PREGNANCY INFORMATION SHEET

NAME:_________________________________ DOB Ht- _________ Pre Pregnancy Wt-_________

E-MAIL ADDRESS (**NO** mail.mil):____

Address:____ PATIENT PHONE #________________

Spouse's name:____ Spouse's Phone # ______________

EMERGENCY CONTACT (*other than above*) _______________________ Phone# ______________ How related? ____________

ARE YOU? Active Duty Dependent Daughter Married Single Divorced Widowed

ETHNIC BACKGROUND:_____________________ FATHER ETHNIC BACKGROUND__________________________________

RELIGIOUS PREFERENCE____________OCCUPATION_____________Highest Level of Education ____________________

Patient/Significant other deployed within the last 2 years? Yes No Where/When? ___________________

Currently Deployed: ◯ Yes ◯ No Where/When ___________________

Have you traveled **outside the country** in the last 6 months? Yes No if yes, where? ________________

Primary language?________________

How do you learn best? Reading Listening Demonstration Pictures

Do you have any learning Disabilities: Vision Problems Hearing Deficit Psychological Concerns None?

Will you be PCS/ETCing during this pregnancy? (if so when and where) ___________________________

1st day of Last Menstrual Period

Are you **sure** of the first day of your last period? Yes No

Do you have regular periods? Yes No

Pregnancy & Delivery History

Total # of pregnancies, including this pregnancy?

Living children_____Full term deliveries_____Preterm deliveries_____Miscarriages/ ectopic _____Elective terminations_____

In the table below, please list your pregnancies, including miscarriages/terminations

Date of Birth	Weeks	Length of labor	Vaginal or cesarean	Epidural/Spinal/None	Hospital name & state	M/F	WT	COMPLICATIONS

Medications and Allergies

Please list any medication allergies and reactions: ____

Please list any food or latex allergies and reactions: ____

Please list all medications you are currently taking: ____

Do you feel safe at home?

Do you exercise regularly?

Have you received an influenza vaccine this season?

Have you ever received the HPV vaccine?

Are you willing to accept a blood transfusion in life threating emergencies?

PATIENT Medical History	YES	NO	COMMENTS *include medications if taken for the condition*	FAMILY HISTORY **Do you, father of the baby, or anyone in either family with:** *include who had the disorder*	YES	NO
DIABETES				DOWN SYNDROME		
HIGH BLOOD PRESSURE				HEART DEFECT		
MAJOR ACCIDENT/TRAUMA				NEURAL TUBE DEFECT (meningocele, Spina bifida, or anencephaly)		
NEURO/EPILEPSY/MIGRAINE				TAY-SACHS		
THRYOID DISEASE				MUSCULAR DYSTROPHY		
HEART DISEASE				CYSTIC FIBROSIS		
MITRAL VALVE PROLAPSE				HUNTINGTON'S CHOREA		
PRIOR BLOOD TRANSFUSION				SICKLE CELL DISEASE OR TRAIT		
ASTHMA/LUNG DISEASE				HEMOPHILIA		
DIGESTIVE DISORDERS OR COLITIS *(Crohn's or UC)*				THALASSEMIA		
HEPATITIS/LIVER DISEASE				PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED		
PRIOR ABNORMAL PAP OR CERVICAL PROCEDURE				OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDERS		
UTERINE ABNORMALITIES				**Does anyone in your immediate family have:** *list who is affected*		
BREAST ABNORMALITIES				DIABETES		
KIDNEY DISEASE/UTI/STONES				HIGH BLOOD PRESSURE		
VARICOSITIES/PHLEBITIS				MULTIPLES (Twins)		
AUTOIMMUNE DISORDERS				BLOOD CLOTS (pulmonary, deep arterial/venous embolism)		
DEPRESSION, ANXIETY, OR OTHER PSYCHIATRIC ILLNESS				CANCER *(breast, uterus, ovary, colon, pancreas, prostate)*		
DOMESTIC VIOLENCE/ABUSE				**Have you now or ever used the following?** *Include amount currently used*		
PRIOR SURGERIES & YEAR				TOBACCO, E-CIGARETTES		
ANESTHESIA COMPLICATIONS				ALCOHOL		
WILL YOU BE AGE 35 OR AT TIME OF DELIVERY				MARIJUANA		
STILLBIRTH				ALTERNATIVE STREET DRUGS		
TUBERCULOSIS OR TB EXPOSURE				**Do you live with cats?**		
HAVE YOU OR YOUR PARTNER HAD: Genital herpes, chlamydia, gonorrhea, syphilis, HIV, hepatitis B or C (indicate which in the comments)				Will you be PCS/ ETSing during this pregnancy?		
Additional comments:						

NUTRITION

1. Would you like to attend a class about nutrition and diet?
2. Have you ever had weight loss surgery?
3. Have you ever had any kind of diabetes?
4. Do you know how to eat properly during pregnancy?
5. Do you eat more now than before pregnancy?

SKIN INFECTION

1. Have you or anyone you live with ever had a "staph" or MRSA infection or colonization?
2. Have you had a recent admission (last 30 days) to a hospital, rehab, or other medical facility?
3. Do you have any open skin wounds or ulcers?
4. Do you live in crowded conditions (dorm or barracks)?
5. Do you have chronic dermatitis?

If there is any additional information that you feel you need to provide, please explain below: