

Chico Nurse Midwifery Service, Inc. – Prenatal Worksheet

Please fill out as much as you can, if you have any questions or don't understand a question, leave it blank.

Personal Information

First Name: _____ MI: _____ Last Name: _____
 Religious Preference: _____ Marital Status: Single Married Divorced Separated
 Occupation: _____ Education: _____
 Husband/domestic partner: _____ Father of Baby: _____
 Insurance: _____ Emergency Contact: _____
 Home Phone: _____ Work Phone: _____
 Have you seen any other physicians/midwives during this pregnancy? Yes No _____

Menstrual History

Last menstrual period: _____ Definite Approx. Monthly Unknown Prior menses: _____
 Menarche (age of onset): _____ On BCP at conception: Yes No Date Discontinued: _____
 Using any birth control: Yes No _____
 Breast feeding at conception: Yes No Pregnancy planned: Yes No
 Date of last Pap smear: _____ Where? _____ Pregnancy test date: _____ Urine Blood

Past Pregnancies

Date Month Year	GA Weeks	Length Of Labor	Birth Weight	Sex M/F	Type Delivery	Anes	Place of Delivery	Preterm Labor Yes/No	Comments/Complications (Breast/bottle feed, toxemia, Rhogam, Group B Strep, etc.)

Total Pregnancies: _____ Full Term: _____ Preterm (<37 weeks): _____ Twins: _____
 Miscarriage: _____ Abortion: _____ Ectopic: _____ Living Children: _____

Symptoms Since LMP

	Yes	No		Yes	No
Nausea			Cramps		
Vomiting			Difficulty Sleeping		
Weight Loss			Abnormal Discharge		
Fever			Swelling of hands/feet		
Diarrhea			Headaches		
Spotting			Other :		

Alcohol, Drug Use and Domestic Violence

Did either of your parents ever have a problem with drinking or using drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your partner have any problems with drinking or using drugs? <input type="checkbox"/> IV drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your partner's temper ever a problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever drunk beer, wine or liquor or used drugs? _____ Beers/day _____ oz. liquor/wine/day <input type="checkbox"/> crack <input type="checkbox"/> cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> IV drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the month before you knew you were pregnant how many beers glasses of wine or glasses of liquor did you drink? _____ # Beers _____ # Wine _____ Oz. Liquor	<input type="checkbox"/> Any <input type="checkbox"/> None
In the month before you knew you were pregnant how many cigarettes did you smoke? Current cigarette use: _____ cigarettes/day	<input type="checkbox"/> Any <input type="checkbox"/> None
Have you attended AA, NA or other rehab programs? Are you currently attending <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Personal Medical History

	Yes	No		Yes	No		Yes	No
Immunizations.....	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine, intravenous.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal weight loss.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disease			Iodine, topical.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal weight gain.....	<input type="checkbox"/>	<input type="checkbox"/>	Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Postpartum.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization.....	<input type="checkbox"/>	<input type="checkbox"/>	Breast Problems		
Eye Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt.....	<input type="checkbox"/>	<input type="checkbox"/>	Lumps.....	<input type="checkbox"/>	<input type="checkbox"/>
Glasses.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Discharge.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease			Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries		
Skin Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal hernia.....	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes			Hemorrhoids.....	<input type="checkbox"/>	<input type="checkbox"/>	Breast Biopsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Diet controlled.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Cholecystectomy.....	<input type="checkbox"/>	<input type="checkbox"/>
Oral Medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Other			Cone Biopsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Insulin dependent.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease			D & C.....	<input type="checkbox"/>	<input type="checkbox"/>
During pregnancy.....	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery.....	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension			Hyperthyroid.....	<input type="checkbox"/>	<input type="checkbox"/>	Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>
On Medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy.....	<input type="checkbox"/>	<input type="checkbox"/>
During Pregnancy.....	<input type="checkbox"/>	<input type="checkbox"/>	Trauma/Violence			Tonsils/Adenoids.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease			Blood Transfusions.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones.....	<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic complication.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Domestic abuse.....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap smear.....	<input type="checkbox"/>	<input type="checkbox"/>
Thrombophlebitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Head injury.....	<input type="checkbox"/>	<input type="checkbox"/>	Infertility		
Varicose veins.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse.....	<input type="checkbox"/>	<input type="checkbox"/>	Anovulation.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Problems			Endometriosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorder			Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	In vitro.....	<input type="checkbox"/>	<input type="checkbox"/>
Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Male factor.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to TB.....	<input type="checkbox"/>	<input type="checkbox"/>			
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	Normal Weight: _____		
Kidney Disease			Seasonal allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Height: _____		
Bladder infections.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis.....	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney stones.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>			
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies					
Neurologic Disease			Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa.....	<input type="checkbox"/>	<input type="checkbox"/>			

Sexual History

Age at first intercourse: _____ Number of sexual partners: _____

Have you or your partner had any of the following?

Hepatitis C or Hepatitis B..... Yes No

Trichomonas..... Yes No

Genital herpes..... Yes No

Genital warts (HPV)..... Yes No

Chlamydia..... Yes No

Gonorrhea..... Yes No

Syphilis..... Yes No

Pelvic inflammatory disease (PID)..... Yes No

Have you or your partner used IV drugs?..... Yes No

Have you been exposed to AIDS, shared needles or had intercourse with an HIV positive person?..... Yes No

Have you been tested for HIV (AIDS)?..... Yes No

Will you allow testing during this pregnancy?..... Yes No I need more information

Rash or viral illness since last menstrual period?..... Yes No

Medications
List details about any medications or other drugs you have taken during pregnancy.

Name/Dose	Day Started	Day Ended	Indication

Genetic Screening
Include patient, baby's father, or anyone in either family with the following:

	Yes	No		Yes	No
1. Over 35 years as of estimated date of delivery?			12. Huntington's Chorea		
2. Thalassemia (Italian, Greek, Mediterranean or Asian Background; MCV < 80).			13. Mental Retardation/autism Fragile X Syndrome		
3. Neural tube defect: meningomyelocele, spina bifida, or anencephaly.			14. Other inherited genetic or chromosomal disorder		
4. Congenital heart defect			15. Maternal metabolic disorder: Type I diabetes, PKU, etc.		
5. Down Syndrome			16. Patient or baby's father had a child with birth defects not listed above.		
6. Tay-Sachs (Jewish, Cajun, French Canadian)			17. Recurrent pregnancy loss or stillbirth		
7. Canavan Disease			18. Medications (including supplements, vitamins, herbs or OTC drugs)/illicit drugs/alcohol since last menstrual period.		
8. Sickle cell disease or trait (African)			19. Family history of ovarian cancer, breast cancer, or colon cancer		
9. Hemophilia or other blood disorders			20. Family history of diabetes, blood clots or Hypertension		
10. Muscular dystrophy					
11. Cystic Fibrosis					
21. Are you interested in information on genetic testing, genetic counseling, amniocentesis, chorionic villus sampling or alpha fetoprotein testing (AFP) ?			<input type="checkbox"/> I need more information		
22. Are you interested in information on genetic testing for cystic fibrosis?			<input type="checkbox"/> I need more information		

Plans/Education

Do you plan to take prepared childbirth classes?..... Yes No
 If you have taken classes before, are you interested in a refresher course?..... Yes No
 Do you want information on the availability of classes?..... Yes No
 Chico Paradise Oroville
 If you are on Medi-Cal, are you involved in the Comprehensive Perinatal Program?..... Yes No
 Chico Paradise Oroville
 Do you eat raw/undercooked meat or fish?..... Yes No
 Do you have a cat?..... Yes No
 Do you change the litter box?..... Yes No
 Do you eat a well-balanced diet?..... Yes No
 Are you on a special diet?..... Yes No
 Do you drink one quart of milk daily?..... Yes No
 Are you on the WIC program?..... Yes No
 Do you need information on eligibility or signing up?..... Yes No
 Do you want information on birth control options?
 Birth control pills..... Yes No
 Mini-pills..... Yes No
 Rhythm method..... Yes No
 Barrier methods (condoms, foam, diaphragm, cervical cap)..... Yes No
 Intrauterine devices..... Yes No
 Tubal Ligation..... Yes No
 Vasectomy..... Yes No
 Other..... Yes No
 Do you have any concerns about environmental/work hazards that might affect you?..... Yes No
 Do you wear your seat belt?..... Yes No
 Do you plan to breast feed?..... Yes No
 Do you have a pediatrician? Pediatrician's Name: _____ Yes No
 Would you accept blood transfusions if recommended?..... Yes No

