

Vanderbilt School of Nursing Faculty Practice

Vanderbilt Midwives Melrose

Patient Health History: NOB

Name _____ Race/Ethnicity: _____

Preferred Name _____ Preferred Pronouns: She/her He/Him They/them

Date of Birth: _____ Height: _____

Weight prior to pregnancy _____

Phone number: _____ Email address: _____

Preferred Pharmacy (Name, phone #): _____

Medication allergies: _____

Other allergies: _____

Current medications (include prescription and non-prescription medications with dosage, supplements, and vitamins):

How did you hear about our practice?

Have you received prenatal care prior to today's visit? If so, where? _____

Social History

Relationship status: single married divorced/separated widowed partnered other

Who lives with you? _____

Your Occupation and Employer _____

What is the highest level of education you have completed? _____

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

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

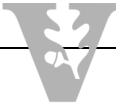
WIC Social Security AFDC SNAP (food stamps)

Do you live in Davidson County? YES NO

Do you have any spiritual/cultural needs that would affect how we care for you? YES NO

If so, please specify: _____

Do you have any objection to receiving blood products? YES NO



NAME:			
DOB:	/	/	
DATE:	/	/	
MRN:			

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 Family/Friends TennCare

Father of baby or partner's name and contact # _____

Father of baby or partner's occupation _____

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 drink alcohol? Yes No If yes, how much and how often? _____

Do you drink caffeine? (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? _____

Health Maintenance

Do you have a primary care provider (PCP)? Yes No

If so, who (Name, Practice location) _____ Do you need a PCP? Yes No

Do you regularly exercise? Yes No If yes, how often? _____ Type of exercise? _____

Do you follow a special diet? No Vegetarian Vegan Other _____

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

Do you have: current/past disordered eating?

Immunizations (check if current/immune) Tetanus/pertussis Chicken pox Rubella Influenza

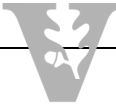
Shingles Pneumonia HPV (Gardasil)

Do you have an advanced directive/ living will? Yes No Would you like information about this? Yes No

Do you wear a seat belt? Yes No

When was your last Dental cleaning/exam? _____ Do you need referral to a dentist? Yes No

When was your last Eye Exam _____ Mammogram? _____ Colonoscopy? _____



NAME:			
DOB:	/	/	
DATE:	/	/	
MRN:			

Reproductive History

1st day of last menstrual period: _____ Estimated date of conception: _____

Frequency: every _____ days Periods are: regular irregular

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

Have you ever been treated for an STI Yes No If yes, which? _____ When? _____

When was your last Pap smear? _____ History of abnormal pap smears? Yes No

Details (dates, type of abnormality, treatments) _____

Pregnancy and Birth History:

Have you breastfed before? Yes No

How do you want to feed your baby? Breast Pump Formula Combination Unsure

When you deliver your baby, what type of pain medicine do you want?
 Epidural IV Medication Nitrous Oxide ("Laughing Gas") None Unsure

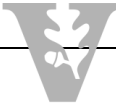
Have you ever attended or do you plan on attending childbirth education classes? Yes No

If your baby is a boy, do you want him circumcised? Yes No Unsure

What type of birth control would you like to use use after your baby is born?
 Pills Nuva Ring Condoms Depo Shot IUD (Mirena, Kyleena, Paragard) Diaphragm
 Nexplanon (arm implant) Tubes Tied (sterilization) Other _____ Unsure

Pregnancy History

Pregnancy Number	Date of birth	Sex	Infant's Weight at Birth	Type of Delivery (Vaginal, Cesarean, Forceps, Vacuum)	Pain Mgmt	Feeding Breast or Bottle	Name of Baby	Weeks pregnant at delivery	Hours In Labor	Details or Complications
1.										
2.										
3.										
4.										
5.										



NAME:			
DOB:	/	/	
DATE:	/	/	
MRN:			

Personal Medical History

Please check the boxes below as they apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Hypothyroidism (under active) | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hyperthyroidism (over active) | <input type="checkbox"/> GERD/Acid Reflux |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Diabetes during pregnancy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Preeclampsia |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Genetic Disorder |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Uterine fibroids | (type)_____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Blood clotting disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Allergies | <input type="checkbox"/> Postpartum Depression |

Please list past surgeries or hospitalizations and dates _____

Family Medical History

*Please check the boxes below as they apply. Indicate family member(s) (ie, grandma, aunt, cousin) **and** side of family (i.e. maternal **M**, paternal **P**) with this history on the line that follows.*

- | | | |
|---|---|--|
| <input type="checkbox"/> Bipolar disorder _____ | <input type="checkbox"/> Addiction (alcohol, drugs) _____ | <input type="checkbox"/> Blood Clotting Disorder _____ |
| <input type="checkbox"/> Breast Cancer : _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Kidney disease _____ |
| <input type="checkbox"/> Colon Cancer : _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Schizophrenia _____ |
| <input type="checkbox"/> Ovarian Cancer : _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Other Cancer : _____ | <input type="checkbox"/> Hypo or Hyperthyroidism (circle) _____ | <input type="checkbox"/> Preeclampsia _____ |
| <input type="checkbox"/> Osteoporosis : _____ | <input type="checkbox"/> Parkinson's : _____ | <input type="checkbox"/> Heart Attack _____ |
| <input type="checkbox"/> Crohn's disease _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Blood Clot _____ |
| <input type="checkbox"/> Celiac disease _____ | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Alzheimers, other dementia _____ | | |

NAME:			
DOB:	/	/	/
DATE:	/	/	/
MRN:			

Do you have a family history of breast, colon, or uterine cancer?

Relationship _____ Age at diagnosis _____

Do you have a family history of heart attacks or stroke before the age of 55?

Relationship _____ Age at diagnosis _____

Pain

Are you currently experiencing pain? If so, where _____?

Because abuse is an enormous problem among women, we ask all of our patients about a history of or present abuse so we may best meet your needs as your care provider.

Have you ever experienced violence or abuse? Yes No I'm not sure. I prefer not to answer.

If yes, please check all that apply: Emotional Physical Sexual Verbal Spiritual Other: _____

I would like to discuss this in more detail. I do not wish to talk about this during my visit today.

NAME:			
DOB:	/	/	/
DATE:	/	/	/
MRN:			

ACOG recommends universal screening of all pregnant women for changes in mood and substance abuse. Please complete these questions as part of our care for you.

5 Ps

Substance Use Interview:

Did any of your parents have a problem with alcohol or other drugs?

Yes

No

Do any of your friends (peers) have a problem with alcohol or other drug use?

Yes

No

Does your partner have a problem with alcohol or other drug use?

Yes

No

In the past, have you had any difficulties in your life due to alcohol or other drugs, including prescription drugs?

Yes

No

In the past month, did you drink beer, wine, or liquor, or use other drugs?

Yes

No

NAME:			
DOB:	/	/	
DATE:	/	/	
MRN:			

PHQ-2 - Mood interview:

Over the last 2 weeks, how often have you been bothered by the following problems?

0=not at all 1= several days 2= more than half the days 3=nearly every day

Little interest or pleasure in doing things	0	1	2	3
Feeling down, sad, or hopeless	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you answered positively above, how difficult have these issues made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

NAME:			
DOB:	/	/	
DATE:	/	/	
MRN:			

PHQ-7

Additional Mood interview – to be completed ONLY if you answered 1,2 or 3 to any of the previous three questions:

Over the last 2 weeks, how often have you been bothered by the following problems?

0=not at all 1= several days 2= more than half the days 3=nearly every day

Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3