MCMC MID-COLUMBIA MEDICAL CENTER | COLUMBIA RIVER WOMEN'S CENTER

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A DESIGNATED PLANETREE PATIENT-CENTERED HOSPITAL

# PRENATAL HEALTH HISTORY

Please be as complete as possible with your answers. If you are uncomfortable answering any questions, leave them blank and talk with your provider or nurse about them in person. We look forward to caring for you!

Name: _____

Name you like to be called: _____ Date of Birth: _____ Age: _____

***LMP (Last Menstrual Period):*** _____ Was this pregnancy planned? ☐Yes ☐No

**Father of Pregnancy**

Name:_____ Date of Birth: _____ Age: _____

Occupation: _____ Involved in pregnancy? ☐Yes ☐No

## ALLERGIES

Have you ever had an *allergic reaction* (bad effect) to a medicine or a shot?

| Allergic to | What happens |
|---|---|
| | |
| | |
| | |

## MEDICATIONS

*Preferred Pharmacy*: _____

Please list any medications or supplements (*no need to fill out if you brought a list or your medication bottles*)

| Medication/Supplement | Strength or Amount | Last time it was taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Label

*ZMC025* ZMC025

## MEDICAL HISTORY

Do you currently or have you had any of the following? (☒ *check all that apply*)

- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Blood Transfusion
- ☐ Diabetes (Type 1, Type 2, Gestational)
- ☐ Genital Herpes (or your partner)
- ☐ Group B Strep in prior pregnancy
- ☐ Headaches
- ☐ Hepatitis
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Mental Health Issues/Depression
- ☐ Post Partum Depression
- ☐ Positive PPD/Tuberculosis
- ☐ Pre-Eclampsia with prior pregnancy
- ☐ Prior Preterm Birth
- ☐ Recurrent Urinary Tract Infection
- ☐ Seizures
- ☐ Stroke
- ☐ Suicide Attempts
- ☐ Thyroid Disorder
- ☐ GYN Problems (*please specify)* _____

***Other health or mental health problems?*** _____

_____

## SURGICAL HISTORY Please list all surgeries you have had and dates (if you can)

*(Examples: C-section, LEEP, Conization, D&C, Cryosurgery, any gynecologic or pelvic surgery*)

| SURGERY | DATE(S) |
|---|---|
| | |
| | |
| | |
| | |
| | |

## PREGNANCY HISTORY ☐ *I have never been pregnant before*

Have you had trouble becoming pregnant? ☐No ☐Yes _____

*Please list approximate dates below:*

Miscarriages _____ D&C done? ☐No ☐Yes Abortions_____ Ectopic_____

| | Date of birth | Baby's weight | Sex | Weeks | Delivery (vaginal, with vacuum, forceps, c-section) | Complications (high blood pressure, diabetes, pre-eclampsia, previa, abruption, etc.) |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |

## SOCIAL HISTORY AND HABITS

***Substance Use***

Do you use tobacco? ☐ Never ☐ Yes ☐ Quit, Year:_____ ☐Smokeless ☐ Passive (secondhand smoke)

If yes, packs per day? _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per week _____

Do you now or have you ever used any drugs? ☐ No ☐ Yes If yes, how often _____

What type (*marijuana, methamphetamine, heroine, etc.)* _____ Last use: _____

***Diet and Exercise***

Do you drink soda? ☐ No ☐ Yes, Amount per day: _____

Servings of fruits and vegetables per day? _____ How often do you eat fast food? _____

How often do you exercise? ☐ Never ☐Occasional ☐2-3x/week ☐3-4x/week ☐Daily

Type? _____

Do you drink caffeine? ☐ No ☐ Yes If yes, how many drinks per day_____

***Employment/Education***

Occupation: _____ Hours per week? _____

Education: (*check highest level completed*) ☐Grade school ☐High school/GED ☐Tech school ☐College ☐ Graduate School

***Homelife and Safety***

Who lives in your household? _____

What is your living situation? _____

Are you able to cover basic needs: food, clothing, utilities? ☐No ☐Yes Explain: _____

_____

Do you have transportation? ☐No ☐Yes Explain: _____

Firearms in the home? ☐No ☐Yes Smoke Detectors in the home? ☐No ☐Yes

Animals in the home? ☐No ☐Yes Seat belt use regularly? ☐No ☐Yes

Please list types of animals:_____

## HEALTH/INFECTION SCREENING

Date of last Pap test _____

History of abnormal Pap smears? ☐No ☐Yes, Result? _____

Treatment for abnormal Pap smears? ☐No ☐Yes If yes, what? (*LEEP, cryo, etc.*) _____

History of sexually transmitted infection (STI) or gynecologic infection? (chlamydia, gonorrhea, herpes, etc.) ☐No ☐Yes

If yes, what: _____

Have you had chickenpox or the varicella vaccine? ☐No ☐Yes If yes, what: _____

Do you have tattoos? ☐No ☐Yes

Have you (or the father of the baby) been incarcerated (been in jail/prison)? ☐No ☐Yes

Are you receiving regular dental care? ☐No ☐Yes Date of last dental exam & provider _____

Would you agree to a blood transfusion if necessary? ☐No ☐Yes

**Mood**

During the last 2 weeks, have you been bothered by little interest or pleasure in doing things? ☐No ☐Yes

During the last 2 weeks, have you been bothered by feeling down, depressed, or hopeless? ☐No ☐Yes

## GENETIC HISTORY

Your Ethnic Background: _____

Father of Pregnancy Ethnic Background: _____

**Do you, the father of the pregnancy, any previous children, or *anyone in either of your families* have any of the following:**
***(If yes, please tell us who next to the box marked Yes)***

| | | | | | |
|---|---|---|---|---|---|
| Sickle Cell Disease or Trait? | ☐No | ☐Yes | Seizure Disorder? | ☐No | ☐Yes |
| Thalesemia? | ☐No | ☐Yes | Bone or Skeletal Disorder? | ☐No | ☐Yes |
| Tay Sachs Disease? | ☐No | ☐Yes | Neurofibromatosis? | ☐No | ☐Yes |
| Down's Syndrome? | ☐No | ☐Yes | Polycystic/other Kidney Disorder? | ☐No | ☐Yes |
| Cystic Fibrosis? | ☐No | ☐Yes | Heart Defect (at birth)? | ☐No | ☐Yes |
| Huntington's Disease? | ☐No | ☐Yes | Cleft Lip/Palate? | ☐No | ☐Yes |
| Muscular Dystrophy? | ☐No | ☐Yes | Phenylketonuria (PKU)? | ☐No | ☐Yes |
| Hemophilia or Bleeding Disorder? | ☐No | ☐Yes | Deafness? | ☐No | ☐Yes |
| Definite or probable ADD/ADHD | ☐No | ☐Yes | Blindness? | ☐No | ☐Yes |

Neural Tube Defect? (Meningomyelocele, Spina Bifida, Anencephaly) ☐No ☐Yes

Mental Retardation/Autism? ☐No ☐Yes
Please indicate cause, if known _____

Genetic Condition, chromosome abnormality, or inherited disorder not listed above? ☐No ☐Yes
Please describe _____

Birth Defect, not listed above? ☐No ☐Yes
Please describe _____

Serious medical problem that you are concerned about? ☐No ☐Yes
Please describe _____

## FAMILY HISTORY (Mother of the baby's family only)

Are there any conditions that run in your family? (For example: diabetes, cancer, heart disease, clotting disorders, etc.)

*If so, please list the condition and who is affected:*_____

_____

_____

_____

## REPRODUCTIVE HISTORY

Have you or the baby's father had a baby who died shortly after birth or in the first year? ☐No ☐Yes

Have you or the baby's father had recurrent pregnancy loss (≥2) or stillbirth? ☐No ☐Yes

Pregnancy the result of assisted reproductive technology (IUI, IVF, ICSI, PGD, Donor)? ☐No ☐Yes

**Anything else you would like to talk about today?**