CentraCare™

Obstetrics & Women's Health
1900 CentraCare Circle – Suite 2300
St. Cloud, MN 56303

Pre-baby Health History Form

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, we may recommend that you are screened for Gestational Diabetes earlier in your pregnancy.	Yes	No
Will you be 35 years or older when you deliver your baby?	☐	☐
What was your weight one month prior to pregnancy? _____ ** [BMI >29.5 = early screening]	☐	☐
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 currently taking Metformin? ** [If Yes, Complete 2 hr GTT at 14 weeks]	☐	☐
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? ** [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)? ** [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? _____

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?

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.)_____

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?
				☐	
				☐	
				☐	
				☐	

Medical History

	Yes	No		Yes	No		Yes	No
Abdominal pain	☐	☐	Endometriosis	☐	☐	Osteoporosis	☐	☐
Abnormal uterine bleeding	☐	☐	Fibrocystic breast	☐	☐	Ovarian Cyst	☐	☐
Anemia or low hemoglobin	☐	☐	Fibroids	☐	☐	Pelvic pain	☐	☐
Anxiety	☐	☐	Gonorrhea	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Headaches, recurrent	☐	☐	Polycystic ovarian syndrome (PCOS)	☐	☐
Bleeding or clotting problems	☐	☐	Heart disease	☐	☐	Rectocele	☐	☐
Breast mass	☐	☐	Heartburn or reflux	☐	☐	Seasonal or environmental allergies	☐	☐
Cancer	☐	☐	Heavy periods	☐	☐	Seizures or epilepsy	☐	☐
Cancer, breast	☐	☐	Hepatitis	☐	☐	Sexual dysfunction	☐	☐
Cancer, cervical	☐	☐	Herpes	☐	☐	Shingles	☐	☐
Cancer, endometrial	☐	☐	High blood pressure	☐	☐	Stroke	☐	☐
Cancer, ovarian	☐	☐	Hirsutism	☐	☐	Substance abuse	☐	☐
Cancer, vaginal	☐	☐	HPV	☐	☐	Syphilis	☐	☐
Cancer, vulvar	☐	☐	Infertility	☐	☐	Thyroid problems	☐	☐
Chlamydia	☐	☐	Inflammatory bowel disease (IBS)	☐	☐	Trichomonas	☐	☐
Cholesterol or lipid problems	☐	☐	Kidney disease	☐	☐	Tuberculosis	☐	☐
Depression	☐	☐	Liver disease	☐	☐	Urinary incontinence	☐	☐
Diabetes	☐	☐	Menopause	☐	☐	Uterine prolapse	☐	☐
Eating disorder	☐	☐	MRSA			Vaginal infection (recurrent)	☐	☐
Ectopic pregnancy	☐	☐	Obesity or overweight	☐	☐	Vancomycin-resistant enterococcus (VRE)	☐	☐
Chicken pox	☐	☐	ParvoVirus B19 or Fifth's disease	☐	☐			

Surgical History

	Yes	No		Yes	No		Yes	No
Appendectomy	☐	☐	Cholecystectomy	☐	☐	Hysterectomy	☐	☐
Bladder suspension	☐	☐	Colposcopy	☐	☐	Hysteroscopy	☐	☐
Breast augmentation	☐	☐	Cystocele repair	☐	☐	Laparoscopy	☐	☐
Breast biopsy	☐	☐	Dilate and curettage	☐	☐	LEEP	☐	☐
Breast lumpectomy	☐	☐	Endometrial ablation	☐	☐	Oophorectomy	☐	☐
Breast reconstruction	☐	☐	Fibroid removal (myomectomy)	☐	☐	Rectocele repair	☐	☐
Cervical conization	☐	☐	Genital wart removal	☐	☐	Tubal ligation (ESSURE)	☐	☐
Cesarean section	☐	☐						

Please list your surgical history, if not listed above: ☐ Never had surgery

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

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

Job & Training

Job: _____ Current employer: _____

Years of education/highest degree: _____

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 <u>not</u> routinely wear your seat belt.	❑ Yes ❑ No
Do you have unlocked weapons in your home?	❑ Yes ❑ No
Are you having major stress?	❑ Yes ❑ No

Partner and Family Information

Significant other/spouse's name _____ Age: _____

Partner's job/employer: _____

How many children do you have in your home? _____

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

E-Cigarette/Vaping:
Do you use E-cigarettes or vaping products? ❑ Yes ❑ Never ❑ Quit, date _____
Cartridges per day? _____

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 – Diphtheria – 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? _____
Do you work with children? ❑ Yes ❑ No If yes, have you ever tested immune to Parvo Virus B19/Fifth's Disease? ❑ Yes ❑ No

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: Experienced nausea? ❑ 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
Have you had gestational hypertension or preeclampsia in any previous pregnancy? ❑ 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
Are you now or have you completed refugee status? ❑ Yes ❑ No
Have you even been treated for tuberculosis (TB) before? ❑ Yes ❑ No
If yes, when did your complete treatment? _____
Are you now or have you been homeless or incarcerated in the last 5 years? ❑ 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? ❑ Yes ❑ No 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

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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