Your History

If you have any questions, please ask the health care provider who reviews this form

How old are you? _____ How old is the father of the baby? _____

Date of last menstrual period _____ Is this pregnancy a result of In-Vitro Fertilization? ☐Yes ☐No

What is your due date? _____ ☐Unsure At what hospital do you plan to deliver your baby? _____

How much did you weigh at your first prenatal visit? _____ How tall are you? _____

How many times have you been pregnant? _____

Your pregnancy history - list all pregnancies including miscarriages and terminations

Year	How many weeks at delivery	Birth Weight	C-section Yes/No	Living child Yes/No	Miscarriage Yes/No	Termination Yes/No	Complications?

Do you have a history of	YES	NO		YES	NO
Infertility	☐	☐	Seizures	☐	☐
Increased blood pressure	☐	☐	Lupus/connective tissue disorder	☐	☐
Increased blood pressure during pregnancy	☐	☐	Blood clot	☐	☐
Diabetes	☐	☐	Infectious disease	☐	☐
Diabetes only during pregnancy	☐	☐	Cervical surgery	☐	☐
Thyroid disease	☐	☐	Surgery	☐	☐
Other conditions	☐	☐			

If yes to any of the above please describe:

List medications you are taking (prescription & non-prescription): ☐Prenatal Vitamins ☐None

Have you received the Influenza (flu) vaccine this year? ☐Yes ☐No

Do you have any allergies? ☐No ☐Yes ☐Latex ☐Betadine ☐Other, please describe

Since your last menstrual period :

How much alcohol have you had?_____

How many cigarettes do you smoke each day? _____

What drugs have you used (cocaine, heroin, marijuana)?_____

Health care provider use only:

BMI

☐ BMI ≥35 ☐BMI <18.5

Weight gain information provided
☐Verbal ☐Written

☐Referral to Dietician

☐Risk for PTD

☐Fetal loss >1st trimester

☐>2 miscarriages

☐Medication exposure
☐ReproTox report reviewed

Vaccination information provided
☐Verbal ☐Written

Information provided on cessation
☐Verbal ☐Written
☐Referral

HCA Virginia
The Perinatal Center
YOUR HISTORY

NNS

Form continued on back→→→

PATIENT LABEL

Revised 3/24/2015– LJD

Do you have a history of mental illness, including anxiety or depression? ☐Yes ☐No
Have you ever had post partum depression? ☐Yes ☐No
During the past 2 weeks, how often have you been bothered by either of the following problems?

	Not at all	*Several days*	*More than half the days*	*Nearly every day*
Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3

Are you or the baby's father…

	You	Baby's Father		You	Baby's Father
Caucasian	☐	☐	Greek or Italian	☐	☐
Asian Indian	☐	☐	Jewish	☐	☐
African American	☐	☐	French Canadian or Cajun	☐	☐
Southeast Asian	☐	☐	Other:	☐	☐
Hispanic	☐	☐			

Are you and the father of the baby first cousins or in any other way blood relatives? ☐**Yes** ☐**No**

Do you or your family or the father of the baby (FOB) or his family have a history of:

Include yourself, FOB, siblings (full & half), parents, children, grandparents, aunts, uncles, nieces, nephews, 1st cousins.	No	YES			
		Myself	My family	FOB	FOB family
Anencephaly or spina bifida (openings in skull or spine)	☐				
Hydrocephalus (water on the brain)	☐				
Heart defect (hole in heart, etc.)	☐				
Birth defects or malformations (cleft lip, palate, etc.)	☐				
Learning disabilities, developmental delay, or ADHD	☐				
Autism	☐				
Muscular dystrophy	☐				
Blindness or deafness	☐				
Polycystic, extra, missing, unusually formed kidneys	☐				
Early onset cancer (before the age of 50)	☐				
Mental illness (such as depression, bipolar, etc)	☐				
Multiple miscarriages or infant death	☐				
Cystic fibrosis (include carriers of CF)	☐				
Hereditary anemia (sickle cell, thalassemia, include trait)	☐				
Bleeding or clotting disorder	☐				
Down syndrome or other genetic syndrome	☐				

Is there anything else related to this pregnancy or family history that concerns you? ☐Yes ☐No
If yes, please describe:

Health care provider use only:
Postpartum depression information provided
☐Verbal ☐Written

☐Screen positive for depression

☐Referred to Genetic Counselor
☐Accepted ☐Declined
GC Letter ☐Yes ☐No

Follow-up appointment scheduled in _____ wks

_____
HCP signature

_____
Date/Time

HCA Virginia
An HCA affiliate
HCA Virginia
The Perinatal Center
YOUR HISTORY
NNS

Patient's Signature_____
Date_____

PATIENT LABEL