ADDRESSOGRAPH

NH2145

NORTHSIDE HOSPITAL

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Date: _____

First Name: _____ Last Name: _____

Name Preference: _____

First Day of last menstrual period: _____ Estimated Due Date: _____ Referring OB/MD: _____

Is this an IVF pregnancy? Yes ___ No ___ If donor egg pregnancy, age of donor? _____ What is your current **weight** _____ **height** _____

What will your age be on your due date? _____

How many times have you ever been pregnant (including this pregnancy)? _____

How many were: Full term (**37+ weeks**)? _____ Pre-term (**20-36 weeks**) _____ Miscarriages _____ Abortions _____ Ectopics _____

How many living children do you have? _____ Have you had 3 or more miscarriages **OR** a stillbirth? Yes ___ No ___

If yes, please explain: _____

Do you have?

High Blood Pressure Yes ___ No ___ History of blood clots Yes ___ No ___ Lupus Yes ___ No ___ **Progressive wt. loss Yes ___ No ___

Diabetes Yes ___ No ___ Thyroid Disease Yes ___ No ___ **Hyperemesis Yes ___ No ___ **Special dietary needs Yes ___ No ___

Asthma Yes ___ No ___ Epilepsy Yes ___ No ___ **Excessive wt. gain Yes ___ No ___

If yes, please explain: _____

If you answered Yes to any starred items (**), would you like a referral to a dietician? _____

Please list any surgeries you have had: _____

Please list **MEDICATIONS** you are taking during your pregnancy: _____

Please list any **ALLERGIES** you have to drugs, food, or Latex: _____

Do you drink alcoholic beverages?: Yes ___ No ___ If yes, number of drinks per week: _____

Do you smoke cigarettes?: Yes ___ No ___ If yes, number of packs per day: _____

If you are 40 or over, have you had a screening mammogram? Yes ___ No ___

Have you had an x-ray examination during this pregnancy? Yes ___ No ___ If yes, please specify: _____

Do you, the baby's father, or anyone in either of your families have?

Spina bifida (open spine)	Yes ___	No ___	Hydrocephalus	Yes ___	No ___	Hemophilia	Yes ___	No ___
PKU	Yes ___	No ___	Muscular Dystrophy	Yes ___	No ___	Cystic Fibrosis	Yes ___	No ___
Down Syndrome	Yes ___	No ___	Tay Sach's Disease	Yes ___	No ___	Mental Retardation	Yes ___	No ___
Cleft lip or Palate	Yes ___	No ___	Clubbed foot	Yes ___	No ___	Heart Defect	Yes ___	No ___

Please list if you, the baby's father, or any relative have ever had a birth defect, chromosomal abnormality or inherited health problem not mentioned above?

_____

Are you or the baby's father of Jewish, French Canadian or of Cajun ancestry? Yes ___ No ___

If yes, have either of you been screened for Tay Sach's disorder? Yes ___ No ___

If yes, please explain: _____

Are you or the baby's father African American or Latino? Yes ___ No ___

If yes, have either of you been screened for Sickle Cell? Yes ___ No ___

If yes, give results: _____

Are you or the baby's father of Italian, Greek, Mediterranean, or Asian background? Yes ___ No ___

If yes, have either of you been screened for Thalassemia? Yes ___ No ___

If yes, please give results: _____

Are you and the baby's father related in any way (i.e. cousins)? Yes ___ No ___

Do you have any concerns about your personal safety, the personal safety of anyone in your home, or the security of your property? Yes ___ No ___

Please explain any major concerns you have about your pregnancy or family history which are not mentioned above:

_____

_____

Patient Signature: _____ Reviewer's Signature: _____

Date: _____ Time: _____ AM/PM

Interpreter Signature: _____

Note: If phone interpretation used, record interpreter ID #

Reorder #13535 NH2145 **U**
Piedmont Graphics 03/13/12

CENTER FOR PERINATAL MEDICINE QUESTIONNAIRE