



Name _____

Due Date _____

Your Health History

Allergies: ___ None

___ Medication/s/ Reaction: _____

___ Latex or Food Reactions: _____

Special Diet _____

OB Procedures with this pregnancy:

___ Amniocentesis ___ Ultrasound ___ Preterm labor meds

Previous or Current History of: "P" for Previous & "C" for Current pregnancy issue

___ Twins, Triplets... ___ Ectopic Pregnancy ___ Stillbirth

___ Cesarean Section ___ Postpartum Hemorrhage ___ Anemia

___ Preeclampsia ___ Chronic High B/P ___ Cardiac Disease

___ Genital Herpes ___ Preterm delivery ≤37wk ___ Lung Disease

___ Polyhydramnios ___ Oligohydramnios ___ Uterine Bleeding

___ Previous infant over 8# 13oz ___ Incompetent Cervix ___ None

Your Height ___ ft ___ Inches **Pre-pregnancy Weight** _____

Routine Prescribed **Medications**/Dose/Frequency: _____

Medical Conditions _____

Past Surgeries/Year _____

Chronic Pain not related to your pregnancy NO Yes

Comment: _____

Diabetic ___ **Gestational** ___ **Type I** ___ **Type II** NO Yes

Positive for "Resistant Organisms" like MRSA or VRE NO Yes

Congestive Heart Failure (CHF) NO Yes

COPD NO Yes

Caffeine Use Amount (per day) _____ NO Yes

Tobacco Use (cigs/day) _____ NO Yes

Alcohol during Pregnancy (amt/day) _____ NO Yes

Use of Street Drugs/Inhalants-Type/months using _____ NO Yes

Are you an Organ Donor?

NO Yes

Do you have a health care directive (a "Living Will")?

NO Yes

If yes, Location _____

Do you have a health care proxy?

NO Yes

Do you have a power of attorney?

NO Yes

Do you have a legal guardian?

NO Yes

Religious/Cultural Needs _____

NO Yes

Are your basic needs (housing, clothing food, etc.) being met?

NO Yes

Do you have unusual stress in your life (living or working conditions, serious illnesses or a recent family death, etc.)?

NO Yes

What is your highest level of education?

___ Grade ___ GED ___ High School ___ College

Do you have any barriers to learning?

___ Dyslexia ___ Reading ___ Memory ___ None