NORTHBAY Center for Women's Health

NAME: _____ **DATE OF BIRTH:** _____

OBSTETRICAL HISTORY **Height:** _____ **Weight:** _____

PREGNANCIES: (Outcome is vaginal delivery, cesarean, miscarriage, abortion or ectopic) **Pre-Pregnancy weight:** _____

#	Date (M/D/Y)	Outcome	Gestational Age (week)	Gender M / F	Living now?	Birth Weight	Vacuum/ Forcep	Preterm Under 37 weeks	Anesthesia Epidural or IV meds	Labor Length Days/Hours	Twins
1											
2											
3											
4											
5											
6											

ADDITIONAL PREGNANCY INFORMATION

Was this pregnancy: Planned / Unplanned

Were you on hormonal contraceptives within 2 months of LMP? NO / YES

Breastfeeding at Conception: NO / YES

Pregnancy result from infertility treatment: NO / YES

Support Person's Name: _____ **Relationship:** _____ **Father of baby involved?** YES / NO

Is this baby up for adoption: NO / YES **Is this a surrogate pregnancy:** NO / YES

FEEDING HISTORY AND PLAN

Successful breastfeeding in the past? □ YES □NO □ Never breastfed before

Previous Feeding History: □ Exclusively breastfed □ Pumping, fed via bottle □ Breastfed with formula supplementation
□ Exclusively formula fed □ Other : _____

Length of previous breastfeeding: _____ months □ Over 1 year

Previous breastfeeding issues:

□ None
□ Breast Surgery
□ Congenital Anomalies
□ Gestational age less than 37 weeks
□ Inverted/flat nipple
□ Lack of support
□ Less than 1 year since last pregnancy
□ Maternal stress
□ Medical issue
□ Mom and baby separated
□ Multiple birth delivery
□ Return to work
□ No access to nutritional l advice
□ Pain
□ Poor coping mechanism
□ Poor latch
□ Poor milk supply
□ Psychological factors
□ other: _____

Plans for breastfeeding this baby:

□ Breast milk
□ Formula
□ Breastmilk/formula
□ no bottle to baby
□ Undecided

ALLERGIES (Substance and Reaction)

_____
_____

□ **Latex Allergy? Reaction:** _____
_____
_____

ANESTHESIA / TRANSFUSION / SEDATION

Family history of anesthesia adverse reactions? YES / NO

Anesthesia/Transfusion history (Have you ever had a complication?)

□ Not applicable □ Prior transfusion
□ Prior anesthesia reaction □ Prior transfusion reaction
□ Unknown

Type of reaction: _____

Moderate sedation history:

□ No prior sedation
□ Prior sedation procedures

Problems with sedation:

□ None □ Vomiting □ Other: _____
□ Nausea □ Unknown

TRANSFUSION CONSENT: Is a blood transfusion acceptable? YES / NO

If NO, what is the blood refusal reason: □ Religious Reasons □ Other: _____

MEDICATIONS (Please list all medications you are currently taking)

_____ Dose: _____ Route: _____ Frequency: _____
_____ Dose: _____ Route: _____ Frequency: _____
_____ Dose: _____ Route: _____ Frequency: _____
_____ Dose: _____ Route: _____ Frequency: _____

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MEDICAL HISTORY (Have you ever had any of the following? If YES, please explain)

Asthma	Yes / No	Heart Disease	Yes / No	Rh Negative	Yes / No
Anxiety	Yes / No	Hepatitis	Yes / No	Seasonal allergies	Yes / No
Autoimmune Disease	Yes / No	History of abnormal pap	Yes / No	Thyroid Disease	Yes / No
Breast	Yes / No	Hypertension	Yes / No	Trauma	Yes / No
Depression	Yes / No	Kidney disease	Yes / No	Tuberculosis	Yes / No
Diabetes	Yes / No	Liver Disease	Yes / No	UTI (Urinary tract infections)	Yes / No
Gestational Diabetes	Yes / No	Phlebitis	Yes / No	Uterine	Yes / No
Epilepsy	Yes / No	Postpartum Depression	Yes / No	Varicosities	Yes / No
Gynecological Surgery	Yes / No	Psychological Problems	Yes / No	Do you have cats	Yes / No
				Other: _____	

Operations/Hospitalizations (Please list year and procedure)

INFECTION HISTORY (Have you ever had any of the following?)

□ Live with someone with TB or exposed to TB
□ You or your partner have history of genital herpes
□ Rash or viral illness since LMP
□ Hepatitis B or C
□ History of gonorrhea
□ History of chlamydia
□ History of HPV
□ History of HIV
□ History of syphilis
□ History of varicella
□ Other: _____

IMMEDIATE FAMILY HISTORY Please indicate who (Mother, Father, Child, Sibling, Maternal or Paternal Grandparents)

Cardiovascular	**Endocrine/ Metabolic**	**Gastrointestinal**	**Musculoskeletal**
Congestive heart failure	Diabetes type 1	Colitis	Arthritis
Coronary artery disease	Diabetes type 2	Crohn's disease	Osteoporosis
Heart disease	Obesity	Ulcerative colitis	Rheumatoid arthritis
High blood pressure	Thyroid disease		
High cholesterol			
Neurologic	**Oncologic**	**Psychiatric**	**Respiratory**
Alzheimer's disease	Breast cancer	ADD-Attention deficit disorder	Asthma
Dementia	Colon cancer	Alcoholism	COPD
Migraine	Ovary cancer	Anxiety	Cystic fibrosis
Seizures	Prostate cancer	Bipolar	Tuberculosis
Tremors	Gastric cancer	Depression	
	Renal cancer	Suicide	

SOCIAL HISTORY

Have you ever smoked? □ YES □ NO □ Current Smoker □ Quit Last used: _____
Type: □ Cigarettes □ Oral □ Other: _____ How many packs per day? _____ For how many years? _____
Does anyone smoke in the household? □ YES □ NO

Do you drink alcohol? □ YES □ NO □ Occasional □ In past If yes, how many drinks per week? _____
Type: □ Beer □ Wine □ Liquor

Do you now use or have you ever used recreational drugs? □ NO □ YES □ In past If yes, what drugs? _____
Started at age: _____ years Stopped at age: _____ years Last used: _____ IV drug use: □ YES □ NO
Is there someone in the household with substance abuse? □ YES □ NO

Who lives with you at home? □ Alone □ Spouse □ Children □ Other: _____
What is your living situation: □ Home/Independent □ Home with assistance □ Homeless/Shelter □ Other: _____
Is there abuse or neglect in the household? □ YES If Yes, what type: _____ □ NO
Family and friends available to help? □ YES □ NO
Any environmental risk or exposures (i.e., Pesticides, chemicals, radiation) □ YES _____ □ NO

Are you sexually active? □ Yes □ NO
What is your self-described orientation? □ Lesbian, gay or homosexual □ Straight □ Bisexual □ Don't know □ Choose not to disclose □ Other: _
What is your current gender identity? □ Male □ Female □ Female to Male □ Male to Female □ Genderqueer (Neither male nor Female)
□ Choose not to disclose □ Other: _____
Do you use condoms? □ Always □ Sometimes □ Never
Other contraceptive use? □ Oral □ Implant □ Injectable □ IUD □ Other: _____
Any history of sexual abuse? □ YES □ NO
Date of your last pap: _____ Have you ever had an abnormal pap? □ NO □ YES When?_____ Treatment? _____
Birth control preference post-partum? □ Oral □ IUD □ Implant □ Injection □ Other: _____

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Do you exercise? □ NO □ YES Type of exercise: _____ How many times per week? _____

What is your occupation? _____ □ Part-time □ Full-time
Activity level: □ Desk/ Office □ Moderate □ Heavy
What is your highest education level? □ High school □ Some college □ University degree □ Post graduate degree □ Other

COMMUNICABLE DISEASE

Have you been treated for TB in the past? □ NO □ YES If yes, please explain: _____
Have you ever received prophylactic treatment for positive TB? □ NO □ YES If yes, please explain: _____
Did you ever receive Bacille Calmette-Guérin (**BCG**) vaccine? □ NO □ YES
To your knowledge, have you been exposed to any communicable disease in the past 6 weeks? □ NO □ YES □ Unknown
Have you or family member traveled outside the U.S in the past 6 months? □ NO □ YES If yes, where? _____

MENSTRUAL HISTORY

When was the first day of your last menstrual period? ____/____/_____ Was this period normal? □ NO □ YES
Menarche onset: _____ Menstrual period frequency? _____ Menstrual period length? _____ days
What is the date of your menstrual period prior to the last? ____/____/_____ Date of home pregnancy test? ____/____/_____

GENETIC HISTORY

What is your ethnic background?	□ African	□ Asian	□ Caucasian	□ Filipino □ Hispanic □ Other: _____
Father of the baby's ethnic background?	African	□ Asian	□ Caucasian	□ Filipino □ Hispanic □ Other: _____
Birth defect	□ None	□ Self	□ Baby's Father	□ Other: _____
Canavan disease	□ None	□ Self	□ Baby's Father	□ Other: _____
Congenital heart disease	□ None	□ Self	□ Baby's Father	□ Other: _____
Cystic fibrosis	□ None	□ Self	□ Baby's Father	□ Other: _____
Down syndrome	□ None	□ Self	□ Baby's Father	□ Other: _____
Hemophilia	□ None	□ Self	□ Baby's Father	□ Other: _____
Huntington's chorea	□ None	□ Self	□ Baby's Father	□ Other: _____
Maternal metabolic disorders	□ None	□ Self	□ Baby's Father	□ Other: _____
Mental retardation/Fragile x	□ None	□ Self	□ Baby's Father	□ Other: _____
Muscular dystrophy	□ None	□ Self	□ Baby's Father	□ Other: _____
Neural tube defect	□ None	□ Self	□ Baby's Father	□ Other: _____
Recurrent pregnancy loss or stillbirths	□ None	□ Self	□ Baby's Father	□ Other: _____
Sickle cell disease	□ None	□ Self	□ Baby's Father	□ Other: _____
Tay sachs	□ None	□ Self	□ Baby's Father	□ Other: _____
Thalassemia	□ None	□ Self	□ Baby's Father	□ Other: _____

Other:

Any Cystic fibrosis screening in the past? □ NO □ YES, please explain: _____

Preferred pharmacy name and address: _____

Patient Signature: _____ **Date of Completion: _____**