Welcome to Labor and Delivery! The following are questions about your health and history that we need to ask for your admission process. Please complete as completely as possible, and let us know if you have any questions. Thank you.

General Information

Do you have any of the following?

1. A recent fever greater than 100.4 Yes ________ No________
2. A cough not related to allergies or COPD Yes ________ No________
3. A cough with blood produced Yes ________ No________
4. Persistent Cough greater than three weeks Yes ________ No________
5. Sore throat Yes ________ No________
6. Night sweats Yes ________ No________
7. Unexplained weight loss Yes ________ No________
8. Fatigue Yes ________ No________
9. Body Aches Yes ________ No________
10. Rash Yes ________ No________
11. Nasal congestion not related to allergies or sinus infection Yes ________ No________
12. Close contact with anyone who is having a Flu like illness Yes ________ No________
13. Prior history of TB or positive TB skin test Yes ________ No________
14. Close contact with a person who has TB Yes ________ No________
15. Have you been outside the country in the last two weeks? Yes________ No________
    If so where?____
16. History of MRSA Yes ________ No________

What name would you like to be called? ____

Are you part of a Research Study? Yes ________ No________

Your Due Date is: ________________________ Date of Last Menstrual Period?__________________

Pregnancy History: If this is not your first pregnancy, please check all that is applicable for each pregnancy in the box below.

	First	Second	Third	Fourth	Fifth
Abortion					
Miscarriage					
Vaginal Del					
C/Section					
Preterm					
Term					
Stillbirth					
Neonatal Death					

If you are having contractions, what time did they become regular? ____________________

Have you had intercourse in the previous 24 hours? Yes________ No________

Do you think your bag of water broke? Yes __________ No ________ If yes, what time ___________

Are you having any vaginal bleeding? Yes ________ No________

Have you been Hospitalized in the last 30 days? Yes ________ No________

Have you received steroids,(i.e., Betamethasone) this pregnancy? Yes ________ No________

Do you have any allergies to Food? Yes ________ No________

List: ________________________________ Reaction: ______________________________________

Do you have any allergies to Medications? Yes ________ No________

List: ________________________________ Reaction: ______________________________________

Are you allergic to Latex? Yes ________ No________

Do you have any allergies to Contrast Dye? Yes ________ No________

Any other Allergies? Yes ________ No________

Current Pregnancy History

Was a Transvaginal Ultrasound preformed this pregnancy? Yes ________ No________

Are there any pre-diagnosed Fetal Anomalies? **(Circle all that apply)** Yes ________ No________

Cardiovascular Neurological Gastrointestinal Integumentary
Other: ____

Are there complications with this pregnancy? (Circle all that apply) Yes ________ No________

Diabetes High Blood Pressure GBS positive Hyperemesis Preterm Labor
Premature Rupture of Membranes Problems with the Placenta Polyhydramnios
Oligohydramnios Uterine Anomalies Incompetent Cervix or cervical shortening IUGR

Any other complications not listed above? ____

____

Was there any infertility treatment needed? (Circle all that apply) Yes ________ No__________

Fertility Enhancement Medications Artificial Intrauterine Insemination
Surgical Infertility Treatment Assisted Reproductive Technology (handling of eggs or embryos)

Vaccine History

Vaccine Contraindications: Do any of the following apply to you? Yes________ No___________

Anaphylactic Allergy to Eggs	Anaphylactic Latex Allergy	Chemo/Radiation
Guillan-Barre	Bone Marrow within 1-6 mos	Bone Marrow 7-12 mos
Reaction to Pneumococcal Vaccine	Reaction to Flu Vaccine	Recent Shingles Vaccine

Did you receive the Flu Vaccine? Yes ________ No________ Date __________

Have you received the Pneumococcal Vaccine? Yes ________ No________ Date__________

Have you received the TDAP vaccine? Yes ________ No________ Date __________

Have you received any of the following vaccines? **Please circle all that apply**

Chicken Pox Tetanus MMR Hepatitis Polio

Which of the following prenatal tests did you have during your pregnancy? (Circle all that apply)

Non-stress test	Alpha Fetal Protein	Ultrasound	Biophysical Profile
Glucose Tolerance Test	Fetal Fibronectin	Sequential Screen	Nuchal Translucency
Amniocentesis	Contraction Stress Test	Triple Screen	

Do you have a history of any of the following?:

Gonorrhea Yes ________ No________ Treated____________________

Syphilis Yes ________ No________ Treated ____________________

Herpes Yes ________ No________ Date of Last Outbreak __________

Chlamydia Yes ________ No________ Treated ____________________

Trichomoniasis Yes ________ No________ Treated____________________

Condyloma Yes ________ No________

HPV Yes ________ No________

Previous Pregnancy Complications

Have you had prior C section Deliveries, and if so, how many? ______________________

Have you had any of the following? **(Circle all that apply)**

Post Partum Depression   Diabetes with Previous Pregnancies   Pre eclampsia/Eclampsia

Group B Strep Positive   Incompetent Cervix   Twins/Triplets   Post Partum Hemorrhage

Any other complications not listed? ____

Previous Surgeries: Please list any surgery and year of surgery.

____

____

____

Anesthesia

Have you had any complications with Anesthesia?   Yes ________ No________

List: ____

Have you or anyone in your family had any of the following?

Malignant hyperthermia?   Yes ________ No________

Sunstroke, heat stroke or exercised induced muscle breakdown resulting in hospitalization?

Yes ________ No________

Has someone in your family died unexpectedly in the OR?   Yes ________ No________

You are (circle one): Married - Divorced - Single - Widowed - Life Partner

Your support person is your: (circle one): Husband - Sister - Friend - Significant Other – Other

Name of Support Person ____

If people call asking if you are here, is it OK to tell them that you are here? Yes ________ No________

How tall are you? ____

How much do you weigh? ____

How much did you weigh before you were pregnant? ___________________________

Do you have an Advanced Directive for Healthcare?   Yes ________ No________

Are you an Organ Donor? Yes ________ No________

Will you accept blood for transfusion if necessary? Yes ________ No________

Are you doing cord blood collection? Yes ________ No________

Have you ever been a smoker? Yes ________ No________

Quit Less than a year ago   Quit between 1 and 3 years ago   Quit more than three years ago

If you currently smoke, do you smoke: (circle)   Cigarettes - Pipes - Cigars

Last day smoked: ____

Alcohol use during the pregnancy `Yes ________ No________

If yes, the last date/time Alcohol was used: ____

Have you used any of the following during this pregnancy? Yes ________ No________

Circle all that apply.

Amphetamines - Barbiturates - Cocaine/Crack - Marijuana - Heroin - LSD -

Inhalants: Paint/Glue - PCP - Embalming Fluid - Prescription Drugs - Meth

If yes, the last time used: ____

Do you have any implants or medical devices? List: ____

Neurological History

Do you have a history of any the following? **If Yes, circle all that apply:** Yes ________ No________

Headaches – Visual Disturbances – Seizures – Epilepsy – Fainting - Head injury –

Stroke – Neuromuscular disease – Hearing or Vision impairment

Do you wear glasses or contacts? Yes ________ No________

Do you have any problems with your mouth, teeth or gums? Yes ________ No________

Do you have a hearing deficit or a history of TMJ syndrome? Yes ________ No________

Respiratory History:

Do you have any history of the following? If yes, circle all that apply: Yes ________ No________

Asthma   Pneumonia   Bronchitis   Allergies

Cardiovascular History:

Do you have a history of any of the following? If yes circle all that apply: Yes ________ No________

Mitral Valve Prolapse   Anemia   Clotting Abnormalities /ITT   Blood Transfusion
Rheumatic Fever   Cardiomyopathy   Congenital Heart Defect
Cardiac Arrhythmia   Other: ____

Gastrointestinal History:

Do you have a history of any of the following? **If yes circle all that apply:** Yes ________ No________

Nausea/Vomiting - Constipation - Liver Disease - Colitis - Stomach Ulcers - Irritable Bowel Syndrome - Previous Weight Loss Surgery - Hepatitis - Hemorrhoids - Diarrhea - Epigastric Pain

Renal History:

Do you have a history of any of the following? **If yes circle all that apply:** Yes ________ No________

Recurrent Urinary Tract Infections   Kidney Stones   Urinary Stents Placed   Kidney Disease

Musculoskeletal History:

Do you have a history of the following? Yes ________ No________

Chronic Back Pain   Previous Back Surgery   Anomalies   Fractures
Implants   Paralysis   Scoliosis

Endocrine History

Do you have any of the following? **Circle all that apply:** Yes ________ No________

Gestational Diabetes   Diet Controlled Diabetes   Insulin Controlled Diabetes
Oral Hypoglycemic Controlled Diabetes   Thyroid Dysfunction   Polycystic Ovarian Syndrome

Gynecological History

Do you have a history of any of the following? **Circle all that apply:** Yes ________ No________

Cryosurgery   Cervical Biopsy   Cone Biopsy   Cervical Dysplasia
Uterine Fibroids   Incompetent Cervix   Breast Biopsy   Infertility (Meds, In vitro) -
Cancer   Surrogacy   Endometriosis

Mental Health/Psych History

Do you have a history of the following? **Circle all that apply:** Yes______ No_______

Agitation - Aggression/Hostility - Anxiety - Panic Attacks - Unhealthy Coping Skills - Delusional Thinking - Depression/Post Partum Depression - Hallucinations - Compulsive Disorder - Isolating Behavior - Low self esteem - Manic Behavior - Withdrawal - Psychosis ADD - ADHD

Any recent life changes?: Circle as appropriate: Loss of local support system - Recent loss of a Job - Recent loss of a Family Member - Recent Divorce; Other: ______________________________

Do you have any religious or cultural needs that the staff should be sensitive to during your stay? Or is there anything we can do to avoid doing to prevent you from feeling uncomfortable during this hospitalization?

____

____

____

Support Services

Circle any of the support services used prior to this admission.

Home Health   Medical Equipment   WIC   Food Stamps

Do you live at home (circle) :   Alone   With others

Do you need assistance beyond family after discharge? Yes _______ No_______

Domestic Violence

Do you have a history of abuse? Yes _______ No________

Have you experienced abuse within the last year, or during this pregnancy? Yes ______ No________

Do you feel unsafe going home? Yes ________ No _________

Nutritional Screening: Do you have any of the following: **(circle all that apply)**

Gastric Bypass   Diabetes   Unintentional Weight Loss   Eating Disorder

Poor Appetite   Trouble swallowing   Other concerns: ____________________

Do you need a special diet (Vegetarian, Diabetic, Gluten Free, Kosher)? Yes ________ No________

____

Who is your Pediatrician? ____

Mothers Needs

What are your plans for pain management? (please circle)

Epidural   Spinal   IV Medication   General Anesthesia

Spinal Anesthesia   Birthing Ball   Natural Childbirth   Uncertain

Infant Needs

Are you going to: Breast feed _________ Bottle Feed ____________

Have you breast fed before? Yes ______ No _______.

Did you experience any problems breastfeeding?

____

____

If your baby is a boy, would you like him circumcised? Yes __________ No__________

Are you planning a Tubal Ligation (i.e. sterilization)? Yes __________ No __________

Have you fallen in the last 3 months? Yes _______ No ________

Do you have any problems with your skin? Yes _________ No ____________ Please list Below:

____

Are you an organ donor? Yes________ No________

Will you accept blood for transfusion, if needed? Yes ________ No________

Are you doing Cord blood collection? Yes ________ No________

Suicide Assessment

Do you have thoughts of harming yourself or others? Yes ________ No________

In the past week have you been having thoughts about hurting yourself? Yes ________ No________

Did you ever seriously consider killing yourself in the last year? Yes ________ No________

Has something very stressful happened to you in the past few weeks? Yes ________ No________

Are you currently experiencing any Nausea or Vomiting? Yes ________ No________

Are you having any pain in your right upper abdomen? Yes ________ No________

When did you eat or drink last? ____

What day was your last Bowel Movement? ____

Do you currently have a headache? Yes ________ No________

Are you experiencing any visual disturbances? Yes ________ No________

Are your ears pierced? Yes ________ No________

Do you have any other piercings? If so please list: ______________________________

Current Medications: Please list ALL current Prescription and Over the Counter medications, herbs, supplements (including prenatal vitamins, Iron, Calcium etc).

Medication	Dosage	Frequency	Route (oral, SQ, IM)	Date/Time of Last Dose

Family History. Please check if any of your immediate family members had any of the following, and please include the age of onset

Are you adopted? Yes ________ No________

	Mother	Father	Sister	Brother	Daughter	Son
Heart Disease						
Cancer						
Diabetes						
Hypertension						
Stroke						
Age of Onset						