**PREGNANCY INFORMATION AND HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Total # Pregnancies (including this one) | # Term Births (at 37 weeks or more) | # Premature Births(before 37 weeks) | # Abortions | # Miscarriages | # Ectopic Pregnancies | # Multiple Births (twins, etc.) | # Living Children |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # | **Delivery Date** | **Weeks Pregnant** | **Birth Weight** | **Boy or Girl** | **Delivery Type** (vaginal, c-section, vacuum, forceps, VBAC, miscarriage, D&C) | **Epidural**Y/N | **Place of** **Delivery** | **Complications** (diabetes, high blood pressure, pre-eclampsia, pre-term labor, hemorrhage/bleeding,infection, birth defect etc.) |
| 1 |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |

**If there are more than six pregnancies, please use additional sheet.**

|  |  |  |  |
| --- | --- | --- | --- |
| How do you plan to feed your baby? | 🞏 Breast (this is recommended!)🞏 Formula 🞏 Both | Are you currently breastfeeding? | 🞏 No 🞏 Yes  |
| Have you previously breastfed? | 🞏 No 🞏 Yes  | If yes, for how long?(ex. 2 weeks, 6 weeks, 2 years) |  |

**CURRENT/RECENT MEDICATIONS (include vitamins/supplements)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Medication Name** | **Dosage** | **Frequency** | **Reason** | **Currently taking?** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |
| **5** |  |  |  |  |  |
| **6** |  |  |  |  |  |
| **Preferred Pharmacy Name and Location if other than CRDAMC** | **Preferred Pharmacy Phone Number** |

**If there are more than six medications, please use additional sheet.**

**ALLERGIES**

|  |  |  |
| --- | --- | --- |
| **Medication Allergies and Reactions:** |  |  🞏 **No Known**  **Medication Allergies** |
| **Other Allergies:** |  | **Latex Allergy:** 🞏 Yes 🞏 No |

 **YOUR MEDICAL HISTORY** (from your birth until today)- not your partner or your family

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **If yes, please include dates,****treatment, any complications** |  | **Yes** | **No** | **If yes, please include dates,****treatment, any complications** |
| Diabetes |  |  |  | History of MRSA, VRE or C Diff |  |  |  |
| Gestational Diabetes |  |  |  | Do you have any specific stressors (i.e. finances, obtaining quality food…) |  |  |  |
| High Blood Pressure |  |  |  | Do you have a good support system? |  |  |  |
| High Blood Pressure in pregnancy or preeclampsia |  |  |  | Do you receive comfort from spiritual practices? |  |  |  |
| Heart Problem or HeartMurmur |  |  |  | Religious preference |  |
| Stroke/Blood Clots/Pulmonary Embolism |  |  |  | Have you ever been emotionally or physically abused by your partner? |  |  |  |
| Recent Positive TB Testor exposure to TB |  |  |  | Have you been physically hurt by someone in the past year? |  |  |  |
| Kidney Disease orKidney Infection |  |  |  | Has anyone forced you to have sexual activity in the past year? |  |  |   |
| Autoimmune Disorder(Lupus, Crohn’s, RA, etc.) |  |  |  | Have you ever had a blood transfusion? |  |  |  |
| Neurologic Disorder/ Seizures/Migraines |  |  |  | Have you had a reaction to a blood transfusion? |  |  |  |
| Pulmonary (TB, Asthma) |  |  |  | **Will you accept blood products in an emergency?** |  |  |  |
| Thyroid Problems |  |  |  | Have you ever had anesthesia? |  |  |  |
| Cancer of any kind |  |  |  | Have you had a reaction to anesthesia? |  |  |  |
| Scoliosis |  |  |  | History of Chlamydia |  |  |  |
| Chronic neck, back, or joint pain Circle which one(s) |  |  |  | History of Genital or OralHerpes Circle which one(s) |  |  |  |
| Anemia |  |  |  | Date of Last Herpes Outbreak |  |
| Gastrointestinal Disorders |  |  |  | Does your partner haveGenital or Oral Herpes? |  |  |  |
| Anorexia or bulimia |  |  |  | History of Gonorrhea |  |  |  |
| High cholesterol orabnormal lipids |  |  |  | History of HPV |  |  |  |
| Are you on a special diet? |  |  |  | History of Syphilis |  |  |  |
| Liver disease |  |  |  | History of Hepatitis B or C |  |  |  |
| History of chickenpox or exposure to Chickenpox |  |  |  | History of HIV |  |  |  |
| Do you have or think you might have sleep apnea? |  |  |  | Uterine abnormalities |  |  |  |
| Have you recently been exposed to any infectious disease? |  |  |  | Diagnosis of PCOS |  |  |  |
| Have you recently had a rash or fever? |  |  |  | Fertility Treatments |  |  |  |
| Depression, Anxiety, PTSD, Bipolar, or other Psychiatric Disorder Circle which one(s) |  |  |  | Have you ever had an Abnormal Pap |  |  |  |
| Currently in/on treatment for Psychiatric Disorder? |  |  |  | Date of most recent Pap |  |
| Any additional medical or history:(Use additional page, if needed) |  |

**IMMUNIZATION HISTORY**

|  |
| --- |
| When was your last flu vaccine? |
| Have you received the HPV vaccines? 🞏 Yes 🞏 No If so, how many? |
| If you smoke/vape or have asthma, have you received the Pneumococcal Vaccine? 🞏 Yes 🞏 No  🞏 no asthma, smoking or vaping ever, so N/A |

**TELL US ABOUT YOU**

|  |  |  |  |
| --- | --- | --- | --- |
| What would you like us to call you? |  | Your Height: | Pre-PregnancyWeight: |
| Cell phone number: |  | Email: |  |
| Address |  | City | Zip |
| Marital Status: |  | Your Occupation: |  |
| Partner’s Name: |  | 🞏 Husband 🞏 Wife 🞏 Fiancé 🞏 Boyfriend 🞏 Girlfriend 🞏 Not Involved 🞏 Other: |
| Spouse’s Name (if not the same as above): |  | Will you be moving prior to delivery? | 🞏 No 🞏 ETS but staying here 🞏 ETS and moving to: 🞏 PCS to:  |
| How many days per week do you exercise? |  | How many minutes per day do you exercise? |  |

**YOUR SUBSTANCE USE HISTORY** (never means never ever ever)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Amount per day or week **before** pregnancy | Amount per day or week **during** pregnancy | # Years Use |
| Tobacco Use | 🞏 Never |  |  |  |
|  Second Had tobacco exposure | 🞏 Never |  |  |  |
|  Other tobacco use (add form) | 🞏 Never |  |  |  |
| Alcohol Use | 🞏 Never |  |  |  |
| Illicit/Recreational Drug Use | 🞏 Never |  |  |  |
| Edibles, microdosing or mushrooms | 🞏 Never |  |  |  |
| Vaping or E-Cigarette Use | 🞏 Never |  |  |  |

 **YOUR FAMILY HISTORY** – not your partner’s family

Your Mother, Father, Brother(s), Sister(s), Maternal Grandparents, Paternal Grandparents and your Children

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Relationship** |  | **Yes** | **No** | **Relationship** |
| Diabetes |  |  |  | Breast Cancer |  |  |  |
| Gestational Diabetes |  |  |  | Uterine Cancer |  |  |  |
| High Blood Pressure |  |  |  | Ovarian Cancer |  |  |  |
|  |  |  |  | Colon or Rectal Cancer |  |  |  |
| Any additional Family History: |  |

Your dad’s parents are your Paternal Grandmother (PGM) and Grandfather (PGF)

Your mom’s parents are your Maternal Grandmother (MGM) and Grandfather (MGF)

**YOUR SURGICAL HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **General Surgery** | **Yes** | **No** | **Year and Comments** | **GYN Surgery** | **Yes** | **No** | **Year and Comments** |
| Wisdom teeth removed |  |  |  | LEEP |  |  |  |
| Tonsils removed |  |  |  | Cold Knife Conization |  |  |  |
| Gallbladder removed |  |  |  | Fibroids removed |  |  |  |
| Appendix removed |  |  |  | Hysteroscopy or Uterus surgery |  |  |  |
| Back Surgery |  |  |  | Ovary Removed |  |  |  |
| Abdominal Surgery |  |  |  | Surgery for Ovarian Cyst |  |  |  |
| Thyroid surgery |  |  |  | Fallopian tube removed |  |  |  |
| Other surgeries (including surgery as an infant/child): |  |

**GENETIC HISTORY** – include your partner’s family

Mother, Father, Brother(s), Sister(s), Maternal Grandparents, Paternal Grandparents and your Children

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal or Family History** | **Yes** | **No** | **Relationship** | **Personal or Family History** | **Yes** | **No** | **Relationship** |
| Will you be 35 years old or older attime of delivery? |  |  |  | Muscular Dystrophy /NeuromuscularDisease |  |  |  |
| History of birth defects |  |  |  | Neural Tube Defect (Spina Bifida, Anencephaly or Meningomyelocele) |  |  |  |
| Cleft Lip/Cleft Palate  |  |  |  | Recurrent Pregnancy Loss or Stillbirth |  |  |  |
| Congenital Heart Defect (at birth) |  |  |  | Sickle Cell Disease or Trait |  |  |  |
| Cystic Fibrosis |  |  |  | Spinal Muscular Atrophy |  |  |  |
| Down Syndrome |  |  |  | Tay Sachs (Ancestry: Jewish, Cajun, French Canadian) |  |  |  |
| Hemophilia or Other Blood Disorders |  |  |  | Thalassemia (Ethnicity: Italian, Greek, Mediterranean, Asian) |  |  |  |
| Huntington’s Chorea |  |  |  | Consanguinity(Mother related to Father of Baby) |  |  |  |
| Intellectual disability, Autism, or Neurodivergence |  |  |  | Other Inherited Chromosomal Disorder Not Listed |  |  |  |
|  (If yes, were they tested for Fragile X?) |  |  |  | History of infant death |  |  |  |
| Mother or Sister with preeclampsia |  |  |  | Egg /Sperm donor for this pregnancy |  |  |  |
| Your ethnicity |  | Father of baby’s ethnicity |  |
| Any Additional Genetic History: |  |

**GENETIC SCREENING** Have you or your partner had carrier testing, or have you had any of the following tests?

|  |  |
| --- | --- |
| Carrier testing - EVER | Screening – THIS PREGNANCY |
| Cystic Fibrosis |  | You |  | Partner | First Trimester Screen |  | Yes |  | No |
| Spinal Muscular Atrophy (SMA) |  | You |  | Partner | Cell Free DNA (NIPT) |  | Yes |  | No |
| Fragile X |  | You |  | Partner | Chorionic Villus Sampling (CVS) |  | Yes |  | No |
| Other Genetic Disorders |  | You |  | Partner | Amniocentesis (Amnio) |  | Yes |  | No |
| Information on date and results: |  |

|  |  |
| --- | --- |
| What was the first day of your last period (LMP)? |  |
| How sure are you of that date? |  🞏 Very sure 🞏 Could be off by 2 or 3 days  🞏 Could be off by 1 week or more 🞏 Unsure  |
| Are your periods regular? |  🞏 Yes 🞏 No |
| How many days from one period to the next? |  |
| Was this period when you expected it? |  🞏 Yes 🞏 No |
| Was the flow normal? |  🞏 Yes 🞏 No |
| Have you had any bleeding since your LMP? |  🞏 Yes 🞏 No |
| Were you on any hormonal birth control when you got pregnant? |  🞏 Yes 🞏 No |
| Were you using any fertility treatments to get pregnant with this baby? |  🞏 Yes 🞏 No If yes, what treatments? |
| Have you ever had an ectopic pregnancy? |  🞏 Yes 🞏 No |
| Have you had any surgeries on your ovaries or fallopian tubes?  |  🞏 Yes 🞏 No |
| Have you had an ultrasound in this pregnancy? |  🞏 Yes 🞏 No If so, where? |
| Do you have pre-existing Diabetes? \*\* |  🞏 Yes 🞏 No If so, what medications do you take for your diabetes? |
| Are you on any antiseizure medications? \*\* |  🞏 Yes 🞏 No If yes, what medications? |

FOR INTERNAL USE:

\*\*If yes to either of these, schedule short interval appt with Acute Care Physician for medication review

RN/LVN Process: Wt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Vital Signs
2. NOB education
3. Patient completion of New OB Patient Intake Form (NOBPIF)
4. Review of LMP and existing dating criteria
5. Collect NOBPIF and verify completion
6. Review Medications
7. Schedule NOB physical (at 10-12 weeks), OR Transfer-In appointment (in 1-2 weeks)
8. Schedule Acute Care Appt only if needed (including for immediate provider med review prn)
9. Create pregnancy in Genesis; Enter VS and LMP and Medication History
10. Complete RN/LVN Intake note
11. Scan in NOBPIF