Pre-Baby Health History Form

Name: _____ Date of Birth:_____

Diabetes Screening Tool

If you answer yes to any of these questions, it may be recommended that you are screened for Gestational Diabetes earlier in your pregnancy.	**Yes**	**No**
Will you be 35 years or older when you deliver your baby?		
What was your weight one month prior to pregnancy? ***BMI >29.5=early screening*		
Do you have a history of diabetes during previous pregnancy?		
Have you delivered a baby weighing 9 pounds or more?		
Have you been diagnosed with PCOS?		
Are you currently taking Metformin? ***If yes, complete 2-hour GTT at 14 weeks*		
Are you of Hispanic, Asian, or Native American descent?		
Have you had a pregnancy that resulted in a stillbirth or a baby born with malformation?		
Have you had a fasting blood sugar level greater than or equal to 100? ***Check for lab in the past year*		
Do you have a history of an elevated 1-hour Glucose Tolerance Test with a past pregnancy?		
Do any of your family members (mom, dad, brother, sister) have Type 2 Diabetes?		
Do you have a history of weight loss surgery (gastric bypass/gastric sleeve)? ***Refer to GDM RN for testing recommendations*		

OB Providers

Who will be your primary provider for your pregnancy? _____

Do you have any other health care providers? If yes, please list _____

Have you decided on your baby's health care provider? If yes, please list _____

Pregnancy Timing Information

First day of your last period _____ Was this a normal period for you? _____

Do you know the day you might have conceived? _____

Have you had an ultrasound during this pregnancy? _____

Is there any other information we should know that may affect our ability to predict your delivery date? _____

_____

Obstetrical History

Please include all miscarriages and/or elective terminations.

Delivery Date	Weeks along at delivery	Length of delivery	Baby's Weight	Sex of Baby	Delivery Type (Vaginal or C-Section)	Pain Medication	Living	Baby's Name	Where delivered	Delivering Doctor

Did you have any problems/concerns during your pregnancy or delivery? _____

_____

_____

Family History

This is referring to your parents, grandparents, and siblings. Not you partners' family			Alcohol/Drug Problem	Anesthesia Complications	Arthritis	Asthma	Blood/Bleeding Disorder	Cancer, Breast	Cancer, Colon	Cancer, Ovarian	Cancer, Other	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol/Lipids	Genetic Disease	Kidney Disease	Mental Health Problem	Obesity	Stroke	Thyroid Disease	Other
Parent	Mother	Living?																				
Parent	Father	Living?																				
Grandparent	Mom's Mom	Living?																				
Grandparent	Mom's Dad	Living?																				
Grandparent	Dad's Mom	Living?																				
Grandparent	Dad's Dad	Living?																				
Sibling	Bro Sis	Living?																				
Sibling	Bro Sis	Living?																				
Sibling	Bro Sis	Living?																				
Sibling	Bro Sis	Living?																				
Children	Dau Son	Living?																				
Children	Dau Son	Living?																				
Children	Dau Son	Living?																				
Children	Dau Son	Living?																				

Prenatal Genetic Assessment

Are you worried about any medications or drugs that you used during this pregnancy? **Yes** **No**

Are you worried about any exposures during this pregnancy? **Yes** **No**

Baby's Father's History:

Does the baby's father have any ongoing health problems? **Yes** **No**

Was the father of the baby age 40 or older with the baby was conceived? **Yes** **No**

Are you a blood relative to the father of the baby? **Yes** **No**

Race: Some ethnicities can increase your risk of certain illness that can suggest the need for more testing in pregnancy.

Are you or the father of the baby one of these ethnicities?

- Jewish
- Mediterranean (Middle East, Greece, Italy, Spain, etc.)
- Asian (Southeast Asia, China, Taiwan, Philippines, India, etc.)
- Latino/Hispanic
- Black or African
- French Canadian

Family Histories (you or the baby's father)

Are any of these health issues in your family? If so, please write specific health problem:

- History of stillbirth or more than one miscarriage in immediate family? _____
- Birth Defects: _____
- Mental retardation, autism or learning disability:_____
- Chromosome problems (down syndrome, klinefelter syndrome, trisomy 13 or 18)_____
- Other genetic problems (cystic fibrosis, marfan syndrome, sickle cell anemia, hearing loss, bleeding disorders, etc.)_____

Allergies

Do you have any allergies to medications or anything else?

Medication or Other	Reaction

Medications

List any prescription, over-the-counter medications or supplements you are taking or have taken during your pregnancy.

Are you taking prenatal vitamins or a folic acid supplement? **Yes** **No**

Current Medication	Pill Strength	Dose	Taking currently?	Prescribing Provider

Medical History

	Yes	No		Yes	No		Yes	No
Abdominal Pain			Endometriosis			Osteoporosis		
Abnormal Uterine Bleeding			Fibrocystic Breast			Ovarian Cyst		
Anxiety			Fibroids			Pelvis Pain		
Anemia			Gonorrhea			Pneumonia		
Asthma			Headaches, Recurrent			PCOS		
Bleeding Problems			Heart Disease			Rectocele		
Breast Mass			Heartburn/Reflux			Environmental Allergies		
Cancer, Other			Heavy Periods			Seizures or Epilepsy		
Cancer, Breast			Hepatitis			Sexual Dysfunction		
Cancer, Cervical			Herpes			Shingles		
Cancer, Endometrial			High Blood Pressure			Stroke		
Cancer, Ovarian			Hirsutism			Substance Abuse		
Cancer, Vaginal			HPV			Syphilis		
Cancer, Vulvar			Infertility			Thyroid Problem		
Chlamydia			IBS			Trichomonas		
Cholesterol Problem			Kidney Disease			Tuberculosis		
Depression			Liver Disease			Urinary Incontinence		
Diabetes			Menopause			Uterine Prolapse		
Eating Disorder			MRSA			Vaginal Infection, Recurrent		
Ectopic Pregnancy			Obesity or Overweight			VRE		

Surgical History

	Yes	No		Yes	No		Yes	No
Appendectomy			Cholecystectomy			Hysterectomy		
Bladder Suspension			Colposcopy			Hysteroscopy		
Breast Augmentation			Cystocele Repair			Laparoscopy		
Breast Biopsy			Dilate and Curettage			LEEP		
Breast Lumpectomy			Endometrial Ablation			Oophorectomy		
Breast Reconstruction			Fibroid Removal			Rectocele Repair		
Cervical Conization			Genital Wart Removal			Tubal Ligation		
Cesarean Section								

Please list your surgical history, if not listed above:

Procedure or Surgery	Date	Place of Surgery	Any Complications?

Any problems with anesthesia? **No** **Yes, please explain**:_____

Job & Education

Job: _____ Current Employer:_____

Years of Education/Highest Degree:_____

Eating Habits & Safety Information

Do you need support with healthy eating?	**Yes**	**No**
Are you on a special diet?	**Yes**	**No**
Do you feel you have a weight problem?	**Yes**	**No**
Do you exercise less than 3-4 days per week?	**Yes**	**No**
Do you often get sleepy during the day?	**Yes**	**No**
Do you **not** routinely wear your seatbelt?	**Yes**	**No**
Do you have unlocked weapons in your home?	**Yes**	**No**
Are you having major stress?	**Yes**	**No**

Partner & Family Information

Significant other/spouse's name: _____ Age: _____

Partner's job/employer: _____

How many children do you have in your home? _____

Health Habits & Personal Safety

Tobacco:

Do you use tobacco products? **Yes** **Never** **Quit Date _____**

If yes, what type? **Cigarettes** **Cigars** **Chew** **Snuff** **Pipe**

If cigarettes, how many packs per day? **<.25** **0.5** **1** **1.5** **2** **_____**

Do you want to quit? **Yes** **No**

Alcohol:

Before you knew you were pregnant:

How often on average did you drink alcohol?

Don't Drink **Less than one a month** **At least once a month** **At least once a week** **Everyday**

When you did drink, how many drinks did you have?

Don't Drink **1 to 2** **3 to 4** **5 to 6** **At least 7**

Since knowing you were pregnant:

How often do you drink alcohol?

Don't Drink **Less than one a month** **At least once a month** **At least once a week** **Everyday**

When you did drink, how many drinks did you have?

Don't Drink **1 to 2** **3 to 4** **5 to 6** **At least 7**

When was the last time you had a drink? _____

Drugs:

Before you knew you were pregnant:

Did you use street drugs?

No **Heroin** **Methadone** **Methamphetamine** **Cocaine** **Ecstasy** **IV** **Other**

Did you use prescription pain medications?

No **Vicodin** **Percocet** **Other**

How often on average did you use drugs?

Don't use drugs **less than once per month** **at least once per month** **Weekly** **Everyday**

Since knowing you were pregnant:

Do you use street drugs?

No **Heroin** **Methadone** **Methamphetamine** **Cocaine** **Ecstasy** **IV** **Other**

Do you use prescription pain medications?

No **Vicodin** **Percocet** **Other**

How often on average do you use drugs?

Don't Drink **1 to 2** **3 to 4** **5 to 6** **At least 7**

Have you ever been in treatment for alcohol or drugs? **Yes** **No**

Immunizations

Most Recent Immunization dates, if known:

Tetanus	__/__/____	Influenza	__/__/____	Pneumovax	__/__/____
Hepatitis B	__/__/____	Varicella (Chicken Pox)	__/__/____	TDAP	__/__/____
Hepatitis A	__/__/____				

Workplace Assessment

At work, are you exposed to chemical, radiation or significant infections? **Yes** **No**

If so, what are you exposed to? _____

At work, do you often lift heavy objects? **Yes** **No**

If so, how many pounds? _____

Eating Habits

Do you often skip meals? **Yes** **No**

Do you drink caffeinated beverages? **Yes** **No**

If yes, how much daily? _____

Do you eat less than 5 servings of fruits/vegetables daily? **Yes** **No**

Do you have concerns about toxoplasmosis? **Yes** **No**

Do you have a history of an eating disorder? **Yes** **No**

Do you exercise regularly? **Yes** **No**

Early Pregnancy History

Since your last menstrual period, have you:	Experienced nausea?	**Yes**	**No**
	Thrown up?	**Yes**	**No**
	Had continued or worsening stomach pain?	**Yes**	**No**
	Had any vaginal bleeding?	**Yes**	**No**

Social History

Was this pregnancy planned?	**Yes**	**No**
Plans for newborn: **Parent** **Place baby for adoption** **Unsure of plans**		
Do you need extra support in this pregnancy?	**Yes**	**No**
Do you feel unsafe in any current relationship or have a history of abuse?	**Yes**	**No**
Do you have any money concerns?	**Yes**	**No**
Are in a relationship? Partners name: _____	**Yes**	**No**

Pregnancy History

Have you had any previous pelvic surgery? What kind? _____	**Yes**	**No**
Have you had any miscarriages? At how many weeks? _____	**Yes**	**No**
Have you ever delivered any pregnancies prior to 37 weeks?	**Yes**	**No**
Were you ever treated for preterm labor?	**Yes**	**No**
Have you ever had a stillborn baby?	**Yes**	**No**
Have you had any illness during this pregnancy?	**Yes**	**No**
Do you have any chronic medical conditions?	**Yes**	**No**

Tuberculosis Exposure Assessment

Have you been in close contact with people with known TB?	**Yes**	**No**
Are you an immigrant from Africa, Asia, or Latin America?	**Yes**	**No**
Have you ever been diagnosed with HIV?	**Yes**	**No**

Lead Exposure Assessment

Do you or others in your household have a job that involve possible lead exposure?	**Yes**	**No**
Do you ever have the urge to eat things that are not food, such as clay, soil, or paint chips?	**Yes**	**No**
Do you live in a home built before 1978 that has updates that made dust?	**Yes**	**No**
To your knowledge, has your home been tested for lead? If so, was it high?	**Yes**	**No**
Do you use any homemade remedies/cosmetics that are not sold in stores?	**Yes**	**No**