West End Women's Health Center and the Vanderbilt Nurse-Midwives at Melrose

Vanderbilt Faculty Nurse-Midwifery Practice

New OB Patient History

MR # ______________________

Date______________________

Name: ____ DOB: ____________________

Height: ________________ Current Weight: __________________ Pre-Pregnancy Weight: ______________

Email Address: ____

Do you have an advanced directive/living will? □ Yes □ No

Would you like to information about an advance directive/living will? □ Yes □ No

Are you currently having any discomfort or pain? □ Yes □ No

If yes, please explain: ____

General Intake

Is English your primary spoken language? □ Yes □ No

Last grade level completed: ____

Did you have any special educational needs in school? □ Yes □ No

How do you learn best? □ Visual □ Audio

Do you have any questions for your provider today? ____

Please check if you have any of the following: □ Difficulty with activities of daily living □ Deaf/difficulties hearing □ Blind/difficulties seeing □ Difficulty concentrating, remembering, making decisions □ Difficulty walking or climbing stairs

Are you Hispanic, Latina, or of Spanish origin? □ Yes □ No

What do you identify as your race(s)? ____

Medication allergies: ____

Other allergies: ____

Current medications and dosages (include non-prescription medications, supplements, vitamins, and birth control):
____

Occupation/Employer: ____

Father of the Baby Name/Contact Number: ____

Father of the Baby Occupation/Employer: ____

If married, how long: ____

Emergency Contact Name/Number/Relationship: ____

Please circle any symptoms you *currently* have if severe or particularly troublesome:

GENERAL
Unexplained weight loss
Weight gain
Excessive thirst
Excessive fatigue

SKELETAL
Joint swelling
Gout
Muscle weakness

SKIN
Skin/hair changes
New/changing moles

NEUROPSYCHIATRIC
Severe headaches
Numbness or tingling
Feeling "blue"
Crying spells
Suicidal thoughts
Desire psychiatric help/counseling

EYE, EAR, NOSE, & THROAT
Vision changes
Hearing changes
Allergies
Swollen glands
Hoarseness
Snoring
Difficulty swallowing

LUNGS
Bad cough
Coughing up blood
Wheezing
Difficulty breathing

HEART
Chest pain
Irregular heart beat
Murmur
Ankle swelling

GASTROINTESTINAL
Loss of appetite
Frequent heartburn
Abdominal pain
Nausea
Vomiting
Persistent constipation
Frequent diarrhea
Rectal bleeding

GENITOURINARY
Pain with urination
Passing blood
Kidney stones
Urinating at night
Sexual function problems

SEXUAL
Problem with sex life
Request HIV/STI testing

Pregnancy History

Pregnancy Number	Mo/Yr of Birth	Sex	Infant's Weight at Birth	Type of Delivery (Vaginal *or* Cesarean)	Pain Mgmt	Feeding Breast or Bottle	Name of Baby	Term>37 wks *or* Preterm < 37 wks	Hours In Labor	Details or Complications
1.										
2.										
3.										
4.										

Have you given birth with the Vanderbilt Nurse-Midwives before? □ Yes □ No

Have you received prenatal care prior to this appointment for this pregnancy? □ Yes □ No

*If yes, please explain :*____

Who referred you to us? ____

At what age was your first menstrual period? ____

FIRST day of LAST menstrual period: ____

Do you have regular periods every 28-30 days? □ Yes □ No If no, how often do you menstruate? ________________

Date of last Pap : __________________ Results ________________ Any abnormal Paps? ________________________

Have you had any abortions/miscarriages? □ Yes □ No If yes, how many? ______ When? ___________________

What is the estimated date of your baby's conception? ____

How was your pregnancy confirmed? □ Home pregnancy test □ Healthcare provider's office

Personal and Family Medical History

Please check the boxes below as they apply to you or your family members. If applicable, indicate family member(s) with this history on the line that follows.

□ Abnormal pap __________________	□ Gestational Diabetes _________	□ Polycystic ovary syndrome ________
□ Anemia _______________________	□ Headache – Migraine _____________	□ Pulmonary embolism _____________
□ Autoimmune disease _____________	□ Hepatitis _______________________	□ Recurrent miscarriages ___________
□ Cancer (type: __________________) ________________________________	□ HPV infection ___________________	□ Seizures _______________________
	□ Hypertension ___________________	□ Sickle cell anemia _______________
□ Congestive heart failure ___________	□ Hyperthyroidism ________________	□ STD/STI _______________________
□ Crohn's disease _________________	□ Glucose intolerance ______________	□ Stroke _________________________
□ Depression _____________________	□ Infertility ______________________	□ Thyroid disease _________________
□ Diabetes mellitus ________________	□ Kidney stones or disease __________	□ Trauma / Violence _______________
□ Endometriosis __________________	□ Lupus _________________________	□ Tuberculosis ____________________
□ Epilepsy _______________________	□ Ovarian cancer __________________	□ Varicella _______________________
□ Fibroids _______________________	□ Pelvic Inflammatory Disease ________________________________	□ Other __________________________

Please list past surgeries or hospitalizations and date. ____

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Social History

Do you smoke? □ Yes □ No If yes, how much? _______________________ Are you interested in quitting? □ Yes □ No

Have you ever smoked? □ Yes □ No If yes, when did you start and stop (month/year)? ____________________________

Do you use other forms of tobacco? □ Yes □ No If yes, which? ______________________________

Do you drink alcohol? □ Yes □ No If yes, how much and how often? __________________________________

Do you drink caffeine? (e.g. coffee, tea, soda) □ Yes □ No If yes, how much and how often? ___________________________

Do you currently use any recreational drugs? □ Yes □ No If yes, what drugs? _______________________________________

Have you used recreational drugs in the past? □ Yes □ No If yes, what drugs? ____________________________________

Are you currently sexually active? □ Yes □ No If yes, □ with men □ with women □ with both

Lifetime # of sexual partners: □ Fewer than 5 □ 5 or more

Do you regularly exercise? □ Yes □ No If yes, how often? _________ Type of exercise? _____________________________

How many meals/snacks do you eat a day? ____

Do you follow a special diet? □ No □ Vegetarian □ Vegan □ Other ____

Do you live in Davidson County? □ Yes □ No

Where do you live? □ House □ Apartment/Condo

Where you live do you have: □ Electricity □ Water □ Cooking Facilities □ Stairs

Form of transportation: □ Own a car □ Public transportation □ Family/Friends □ TennCare

Are you enrolled (or would you like to enroll) in any of the following programs?

□ None □ WIC □ Social Security □ AFDC □ SNAP (food stamps)

Prenatal Genetic History

Please check any of the following that relate to you, father of the baby, and both of your families.

□ Patients age > 35 at delivery

□ Thalessemia

□ Neural Tube Defect

□ Congenital Heart Defect

□ Down syndrome

□ Tay-Sachs

□ Canavan/Gaucher's disease

□ Familial dysautonomia

□ Hemophilia or other blood disorders

□ Muscular dystrophy

□ Cystic Fibrosis

□ Huntington's chorea

□ Intellectual disability/autism

□ Other inherited genetic/chromosomal disorder

□ Maternal metabolic disorder (e.g. Type 1 diabetes, PKU)

□ PT or baby's father had a child with birth defects not listed

□ Recurrent pregnancy loss (>2), or a stillbirth

□ Other structural birth defects

Is there anything else we should know about you to help care for you better?

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