West End Women's Healthcare Center

Vanderbilt Nurse Midwifery Program

New OB Patient History

MR # _____

Date_____

Name: _____Race:_____Height_____Weight_____

Email Address: _____

Occupation/Employer: _____

Medication Allergies: _____

Current
Medications/Dosages_____

Previous Surgeries: _____

FIRST day of LAST MENSTRUAL PERIOD: _____

Pre-Pregnancy Weight: _____

Who referred you to West End Women's Health Center: _____

Have you received prenatal care prior to t his appointment for this pregnancy O NO O YES, please specify.

Father of the baby

Name/Contact number: _____

If married, how long: _____

FOB occupation/employer: _____

Emergency Contact

Name/number/relationship: _____

Patient Demographics

Country of birth: _____

Religious preference: _____

Last grade level completed: _____

Did you have any special educational needs in school? O NO O YES

How do you learn best? O Listening/Watching O Demonstration O Reading

Are you enrolled in any of the following programs? O WIC O Food Stamps O AFDC O Social Security

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

Do you have an advanced directive/living will? O NO O YES

Do you want information about an advance directive/living will? O NO O YES

Any spiritual/cultural needs that would affect how we care for you? O NO O YES

Any objection to receiving blood products? O NO O YES

Do you live in a/an? O House O Apartment/Condo

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

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

How do you want to feed your baby? O Breast O Bottle O Both O unsure

If your baby is a boy, do you want him circumcised? O NO O YES O Unsure

When you deliver your baby, what type of pain medicine do you want? O Epidural O IV Medication O Nitrous Oxide O None

What type of birth control do you want to use after your baby is born?

O Oral Contraceptive O Patch O Nuva Ring O Condoms O Depo Provera

O IUD O Tubal Ligation O Unsure

Pregnancy History

Pregnancy Number	Mo/Yr Of birth	Gender	Infants Weight At birth	Type of Delivery (Vaginal or Cesarean	Pain Mgmt	Feeding Breast Or Bottle	Infants Name	Term>37 wks Preterm < 37 wks	Hours In Labor	Details or Complications
1.										
2.										
3.										
4.										

GYN History:

At what age was your first menstrual period? _____

Regular periods every 28-30 days? O NO O YES

Date of last PAP_____ Results_____ Any abnormal PAPS? _____

Have you had any abortions/miscarriages? O NO O YES If yes, how many? _____ When? _____

How was your pregnancy confirmed? O Home pregnancy test O Doctor's office

Health Maintenance

Do you exercise regularly? O NO O YES

Are immunizations/shots up to date? O NO O YES

Do you smoke?	O NO	O YES	If yes, how many cigarettes per day?_____
Any Alcohol use?	O NO	O YES	If yes, how many drinks per week? _____
Any recreational drug use?	O NO	O YES	If yes, how often and what type of drugs? _____

Patient and Family Medical History

Please check any of the following that relate to you or your family

O Multiple births (twins, triplets)	O Gastrointestinal problems	O Infertility & recurrent miscarriages	O Immunological/Infectious disease
O Cancer	O Breast Disease	O STD, HPV, or Group B Strep	O Operations/Accidents
O High Blood Pressure	O Urinary Tract Problems	O Phlebitis/varicosities	O Hematologic
O Heart Disease	O Endocrine/Metabolic (Diabetes/Thyroid)	O Neurological	O History of sexual /physical abuse/trauma
O Lung Disease	O GYN Problems (abnormal pap smears)	O Psychiatric/Mental Illness	O Other_____

Genetic Patient and Family History

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

O Patients age > 34 at delivery

O Thalessemia

O Neural Tube Defect

O Congenital Heart Defect

O Down syndrome

O Tay Sachs

O Hemophilia or other blood disorders

O Huntingtons Chorea

O Other inherited or chromosomal disorder

O Other structural birth defect

O Maternal metabolic/endocrine disorder (Diabetes, PKU)

O Pt or baby's father had a child with a birth defect not listed above

O Recurrent pregnancy loss (>2) and/or still birth

O Canavan Disease, Gauchers

O Cystic Fibrosis

O Mental Retardation/Autism