorrhea/Chlamydia/Syphilis? Date treated:_____Partner treated:_____
☐	☐	HIV/AIDS? Date diagnosed?_____
☐	☐	HPV/Genital warts?_____
☐	☐	Infertility? (clomid /In Vitro Fertilization) This pregnancy/previous pregnancy:_____
☐	☐	Kidney/Urinary disease? (UTIs/Kidney Stones/Renal Disorders)_____
☐	☐	Liver disease? Hepatitis (A, B or C)?_____
☐	☐	Lupus?_____
☐	☐	Mental Disorder? (Depression/Anxiety/Mood/psychiatric disorder)_____
☐	☐	MRSA? Have you ever been diagnosed with MRSA in your lifetime?_____
☐	☐	Postpartum Depression?_____
☐	☐	Rh incompatibility?_____
☐	☐	Seizures/Migraines/Frequent headaches?_____
☐	☐	Sickle cell anemia?_____
☐	☐	Thyroid disease?_____Endocrinologist:_____
☐	☐	Trauma/Violence?_____
☐	☐	Tuberculosis? Do you live with anyone with TB or have you been exposed to TB?_____
☐	☐	Ear, Nose, Throat Disorders?_____
☐	☐	Digestive/Stomach/Intestinal problems/Eating disorder:_____
☐	☐	Bone/Muscle/Joint problems?_____
☐	☐	Chicken Pox? (child or adult)_____Have you had the chicken pox vaccine?_____
☐	☐	Pertussis/Whooping cough? Have you had a Tdap vaccine?_____When?_____
☐	☐	Do you have a cat? Indoor? Outdoor? Do you change the litter box?_____
☐	☐	Any other health concerns not listed above?_____

Surgical History

Please list all surgeries and dates: _____

_____

_____

_____

Family History

Please list family members and relationship to patient (maternal/paternal; Grandmother, Aunt, Brother, Sister, Father of the baby (FOB) etc.) No need to list the family history of the FOB other than twins. Please note if deceased and age at death if known.

Yes	No	
☐	☐	Diabetes:_____
☐	☐	High blood pressure:_____
☐	☐	Kidney problems:_____
☐	☐	Cancer (and type):_____
☐	☐	Twins (and FOB family):_____
☐	☐	Heart disease:_____
☐	☐	Lung disease:_____
☐	☐	Seizure disorders:_____
☐	☐	Preterm labor/ miscarriages etc:_____
☐	☐	Other significant health concerns:_____

_____

_____

Social History

Which best describes your alcohol consumption?

- ☐ I have never drunk alcohol or have drunk less than one drink per month in my lifetime.
- ☐ I stopped drinking alcohol before/after I found out I was pregnant and not drinking now.
- ☐ I drink some alcohol now, but have cut down on the number of drinks per day since I have found out I was pregnant.
  Alcoholic beverages per day_____ Type: _____
- ☐ I drink alcohol now, about the same as I did prior to finding out I was pregnant.
  Alcoholic beverages per day_____ Type:_____

Which statement best describes your smoking status?

- ☐ I have never smoked or used tobacco in my lifetime. (Less than 100 cigarettes/Pipes/Cigars/chew in a lifetime)
- ☐ I stopped smoking/using tobacco before/after I found out I was pregnant and not smoking/using tobacco now.
- ☐ I smoke/Use tobacco some now, but have cut down on the number per day since I have found out I was pregnant. Packs/amount per day_____ .Type of tobacco_____
- ☐ I smoke now, about the same as I did prior to finding out I was pregnant.
  Packs/amount per day_____. Type of tobacco_____

Have you used any of the following Drugs since you have been pregnant? (Anti-anxiety medications, Amphetamines, barbiturates, cocaine, heroin, inhalants, LSD, Marijuana, Methamphetamines, Narcotics, Nitrous oxide, PCP, IV, Other)_____
Do you have history in past of use of any of the above listed drugs?_____

Yes	No	
☐	☐	Do you feel safe in your current relationship?
☐	☐	Have you been hit, slapped, physically hurt or threatened by your partner?
☐	☐	Is anyone misusing your money or property?
☐	☐	Do you have access to shelter, food and money?

Patient Name_____

Previous Pregnancy History

How many times have you been pregnant, including this pregnancy and any miscarriages or terminations?_____

Please list all pregnancies below:

Birth Date	Full Term Pre Term #weeks	Length of labor	Weight	Sex	Vaginal C-Section Vacuum?	Epidural? Spinal? Yes/N0	Describe any Complications	Place of Birth?	Name	Living Yes/No

Please list all miscarriages/terminations below:

Date	Week's Gestation	Miscarriage/ Termination	Ectopic Yes/no	D&C (if miscarriage)	Complications?

Genetic Screening

Do you or the baby's father have any family history of the following? Please explain on all Yes answers and circle any backgrounds that may apply.

Yes **No**

☐ ☐ Will you be 35 years or older when your baby is born? What will your age be?_____

☐ ☐ Thalassemia? (Italian, Greek, Mediterranean, or Asian background)_____

☐ ☐ Neural Tube Defects? (Meningomyelocele, spina Bifida, or Anencephaly)_____

☐ ☐ Congenital Heart Defect?_____

☐ ☐ Down Syndrome?_____

☐ ☐ Tay – Sachs? (Ashakenazi Jewish, Cajun, or French background)_____

☐ ☐ Canavan Disease, Familial Dysautonomia? (Ashakenazi Jewish background)_____

☐ ☐ Sickle Cell Disease or Trait? (African background)_____

☐ ☐ Hemophilia or other Blood Disorders?_____

☐ ☐ Muscular Dystrophy?_____

☐ ☐ Cystic Fibrosis? _____

☐ ☐ Have you or the babies father ever been screened for any of the following? (Tay-Sachs, Sickle Cell, Thalassemia, cystic Fibrosis)_____

☐ ☐ Huntington's Chorea?_____

☐ ☐ Mental Retardation/ Autism? If yes, was the person tested for fragile X?_____

☐ ☐ Have you or the baby's father had a child with birth defects not listed above?_____

☐ ☐ Have you had three or more pregnancies that ended in miscarriage? _____

☐ ☐ Have you or the baby's father had a stillborn baby or baby who died around the time of delivery?_____

☐ ☐ At any time during the first two months of your pregnancy, have you had a rash or fever of 103^{o} F or higher?_____