# Rutland Women's Healthcare

A Department of Rutland Regional Medical Center

**PREGNANCY HEALTH HISTORY**

*Please complete this form and bring to your initial prenatal visit. This information is used to guide us in providing your care. If you are unsure about the questions, answer as best you can; and we will clarify your history at the time of your visit. Thank you.*

## Identifying and Contact Information

Name: ______________________________ Date of Birth: ________________

Address: ____________________________________________

Phone(s): Home ____________ Work ____________ Cell ______________

Email: ____________________________________________

How would you like us to contact you? ____________ Last 4 digits of SS: ____________

Education – highest grade completed: ____________ Occupation: ______________

Ethnic background: ______________________ Religious affiliation: ____________

Marital Status: ❒ Single ❒ Engaged ❒ Married ❒ Civil Union ❒ Living Together ❒ Separated ❒ Divorced ❒ Widowed

Name of Partner: ______________________ Contact Phone: ______________

Emergency Contact (name): __________________ Contact Phone: ______________

Primary Care Provider (PCP): ____________________________________

Preferred Pharmacy: ____________________________________

## Menstrual History/Contraceptive History

What was the *FIRST* day of your last period? ____________ Was it normal? ❒ Yes ❒ No

Do your periods come monthly? ❒ Yes ❒ No …every how many days? ____________

Were you using birth control or any method to try and keep from getting pregnant? ❒ Yes ❒ No

When did you use birth control last: ________ Is this a planned pregnancy? ❒ Yes ❒ No

Did you use fertility treatment or medication to achieve this pregnancy? ❒ Yes ❒ No

## Interval History

What pregnancy symptoms are you experiencing? *(check all that apply)*

❒ Headaches ❒ Nausea/Vomiting ❒ Abdominal Pain ❒ Vaginal Discharge ❒Vaginal Bleeding
❒ Swelling ❒ Fever ❒ Viral Exposure ❒ Radiation Exposure

# Rutland Women's Healthcare

A Department of Rutland Regional Medical Center

## Medications

List of prescription or over-the-counter medications, including vitamins or supplements that you are currently taking, or have taken before pregnancy: please indicate if you have discontinued.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

## Allergies

Are you allergic to any medications, foods, latex or other substances? ❒ Yes ❒ No

*If yes,* please list: ____________________________________________________________

___________________________________________________________________________

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

___________________________________________________________________________

___________________________________________________________________________

## Past Pregnancy History

Please indicate the number of times you have been pregnant: _____________

Full term births: _______ Twin or multiple pregnancies _____ Preterm births (less than 37 weeks) ____

Tubal pregnancies ______ Elective abortion ______ Stillbirths ______

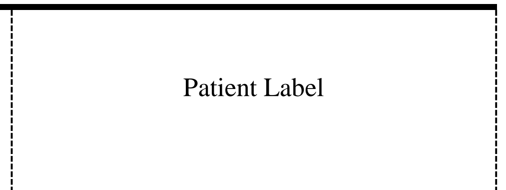
Miscarriages (before 13 weeks) ______ Miscarriages (between 13 and 24 weeks) ______

| Pregnancies (include misc.) | Date of Birth | Weeks Pregnant | Length of Labor | Birth Weight | Sex of Baby | Type of Birth:<br>-Vaginal<br>-Vacuum<br>-C-section | Anesthesia Pain Relief | Place of Birth | Child's Name | Premature Labor? Complications? |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |

Comments: ______________________________________________________________

___________________________________________________________________________





Patient Label

<u>With any of your pregnancies, have you had?</u> *(check all that apply)*

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

Comments about checked items: ________________________________________________________________

________________________________________________________________________________

## Medical History

<u>Do you have now or have you ever had any of the following problems?</u> *(check all that apply)*

- ❒ Abnormal Uterine bleeding
- ❒ Accident, trauma, violence
- ❒ Anemia
- ❒ Autoimmune disease (for example, lupus, rheumatoid arthritis)
- ❒ Blood transfusion
- ❒ Breast disease or treatment
- ❒ Cancer, if yes, please explain _______________
- ❒ Congenital abnormalities,
- ❒ Depression/postpartum depression/anxiety
- ❒ Diabetes or hypoglycemia
- ❒ Disease: Thyroid, Graves, Hashimoto's
- ❒ Drug Abuse, if yes, please explain _______________
- ❒ Gastro Intestinal (GI or stomach problems)
- ❒ Genetic Disease if yes, please explain _______________
- ❒ Heart disease, murmurs that requirement medication
- ❒ Hepatitis, liver disease, jaundice, hepatitis B or C
- ❒ History of abnormal pap smears When was your last pap smear? ___________
- ❒ Hypertension, high blood pressure



Patient Label

- ❒ Infertility
- ❒ Kidney disease, urinary tract or bladder infections, kidney stones
- ❒ Metabolic/Endocrine problems
- ❒ Migraine headaches
- ❒ Neurological disease, epilepsy, seizures, black-out spells
- ❒ Neuropathy
- ❒ Psychiatric: anxiety, panic, post-traumatic stress disorder, bipolar, ADHD
- ❒ Pulmonary or respiratory disease (tuberculosis, asthma)
- ❒ Rheumatic fever
- ❒ Smoking/Alcohol use, if yes, please explain _______________
- ❒ Use complementary or alternative medicine
- ❒ Uterine anomaly? Did your mother take a medication called DES when she was pregnant with you?
- ❒ Varicosities, phlebitis, blood clots, or clotting disorder

Have you received medical treatment for any condition not mentioned above? ❒ Yes ❒ No

If yes, describe: ________________________________________________________________________________

## Surgical History

- ❒ Hospitalizations? ❒ Yes ❒ No *If yes,* note year and reason:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

- ❒ Gynecological surgery, any treatment to the cervix, uterus, ovaries, fallopian tubes
- ❒ Other Operations? ❒ Yes ❒ No *If yes,* note year, reason,
- ❒ Any complications from anesthesia? ❒ Yes ❒ No

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

## Family History

Please check all conditions that have occurred in ***YOUR*** first degree or blood relatives (mother, father, brother, sister, grandparents, or your other children)? *(check all that apply)*

- ❒ Allergies or asthma — Relatives affected: ________________________________
- ❒ Anesthesia complications — Relatives affected: ________________________________
- ❒ Cancer — Relatives affected: ________________________________
- ❒ Clotting disorder, thrombosis — Relatives affected: ________________________________
- ❒ Complicated pregnancies — Relatives affected: ________________________________

- ❒ Congenital anomalies  Relatives affected: ______________________
- ❒ Diabetes  Relatives affected: ______________________
- ❒ Epilepsy  Relatives affected: ______________________
- ❒ Heart disease  Relatives affected: ______________________
- ❒ Hypertension, high blood pressure  Relatives affected: ______________________
- ❒ Neurological disease  Relatives affected: ______________________
- ❒ Stroke  Relatives affected: ______________________
- ❒ Mental health or behavioral problems  Relatives affected: ______________________
  (ADD, ADHD, autism, bipolar disorder, schizophrenia, substance abuse, anxiety, depression, suicide)
- ❒ Pulmonary Disease  Relatives affected: ______________________
- ❒ Renal disease  Relatives affected: ______________________
- ❒ Thyroid/Metabolic/Endocrine disorders  Relatives affected: ______________________

Comments about checked items that you feel is important: ______________________________

______________________________________________________________

## Father of the Baby

Name: ________________ DOB(age): ________ Father's Occupation: ________________

Does he or his family have any medical history that you feel is important to share? ❒ Yes ❒ No

*If yes,* please describe: ______________________________________________

______________________________________________

Is there any other history in your family or the father of the baby's family that will influence your pregnancy or the baby? ❒ Yes ❒ No

*If yes,* please describe: ______________________________________________

______________________________________________

## Substance History/Exposure

Have you used any street drugs or alcohol since your last menstrual period? ❒ Yes ❒ No

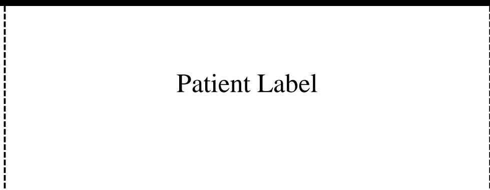
*If* yes, please describe: ______________________________________________

Smoking:

- ❒ 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 smoking? __________





Are you interested in quitting? ❐ Yes ❐ No
Does anyone in your household smoke? ❐ Yes ❐ No

Alcohol:

- Have you had any alcohol in the last two years? ❐ Yes ❐ No
- If yes, have you had ≧ 4 drinks in one day? ❐ Yes ❐ No
- Have you used alcohol during this pregnancy? ❐ Yes ❐ No

Drugs:

- Have you ever used street drugs, recreational drugs, or drugs other than those required for medical reasons (for example, marijuana, heroin, cocaine, speed, hallucinogens, narcotics, inhalants)? ❐ Yes ❐ No
- Have you used drugs during this pregnancy? ❐ Yes ❐ No
- Have you ever been concerned about your use of or had a problem with drugs or alcohol in the past? ❐ Yes ❐ No
- Does your partner have a problem with drugs or alcohol? ❐ Yes ❐ No
- Do you consider one of your parents to be an addict or alcoholic? ❐ Yes ❐ No
- Do you have any concerns about substance use or exposure and your pregnancy? ❐ Yes ❐ No
- Substance Abuse treatment program? If yes, please describe: ___________________________________

## Infection History and Risk Assessment

- Do you have pet cats, birds, turtles, rodents, exotic animals? ❐ Yes ❐ No
- Tuberculosis or exposure to someone who has it? ❐ Yes ❐ No
- Chicken pox or immunization ❐ Yes ❐ No
- Hepatitis B or the vaccine ❐ Yes ❐ No
- Tdap vaccine (tetanus, diphtheria, pertussis) ❐ Yes ❐ No If yes, date: ___________________
- Hepatitis C or exposure to someone who has it, and/or a recent tattoo or piercing ❐ Yes ❐ No
- Have you ever been treated for MRSA (methicillin resistant staph aureus)? ❐ Yes ❐ No
- Have you had a rash or viral illness since your last period? ❐ Yes ❐ No
- History of any sexually transmitted diseases ❐ Yes ❐ No If yes, please check all that apply
- ❐ chlamydia ❐ gonorrhea ❐ HPV (human papilloma virus) ❐ HIV/AIDS ❐ syphilis
- Do you or your partner have genital herpes? ❐ Yes ❐ No
- Any other infections or exposures that you are concerned about at work or home? ❐ Yes ❐ No If yes, describe:
- Recent travel? If yes, where and when? _____________________________________________________

## Nutritional Assessment and Exercise History

- Height: _______________ Weight at last menstrual period: _______________
- Do you avoid milk or milk products? ❐ Yes ❐ No
- Are you on a special diet? ❐ Yes ❐ No
- Do you follow a vegetarian diet? ❐ Yes ❐ No *If yes,* ❐ Ovo-lacto ❐ Vegan

Patient Label

- Ever been diagnosed with or treated for an eating disorder? ❒ Yes ❒ No If yes, describe: ___________________

## 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? ❒ Yes ❒ No
- Do you have concerns about a past or current experience with physical or emotional violence in a dating or family relationship? ❒ Yes ❒ No
- Do you feel safe in your current relationship? ❒ Yes ❒ No
- Do you feel safe within your home? ❒ Yes ❒ No
- Do you feel you have adequate support (family/friends) during this pregnancy? ❒ Yes ❒ No
- Do you have past or current mental health struggles? ❒ Yes ❒ No
- If yes, working with a counselor or therapist? ❒ Yes ❒ No
- Do you feel you need support connecting with community resources? ❒ Yes ❒ No
- Are you currently experiencing any of the following stressful life events/situations?
  ❒ Separation or divorce ❒ Moved ❒ Homeless ❒ Access to transportation
  ❒ Health ❒ Health Insurance ❒ Financial ❒ Legal
  ❒ Job loss partner ❒ Job loss self even though you wanted to keep working
  ❒ Family member illness or hospitalization ❒ Death of someone close to you
  ❒ Other ___________________________________________________________
- Would you find it beneficial to speak with our Social Worker? ❒ Yes ❒ No
- Please list anything else that you would like to discuss or share with your health care providers: _________________

______________________________________________________________________________________________

______________________________________________________________________________________________