McLaren

FLINT

Pregnancy Patient Checklist

Your Name _____ Date _____

GENERAL HEALTH

	YES	NO
DO YOU HAVE:		
High blood pressure?	☐	☐
Diabetes?	☐	☐
Medical Problems?	☐	☐
Have you been hospitalized in the past five years?	☐	☐
Are your menstrual periods regular?	☐	☐
Are you over 34 years old?	☐	☐

Because some religions have ceremonies, beliefs, dietary restrictions which might affect your pregnancy and delivery, are you:

☐ Catholic ☐ Protestant ☐ Jewish ☐ Other _____

OBSTETRIC HISTORY

	YES	NO
HAVE YOU HAD:		
A prior miscarriage, a stillborn, or an abortion? Please describe (ie: how far along, did you have surgery, etc.)? _____ _____	☐	☐
A family member or a child with birth defects?	☐	☐
Problems with prior pregnancies/deliveries?	☐	☐
A baby weighing over 9 pounds at birth?	☐	☐
Are you or your spouse Jewish, Italian, Greek or Black?	☐	☐
Do you have any problems with intercourse?	☐	☐

IF YOU HAVE HAD A PREVIOUS C-SECTION ELSEWHERE, PLEASE OBTAIN A COPY OF THE OPERATIVE REPORT AND BRING WITH YOU.

NUTRITIONAL STATUS

	YES	NO
HAVE YOU BEEN:		
Eating a "balanced" diet?	☐	☐
Dieting?	☐	☐
Taking vitamin, calcium or iron supplements?	☐	☐
Breast feeding in the past 24 months?	☐	☐

CONTRACEPTION

	YES	NO
DID YOU EVER:		
Use Condoms?	☐	☐
Foam/Cream/Sponge?	☐	☐
Take birth control pills?	☐	☐
When did you stop taking them? _____		
Have an intrauterine device?	☐	☐
If so, has it been removed?	☐	☐

INFECTIOUS DISEASE

	YES	NO
HAVE YOU EVER HAD OR BEEN EXPOSED TO:		
Herpes or cold sores?	☐	☐
Blood transfusions?	☐	☐
Gonorrhea, syphilis, VD, AIDS, or pelvic infections (such as trichomonas, HPV, chlamydia, etc)?	☐	☐
German measles or "Rubella" vaccine?	☐	☐

MEDICATIONS OR DRUGS

	YES	NO
DO YOU:		
Take any prescription medicines (whether applied to the skin, injected or swallowed)?	☐	☐
Drink beer, wine or alcohol more than twice a week?	☐	☐
Use over-the-counter medications (cold pills, diuretics, pain killers like ibuprofen or aspirin, etc.)?	☐	☐
Use marijuana, cocaine, tranquilizers, sleeping pills?	☐	☐
Drink more than 4 cups of coffee, tea or cola daily?	☐	☐
Smoke more than 5 cigarettes a day?	☐	☐

WORK AND PLAY

	YES	NO
DO YOU:		
Work around chemicals or drugs?	☐	☐
Jog more than 10 miles a week?	☐	☐
Do aerobic dance or exercise more than twice a week?	☐	☐

MENSTRUAL HISTORY

How old were you at time of your first period? _____

From the start of one period to the start of another is how many days? (ie: 28 days) _____

How many days was the flow? _____

Any recent changes? (before pregnancy) _____

Regular _____ Irregular _____

Explain: _____

	Height	Usual Weight
Yourself:	_____ /	_____
Baby's Father:	_____ /	_____

His Name: _____ Age: _____

His health problems if any: _____

_____

_____

_____

YOUR SOCIAL HISTORY

Highest level of education?

_____

_____

_____

Anything you would like us to know about you (hobbies, interests,

_____

_____

_____

_____

_____

_____

If you work outside your home, describe your job/responsibilities.

_____

_____

_____

_____

_____

_____

OTHER HEALTH HISTORY

Have you ever had the chicken pox? _____

Do you have a cat? _____

How long have you been trying to become pregnant? (Or was this pregnancy unplanned?)

_____

_____

_____

When did you last have a pap smear and what was the result?

_____

_____

PLEASE BRING COPY OF LAST PAP IF DONE ELSEWHERE

What is the name of your prenatal vitamins _____

_____

Did you have a positive pregnancy test? _____

When? _____

Was it: Blood Test? _____

Urine Test? _____

Home Test? _____

Please Bring Copy if not done thru this office.

***IF YOUR PRIMARY/REFERRAL DOCTOR HAS DONE ANY RECENT LAB WORK, X-RAYS, ULTRASOUNDS, ETC., PLEASE BRING COPIES WITH YOU.**

If you have medicine allergies, list the medicine and the reaction.

_____

_____

_____

FAMILY HISTORY

	Age(s)	Health/Problems
Your Mother	_____	_____
		_____
Your Father	_____	_____
		_____
Your Brothers	_____	_____
		_____
Your Sisters	_____	_____
		_____