UW Medicine
PRIMARY CARE

Prenatal Care Visit

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.

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

Pregnancy History			**CLINIC USE ONLY**
Have you ever been pregnant before?	❒ Yes	❒ No	**In Epic: Visit Navigator OB History Section (5th Block)**
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?			

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How many living children do you have?	

Please answer the following questions for each pregnancy you had. If you have not been pregnant before, please skip to the next section.						**CLINIC USE ONLY**
Date of birth or end of pregnancy:						**In Epic: Visit Navigator OB History Section (5th Block)**
How many weeks?						
If you had a baby:						
Vaginal delivery?	❒ Yes	❒ No	Help of a vacuum extractor?	❒ Yes	❒ No	
Help of forceps?	❒ Yes	❒ No	Cesarean section?	❒ Yes	❒ 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?				❒ Yes	❒ No	
Where was the baby delivered?						
What was the name of your pregnancy care provider?						
Did you have anesthetic? If yes, what?				❒ Yes	❒ 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?				❒ Yes	❒ No	

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Second pregnancy (if applicable):						**CLINIC USE ONLY**
Date of birth or end of pregnancy:						**In Epic: Visit Navigator OB History Section (5th Block)**
How many weeks?						
If you had a baby:						
Vaginal delivery?	❒ Yes	❒ No	Help of a vacuum extractor?	❒ Yes	❒ No	
Help of forceps?	❒ Yes	❒ No	Cesarean section?	❒ Yes	❒ 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?				❒ Yes	❒ No	
Where was the baby delivered?						
What was the name of your pregnancy care provider?						
Did you have anesthetic? If yes, what?				❒ Yes	❒ 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?				❒ Yes	❒ No	

Third pregnancy (if applicable):						**CLINIC USE ONLY**
Date of birth or end of pregnancy:						**In Epic: Visit Navigator OB History Section (5th Block)**
How many weeks?						
If you had a baby:						
Vaginal delivery?	❒ Yes	❒ No	Help of a vacuum extractor?	❒ Yes	❒ No	
Help of forceps?	❒ Yes	❒ No	Cesarean section?	❒ Yes	❒ 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?				❒ Yes	❒ No	
Where was the baby delivered?						
What was the name of your pregnancy care provider?						
Did you have anesthetic? If yes, what?				❒ Yes	❒ 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?				❒ Yes	❒ 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?	❒ Yes	❒ 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?	❒ Yes	❒ No	
Was your last period normal?	❒ Yes	❒ No	
If your periods are not regular, what is the shortest and longest time (**in days**) from one period to the next? (*For example: 25-30 days*)			
How many **days** from the beginning of one period to the beginning of the next?			
Do you know what day you became pregnant?	❒ Yes	❒ No	
If yes, when: How do you know?			
Were you taking birth control pills at the time you became pregnant?	❒ Yes	❒ No	
Did you take birth control pills **before** becoming pregnant?	❒ Yes	❒ No	
If **yes**, when did you stop taking them?			
Were you breast-feeding at the time you became pregnant?	❒ Yes	❒ No	

Social History									CLINIC USE ONLY
Do you use Tobacco?	❒ Yes	❒ Never	❒ Quit When: _____	❒ Passive					**In Epic: Visit Navigator Dating Section**
Packs per day:	❒ 0.25	❒ 0.5	❒ 1	❒ 1.5	❒ 2				
Years:	❒ 0.5	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5	❒ 10	❒ 15	❒ >15
Do you drink Alcoholic Beverages?							❒ Yes	❒ 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?				❒ Yes	❒ No				
Use per Week:	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5	❒ 10	❒ 15	❒ >15	

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

Genetic Screening			**CLINIC USE ONLY**
1. Will you be age 35 years or older at the time of delivery?	❒ Yes	❒ No	**In Epic: Visit Navigator OB History Section (4th 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.				Heart (oher)	Heart Disease	Thalassemai	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
Relationship		Name	Status																
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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Past Medical History Questionnaire			**CLINIC USE ONLY**
If you do not know the answer to any of the following questions, please leave blank.			**In Epic: Visit Navigator Questionnaire Form Section**
Have you or do you currently have:			
1. Loss of function or sensation?	❒ Yes	❒ No	
2. Any other neurological problems not stated above?	❒ Yes	❒ No	
3. Are you having problems with crying spells or loss of self-esteem?	❒ Yes	❒ No	
4. Have you ever required psychiatric care?	❒ Yes	❒ No	
5. Have you had excessive bleeding after surgery or dental work?	❒ Yes	❒ No	
6. Do you bleed more than other women after a cut or scratch?	❒ Yes	❒ No	
7. Do you have any other endocrine problems?	❒ Yes	❒ No	
8. Have you ever been in a major accident or suffered serious trauma?	❒ Yes	❒ No	
9. Within the last year, has anyone hit, slapped, kicked, or otherwise hurt you?	❒ Yes	❒ No	
10. In the last year, has anyone forced you to have sex when you didn't want to?	❒ Yes	❒ No	
11. Would you refuse a blood transfusion if a doctor judged it to be medically necessary?	❒ Yes	❒ No	
12a. Would you rather die than receive a blood transfusion?	❒ Yes	❒ No	
12b. If you answered Yes, is this for religious reasons?	❒ Yes	❒ No	
13. Is your blood type Rh negative?	❒ Yes	❒ No	
14. Have you ever had abnormal antibodies in your blood?	❒ Yes	❒ No	
15. Have you ever had any breast problems?	❒ Yes	❒ No	
16. Have you ever breastfed?	❒ Yes	❒ No	
17. Have you ever had any anesthetic complications?	❒ Yes	❒ No	
18. Do you have a history of abnormalities of the uterus?	❒ Yes	❒ No	
19. Did your mother take DES or any other hormones when she was pregnant with you?	❒ Yes	❒ No	
20. Did it take you more than one year to become pregnant?	❒ Yes	❒ No	
21. Have you ever been evaluated or treated for infertility?	❒ Yes	❒ No	
22. Is there a history of medical problems in your family which you feel might adversely affect your health or pregnancy?	❒ Yes	❒ No	
23. Do you have any other problems we have not asked about which you feel may be important to this pregnancy?	❒ Yes	❒ No	
24. Has the patient had any medications/street drugs/alcohol since her last menstrual period?	❒ Yes	❒ No	
25. Does the patient or baby's father have any other genetic risks?	❒ Yes	❒ No	
26. Do you object to being tested for Hepatitis B?	❒ Yes	❒ No	
27. Do you object to being tested for HIV?	❒ Yes	❒ No	

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28. Do you feel that you are at high risk for coming in contact with the AIDS virus?	❒ Yes	❒ No	
29. Have you received the BCG vaccine?	❒ Yes	❒ No	
30. Do you live with someone who has tuberculosis?	❒ Yes	❒ No	
31. Have you ever been exposed to tuberculosis?	❒ Yes	❒ No	
32. Does your partner have genital herpes?	❒ Yes	❒ No	
33. Have you had a rash or viral illness since your last period?	❒ Yes	❒ No	
34. Do you know if you are a genital group B streptococcus carrier?	❒ Yes	❒ No	
35. Have you had chicken pox/varicella?	❒ Yes	❒ No	
36. Have you been vaccinated against chicken pox?	❒ Yes	❒ No	
37. Have you had any other infectious diseases?	❒ Yes	❒ No	
Do you have any other problems we have not asked about which you feel may be important to this pregnancy?	❒ Yes	❒ No	
Symptoms since Last Menstrual Period 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?	❒ Yes	❒ No	
Current Medications:			

Have you experienced any major stress over the last year? *(For example: change in job, changes in household)* **If so, what?**	❒ Yes	❒ No	**For discussion during visit.**

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