My Health History

Allergies: ☐ None ☐ Latex ☐ Food   Medications/Reactions

Food Reactions:
Special Diet:
Medications:

Your Height: ft in.   **Pre-pregnancy Weight**:

Routine Prescribe Medications/Dose/Frequency:

Medical Conditions:

Past Surgeries/ Year:

Chronic Pain not related to your pregnancy:

- **Diabetic** ○ Gestational ○ Type 1 ○ Type 2
- **Positive for "Resistant Organisms" like MRSA or VRE** Yes ○ No ○
- **Congestive Heart Failure (CHF)** Yes ○ No ○
- **COPD** Yes ○ No ○
- **Caffeine Use Amount (per day):** Yes ○ No ○
- **Tobacco Use**: ○ Never smoked ○ Current daily smoker ○ Occasional smoker ○ Former smoker Yes ○ No ○

  Please indicate how many cigarettes smoked per day:

  3 months before pregnancy: 1st Trimester:

  2nd Trimester: 3rd Trimester:

  *Please note that as of August 1, 2016, Northfield Hospital & Clinics is Tobacco Free. Talk to your provider about options during your stay.

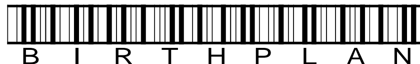
- **Alcohol use during pregnancy (amt/day):** Yes ○ No ○
- **Street Drugs/Inhalants- Type using:**   **# of months using:** Yes ○ No ○
- **Are you an organ donor?** Yes ○ No ○
- **Do you have a Health Care Directive?** Yes ○ No ○
  If yes, location:
- **Would you like information on a Health Care Directive?** Yes ○ No ○
- **Do you have any current concerns of abuse or your personal safety?** Yes ○ No ○
- **Do you have any problems with learning?** Yes ○ No ○

  Type: Communication   Reading   Memory   Motivation

- **Do you have any unusual stress in your life?** Yes ○ No ○
  (Living or working conditions, serious illnesses, or a recent family death, etc.)
- **Any religious or cultural needs we can help you with?** Yes ○ No ○
  Comments:
- **Are your basic needs being met?** (housing, food, transportation, carseat) Yes ○ No ○
- **Do you have a support person when home from the hospital?** Yes ○ No ○

  Significant Other   Family   Friends   Other:

Patient Signature: **Date:**



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