824 North 11th Street
Montevideo MN 56265
Phone: 320-269-8877

Pre-Baby Health History Form

Please fill out this form and bring with you to your first clinic visit on_____________________at______.

Your Name ______________________________________ **Your Date of Birth** ________________________

Taking care of your health is important to us. That's why we want your electronic medical record to include information about your current pregnancy. When answering these questions, please give your best guess if you are not able to recall exact dates or details.

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**
Are you over age 35?	☐	☐
Is your BMI ≥ 30	☐	☐
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 (Polycystic Ovarian Disease)?	☐	☐
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? ** [RN to check for lab in past year]	☐	☐
Do you have a history of an elevated one-hour Glucose Tolerance Test with a past pregnancy?	☐	☐
Do any of your family members (mom, dad, brother, sister) have Type 2 Diabetes Mellitus?	☐	☐
Do you have a history of a weight loss surgery (gastric bypass, gastric sleeve)? ** [RN to 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 name ____________________________

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? ________________

Allergies

Do you have any allergies to medications or anything else?

Medication or Other	**What kind of reaction?**

Medications

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

Are you taking prenatal vitamins or a folic acid supplement?		☐ Yes ☐ No			
Current Medication(s)	**Pill strength, if known**	**Dose**	**When used?**	**Taking Now?**	**Who prescribed this?**
				☐	
				☐	
				☐	
				☐	

Past Health History

Head, eyes, ears, nose, throat, skin, endocrine, muscle/bone/joint, neurological					
	Yes	No		Yes	No
Acne	☐	☐	Joint pain	☐	☐
Arthritis	☐	☐	Memory problems	☐	☐
Back pain	☐	☐	Migraines	☐	☐
Balance problems	☐	☐	Neck pain	☐	☐
Cataracts	☐	☐	Seasonal or environmental allergies	☐	☐
Dental problems	☐	☐	Seizures or epilepsy	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Dry mouth	☐	☐	Thyroid problems	☐	☐
Frequent sinus infections	☐	☐	Unusual headaches	☐	☐
Frequent sore throats	☐	☐	Unusual moles, lesions or sores	☐	☐
Glaucoma (eye disease)	☐	☐	Unusual rashes	☐	☐
Hearing loss	☐	☐	Vision loss	☐	☐

Lungs, Heart, Digestive, Blood, Cancer					
	Yes	No		Yes	No
Abdominal pain	☐	☐	COPD	☐	☐
Anemia or low hemoglobin (low iron)	☐	☐	Difficulty swallowing	☐	☐
Asthma	☐	☐	Gall bladder problems	☐	☐
Bleeding or clotting problems	☐	☐	Heart attack	☐	☐
Blood clots or deep vein thrombosis	☐	☐	Heart disease	☐	☐
Blood in stools	☐	☐	Heartburn or reflux	☐	☐
Cancer	☐	☐	Hepatitis or liver problems	☐	☐
Change in bowel habits, loose stools or no stools	☐	☐	High blood pressure	☐	☐
Chest pain (heart related)	☐	☐	History of blood transfusion	☐	☐
Cholesterol or lipid problems	☐	☐	Irregular/fast heart rate	☐	☐
Chronic cough (> 2 weeks)	☐	☐	Irritable bowel syndrome	☐	☐
Colitis	☐	☐	Shortness of breath	☐	☐
Colon polyps or growths	☐	☐	Stomach ulcers	☐	☐
Congestive heart failure	☐	☐	Vein inflammation or phlebitis	☐	☐

Kidney, Genitourinary, Gynecological, Breast					
	Yes	No		Yes	No
Any breast problems	☐	☐	Painful or problem periods	☐	☐
Bladder or urinary infections	☐	☐	Pelvic pain	☐	☐
Frequent vaginal infections	☐	☐	Sexual concerns	☐	☐
Infertility	☐	☐	Sexually transmitted diseases (STD's)	☐	☐
Kidney disease	☐	☐	Urination difficulties	☐	☐
Kidney stones	☐	☐	Urine leakage	☐	☐

Mental Health, Infections, Childhood Illnesses					
	Yes	No		Yes	No
Alcohol or drug problem	☐	☐	Methicillin resistant staphylococcus (MRSA)	☐	☐
Anxiety	☐	☐	Mumps	☐	☐
Birth defects	☐	☐	Polio	☐	☐
Chickenpox	☐	☐	Rheumatic fever	☐	☐
Depression	☐	☐	Rubella (German measles)	☐	☐
Genetic or hereditary disorders	☐	☐	Serious mental health problems	☐	☐
History of physical, sexual or mental abuse	☐	☐	Tuberculosis (TB)	☐	☐
Measles	☐	☐	Vancomycin resistant enterococcus (VRE)	☐	☐

Surgical History

Please list your surgical history, if any: ☐ Never had surgery

Procedure or Surgery	Date of procedure	Where was the surgery done?	Any complications?

Any problems with anesthesia? ☐ No ☐ Yes, please explain: ____

Eating Habits & Safety Information

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

Job & Training

Job: ______________________________ Current employer: ______________________________________
Years of education/highest degree: ______________

Partner and Family Information

Significant other/spouse's name ____ Age: ______________
Partner's job/employer: ____
How many children do you have in your home? ____________________

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
Ex.:1/9/10	*39wks*	*12 hrs*	*8lb 3ozs*	*Male*	*Vaginal*	*Epidural*	*Yes*	*Jake*	*St. Cloud*	*Dr. Smith*

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

Health Habits & Personal Safety

Tobacco:

Do you use tobacco products? ❑ Yes ❑ Never ❑ Quit, date ____

If yes, what type(s)? ❑ Cigarettes ❑ Cigars ❑ Chew ❑ Snuff ❑ Pipe

If cigarettes, how many packs per day? ❑ <.25 ❑ .5 ❑ 1.0 ❑ 1.5 ❑ 2.0 ❑ _________________________

Do you want to quit? ___ Yes ____No

Alcohol:

Before you knew you were pregnant:

How often, on average, do/did you drink alcohol?

❑ Don't drink ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week, but not daily ❑ Every day

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/did you drink alcohol?

❑ Don't drink ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week but not daily ❑ Every day

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:

Do/did you use street drugs?

❑ No ❑ Heroin ❑ Methadone ❑ Marijuana ❑ Methamphetamines ❑ Cocaine ❑ Ecstasy ❑ IV ❑ Other _______________________

Do/did you use prescription pain medications?

❑ No ❑ Vicodin ❑ Percocet ❑ Other ________________________

How often on average do/did you use drugs?

❑ Don't use drugs ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week but not daily ❑ Every day

Since knowing you were pregnant:

Do/did you use street drugs?

❑ No ❑ Heroin ❑ Methadone ❑ Marijuana ❑ Methamphetamines ❑ Cocaine ❑ Ecstasy ❑ IV ❑ Other _______________________

Do/did you use prescription pain medications?

❑ No ❑ Vicodin ❑ Percocet ❑ Other ________________________

How often on average do/did you use drugs?

❑ Don't use drugs ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week but not daily ❑ Every day

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

Immunizations

Most Recent Immunization Dates, if known: Tetanus (TD) _____________ Influenza ____________ Pneumovax ___________________

Hepatitis A _______________ Hepatitis B ___________Varicella (Chickenpox) ____________

Tetanus – Diptheria – Pertussis (Tdap) _____________

Workplace Assessment

At work, are you exposed to chemicals, 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 coffee, soda or tea? ❑ Yes ❑ No
If yes, how much daily? _____________________________
Do you eat less than five servings of fruits and vegetables daily? ❑ Yes ❑ No
Do you have concerns about toxoplasmosis (caused by eating contaminated meat or by cleaning a cat's litter box) ❑ Yes ❑ No
Do you have a history of an eating disorder? ❑ Yes ❑ No
Do you exercise regularly? Type(s), how much per week. ____________________________________ ❑ Yes ❑ No

Early Pregnancy History

Since your last menstrual period, have you:
- Had an upset stomach? ❑ 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: ❑ Plan to parent ❑ Plan to 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 you in a relationship? Partner or significant other's 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/infection 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 or suspected tuberculosis (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 or hobbies that involve possible lead exposure? ❑ Yes ❑ No
Sometimes pregnant women feel the urge to eat things that are not food, such as clay, soil, or paint chips.
Do you ever have these feelings or eat these things? ❑ Yes ❑ No
Do you live in a home built before 1978 that has required 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 or cosmetics that are not sold in a store? ❑ Yes ❑ No
Do you use homemade pottery or leaded crystal? ❑ Yes ❑ No

PHQ-9 ~ Depression Screening

During the past two weeks, how often have you been bothered by any of these problems?

	Not at all **0**	Some days **1**	More than half the days **2**	Nearly every day **3**
1. Little interest or joy in doing things.	❑	❑	❑	❑
2. Feeling down, sad, or hopeless.	❑	❑	❑	❑
3. Trouble falling/staying asleep, sleeping too much.	❑	❑	❑	❑
4. Feeling tired or having little energy.	❑	❑	❑	❑
5. Poor appetite or overeating.	❑	❑	❑	❑
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	❑	❑	❑	❑
7. Trouble focusing on things, such as reading the newspaper or watching TV.	❑	❑	❑	❑
8. Moving or speaking so slowly that other people could have noticed or being so restless that you have been moving around a lot more than usual.	❑	❑	❑	❑
9. Thoughts that you would be better off dead or of hurting yourself in some way.	❑	❑	❑	❑

If you checked any problem, how hard have these problems made it for you to do your work, take care of things at home or get along with other people?

Not hard at all	Somewhat hard	Very hard	Extremely hard
❑	❑	❑	❑

Family History

(Adopted, no health history for family members)

**** This is referring to your parents, grandparents, and siblings, not your partners family ****

			Alcohol/Drug problem	Anesthesia Complications	Arthritis	Asthma	Blood or Bleeding Disorders	Cancer, Breast	Cancer, Colon	Cancer, Ovarian	Cancer, Other	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol or Lipids	Inherited or Genetic Disease	Kidney Disease	Mental Health Problems	Obesity	Stroke	Thyroid Disease	Other
Parent	**Your Mother**	**☐ Living**																				
Parent	**Your Father**	**☐ Living**																				
Grandparent	**Mom's Mother**	**☐ Living**																				
Grandparent	**Mom's Father**	**☐ Living**																				
Grandparent	**Dad's Mother**	**☐ Living**																				
Grandparent	**Dad's Father**	**☐ 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? (ex: Rubella, CMV, other viral illnesses, X-rays, solvents, unsafe materials, etc)? ❑ 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 when 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 for 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 (from Middle East, Greece, Italy, Spain, etc)
- ❑ Asian (from Southeast Asia, China, Taiwan, Philippines, India, etc)
- ❑ Latino/Hispanic
- ❑ Black or African
- ❑ French Canadian

Family Histories (you and the baby's father's family)

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

- ❑ History of stillbirth or more than one miscarriage in your immediate family? ____
- ❑ Birth Defects (ex: Neural tube defects, heart, cleft palate/lip, limb defect, etc.)____
- ❑ Mental retardation, autism or learning disabilities ____
- ❑ Chromosome problems (ex: Down syndrome, Klinefelter syndrome, Trisomy 13 or 18, Turner)________________________
- ❑ Other genetic problems (ex: Cystic fibrosis, Marfan syndrome, Sickle cell anemia, PKU, Tay Sach's, hearing loss, bleeding disorders, etc.)____

Updated 3//31/17