

This worksheet is used to help you and your health care practitioner determines your pregnancy care needs and will be destroyed after your visit. We will use this form to enter information into UW Medicine's secure medical record system.

**UW Medicine values your privacy. Your answers will be kept confidential.**

<b>Personal Information</b>		<b>CLINIC USE ONLY</b>
<b>Your Name:</b>		<b>In Epic: Demographics Activity</b>
Occupation:		
Ethnic background:		
Language spoken: If you need an interpreter, in what language?		
Religion:		
Marital status:		
<b>Name of partner/father of the baby:</b>		<b>In Epic: Demographics (3<sup>rd</sup> Tab)</b>
Relationship to you:		
Age:		
Occupation:		
Ethnic background:		
Are other people living with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If <b>yes</b> , please answer the following:		
Name, Age, Relationship to you:		
Name, Age, Relationship to you:		
Name, Age, Relationship to you:		

<b>Pregnancy History</b>		<b>CLINIC USE ONLY</b>
Have you ever been pregnant before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>In Epic: Visit Navigator OB History Section (5<sup>th</sup> Block)</b>
How many children do you have?		
How many full term pregnancies?		
How many premature deliveries?		
How many pregnancy terminations (abortions)?		
How many miscarriages?		
How many ectopic (tubal) pregnancies?		
How many multiple births?		
How many living children do you have?		

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<b>Please answer the following questions for each pregnancy you had. If you have not been pregnant before, please skip to the next section.</b>						<b>CLINIC USE ONLY</b>	
Date of birth or end of pregnancy:							
How many weeks?							
If you had a baby:							
Vaginal delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Help of a vacuum extractor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>In Epic: Visit Navigator OB History Section (5<sup>th</sup> Block)</b>	
Help of forceps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cesarean section?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
How long were you in labor?							
How much did the baby weigh?							
What was the sex of the baby?							
What is the baby's name?							
Were there any complications? If yes, what?				<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Where was the baby delivered?							
What was the name of your pregnancy care provider?							
Did you have anesthetic? If yes, what?				<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you know what the baby's one and five minute Apgars were? Apgar 1-minute: Apgar 5-minute:							
Is this child still living?				<input type="checkbox"/> Yes	<input type="checkbox"/> No		

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<b>Second pregnancy (if applicable):</b>						<b>CLINIC USE ONLY</b>
Date of birth or end of pregnancy:						<b>In Epic: Visit Navigator OB History Section (5<sup>th</sup> Block)</b>
How many weeks?						
If you had a baby:						
Vaginal delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Help of a vacuum extractor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Help of forceps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cesarean section?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How long were you in labor?						
How much did the baby weigh?						
What was the sex of the baby?						
What is the baby's name?						
Were there any complications? If yes, what?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Where was the baby delivered?						
What was the name of your pregnancy care provider?						
Did you have anesthetic? If yes, what?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you know what the baby's one and five minute Apgars were? Apgar 1-minute: Apgar 5-minute:						
Is this child still living?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Third pregnancy (if applicable):</b>						<b>CLINIC USE ONLY</b>
Date of birth or end of pregnancy:						<b>In Epic: Visit Navigator OB History Section (5<sup>th</sup> Block)</b>
How many weeks?						
If you had a baby:						
Vaginal delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Help of a vacuum extractor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Help of forceps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cesarean section?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How long were you in labor?						
How much did the baby weigh?						
What was the sex of the baby?						
What is the baby's name?						
Were there any complications? If yes, what?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Where was the baby delivered?						
What was the name of your pregnancy care provider?						
Did you have anesthetic? If yes, what?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you know what the baby's one and five minute Apgars were? Apgar 1-minute: Apgar 5-minute:						
Is this child still living?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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History of Menstrual Periods / Birth Control Use			CLINIC USE ONLY
Do you know the day your last menstrual period started?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	In Epic: Visit Navigator Dating Section
If yes, when did your last menstrual period start (month/day/year):			
Are you sure of this date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was your last period normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If your periods are not regular, what is the shortest and longest time ( <b>in days</b> ) from one period to the next? (For example: 25-30 days)			
How many <b>days</b> from the beginning of one period to the beginning of the next?			
Do you know what day you became pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, when:            How do you know?			
Were you taking birth control pills at the time you became pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Did you take birth control pills <b>before</b> becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If <b>yes</b> , when did you stop taking them?			
Were you breast-feeding at the time you became pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Social History										CLINIC USE ONLY		
Do you use Tobacco?		<input type="checkbox"/> Yes		<input type="checkbox"/> Never		<input type="checkbox"/> Quit When: _____		<input type="checkbox"/> Passive		In Epic: Visit Navigator Dating Section		
Packs per day:		<input type="checkbox"/> 0.25		<input type="checkbox"/> 0.5		<input type="checkbox"/> 1		<input type="checkbox"/> 1.5			<input type="checkbox"/> 2	
Years:	<input type="checkbox"/> 0.5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 10	<input type="checkbox"/> 15	<input type="checkbox"/> >15			
Do you drink Alcoholic Beverages?								<input type="checkbox"/> Yes			<input type="checkbox"/> No	
How many Drinks per week:				_____ Glass(es) of wine _____ Can(s) of beer _____ Shot(s) of liquor								
Drug Use:												
Did you use any of the following: marijuana, speed, cocaine, heroin, hallucinogens, or other recreational drugs?							<input type="checkbox"/> Yes		<input type="checkbox"/> No			
Use per Week:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 10	<input type="checkbox"/> 15	<input type="checkbox"/> >15				

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<b>Past Medical &amp; Surgical History</b>			<b>CLINIC USE ONLY</b>
<b>If you do not know the answer to any of the following questions, please leave blank.</b>			<b>In Epic: Visit Navigator OB History Section (1<sup>st</sup> Block)</b>
<b>Have you been diagnosed with:</b>			
Diabetes Type 1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes Type 2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypothyroidism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hyperthyroidism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Abnormal Pap	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Post Partum Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bleeding/Clotting Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
GYN Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Headaches (Migraines)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Positive PPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Have you had any gynecological surgical procedure such as:</b>			<b>In Epic: Visit Navigator OB History Section (2<sup>nd</sup> Block)</b>
C-Section	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Myomectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
LEEP Procedure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Conization	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Laser	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Dilation and Curettage (D&C)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Surgery on your uterus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
CRYOSURGERY (freezing of the cervix)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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Genetic Screening													CLINIC USE ONLY							
1. Will you be age 35 years or older at the time of delivery?						<input type="checkbox"/> Yes			<input type="checkbox"/> No				In Epic: Visit Navigator OB History Section (4 <sup>th</sup> Block)							
If you do not know the answer to any of the following questions, please leave blank. If you or the baby's father is adopted, fill out this section the best that you can.																				
Have you, the baby's father, or anyone in either family had:																				
Please place a check mark next to the family member that has the medical history. For no history, circle the No History box.																				
Relationship		Name	Status	Heart (other)	Heart Disease	Thalassemia	Neural Tube Defect	Down's Syndrome	Tay-Sachs Disease	Sickle Cell (trait)	Hemophilia	Muscular Dystrophy	Cystic Fibrosis	Huntington Chorea	Mental Retardation	Other Inherited Disorder	Maternal Metabolic Disorder	Birth Defects	Pregnancy Loss or Stillbirth	
Family	No History																			
Parents	Mother																			
Parents	Father																			
Grandparents	Maternal GMo																			
Grandparents	Maternal GFa																			
Grandparents	Paternal GMo																			
Grandparents	Paternal GFa																			
Siblings	Brother(s)																			
Siblings	Sister(s)																			
Aunts/Uncles	Maternal Aunt																			
Aunts/Uncles	Maternal Uncle																			
Aunts/Uncles	Paternal Aunt																			
Aunts/Uncles	Paternal Uncle																			
Other	Baby's Dad																			
Other	Other																			
Details:																				
Comments:																				

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<b>Past Medical History Questionnaire</b>			<b>CLINIC USE ONLY</b>
<b>If you do not know the answer to any of the following questions, please leave blank.</b>			<b>In Epic: Visit Navigator Questionnaire Form Section</b>
Have you or do you currently have:			
1. Loss of function or sensation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Any other neurological problems not stated above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Are you having problems with crying spells or loss of self-esteem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Have you ever required psychiatric care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Have you had excessive bleeding after surgery or dental work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Do you bleed more than other women after a cut or scratch?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Do you have any other endocrine problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Have you ever been in a major accident or suffered serious trauma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Within the last year, has anyone hit, slapped, kicked, or otherwise hurt you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. In the last year, has anyone forced you to have sex when you didn't want to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. Would you refuse a blood transfusion if a doctor judged it to be medically necessary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12a. Would you rather die than receive a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12b. If you answered Yes, is this for religious reasons?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13. Is your blood type Rh negative?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
14. Have you ever had abnormal antibodies in your blood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
15. Have you ever had any breast problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
16. Have you ever breastfed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
17. Have you ever had any anesthetic complications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
18. Do you have a history of abnormalities of the uterus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
19. Did your mother take DES or any other hormones when she was pregnant with you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
20. Did it take you more than one year to become pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
21. Have you ever been evaluated or treated for infertility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
22. Is there a history of medical problems in your family which you feel might adversely affect your health or pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
23. Do you have any other problems we have not asked about which you feel may be important to this pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
24. Has the patient had any medications/street drugs/alcohol since her last menstrual period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
25. Does the patient or baby's father have any other genetic risks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
26. Do you object to being tested for Hepatitis B?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
27. Do you object to being tested for HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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28. Do you feel that you are at high risk for coming in contact with the AIDS virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
29. Have you received the BCG vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
30. Do you live with someone who has tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
31. Have you ever been exposed to tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
32. Does your partner have genital herpes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
33. Have you had a rash or viral illness since your last period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
34. Do you know if you are a genital group B streptococcus carrier?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
35. Have you had chicken pox/varicella?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
36. Have you been vaccinated against chicken pox?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
37. Have you had any other infectious diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have any other problems we have not asked about which you feel may be important to this pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Symptoms since Last Menstrual Period</b> Do you currently have any of the following symptoms: abdominal pain, blood in the stools or urine, chest pain, shortness of breath, coughing or vomiting, pain on urination or vaginal discharge or bleeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Current Medications:</b>			

<b>Have you experienced any major stress over the last year?</b> <i>(For example: change in job, changes in household)</i> <b>If so, what?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>For discussion during visit.</b>
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