CentraCare™

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Pre-baby Health History Form

Your Name ______________________________ **Your Date of Birth** ______________________

Taking care of your health is important to us and it is important that we have accurate information about your current pregnancy and your past history. When answering these questions, please give your best guess if you are not able to recall exact dates or details.

Diabetes Screening Tool

Please answer these questions to determine your Diabetes risk:	**Yes**	**No**
What was your weight one month prior to pregnancy? __________		
High Risk (1 or more)		
Do you have a history of diabetes during previous pregnancy?	☐	☐
Have you been diagnosed with PCOS (Polycystic Ovarian Disease)?	☐	☐
Are you currently taking Metformin? ** [If Yes, Complete 2 hr GTT at 14 weeks – Refer to GDM RN]	☐	☐
Is your BMI (Body Mass Index) ≥ 40	☐	☐
Do you have a history of pre-diabetes?	☐	☐
Fasting glucose ≥ 100, 2 hour fasting glucose ≥ 140, A-1c of 5.7		
Low Risk (2 or more)		
Will you be 35 years or older when you deliver your baby?	☐	☐
Is your BMI (Body Mass Index) ≥ 30-39	☐	☐
Have you delivered a baby weighing 9 pounds or more?	☐	☐
Do any of your family members (mom, dad, brother, sister) have Type 2 Diabetes Mellitus?	☐	☐
Are you of Hispanic, Asian or Native American descent?	☐	☐
Do you have high blood pressure ≥ 140/90	☐	☐
Do you have a history of a weight loss surgery (gastric bypass, gastric sleeve)? ** [Refer to GDM RN for testing recommendations]	☐	☐

Postpartum depression (PPD) is a common problem after pregnancy. On the next page you will find a screening tool called an Edinburgh Postnatal Depression scale. This tool is used during and after pregnancy to help determine your risk of developing postpartum depression. There are resources to help you and we want to be prepared to do that if needed.

Please answer the questions to the best of your ability. ***Of note*:** you do not need to enter any demographic information on this form such as name, address, etc. Simply answer the questions and the nurse will enter them into your chart for you.

Continue to next page.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ______________________________ Address: ___________________________

Your Date of Birth: ____________________ ___________________________

Baby's Date of Birth: ___________________ Phone: _________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by ______________________________ Date ______________________________

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Health Habits & Personal Safety

Tobacco:
Do you use tobacco products? ❑ Yes ❑ Never ❑ Quit, date ______________________________________
If yes, what type(s)? ❑ Cigarettes ❑ Cigars ❑ Chew ❑ Snuff ❑ Pipe
If cigarettes, how many packs per day? ❑ <.25 ❑ .5 ❑ 1.0 ❑ 1.5 ❑ 2.0 ❑ ________________________
Do you want to quit? ___ Yes ____No

E-Cigarette/Vaping:
Do you use E-cigarettes or vaping products? ❑ Yes ❑ Never ❑ Quit, date ___________________________
Cartridges per day? _________________________

Alcohol:

Before you knew you were pregnant:
How often, on average, do/did you drink alcohol?
❑ Don't drink ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week, but not daily ❑ Every day
When you did drink, how many drinks did you have?
❑ Don't drink ❑ 1 to 2 ❑ 3 to 4 ❑ 5 to 6 ❑ At least 7

Since knowing you were pregnant:
How often do/did you drink alcohol?
❑ Don't drink ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week but not daily ❑ Every day
When you did drink, how many drinks did you have?
❑ Don't drink ❑ 1 to 2 ❑ 3 to 4 ❑ 5 to 6 ❑ At least 7
When was the last time you had a drink? ____

Drugs:

Before you knew you were pregnant:
Do/did you use street drugs?
❑ No ❑ Heroin ❑ Methadone ❑ Marijuana ❑ Methamphetamines ❑ Cocaine ❑ Ecstasy ❑ IV ❑ Other ______________________
Do/did you use prescription pain medications?
❑ No ❑ Vicodin ❑ Percocet ❑ Other _______________________
How often on average do/did you use drugs?
❑ Don't use drugs ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week but not daily ❑ Every day

Since knowing you were pregnant:
Do/did you use street drugs?
❑ No ❑ Heroin ❑ Methadone ❑ Marijuana ❑ Methamphetamines ❑ Cocaine ❑ Ecstasy ❑ IV ❑ Other ______________________
Do/did you use prescription pain medications?
❑ No ❑ Vicodin ❑ Percocet ❑ Other _______________________
How often on average do/did you use drugs?
❑ Don't use drugs ❑ Less than once a month ❑ At least once a month, but not weekly ❑ At least once a week but not daily ❑ Every day

Have you ever been in treatment for alcohol or drugs? ❑ No ❑ Yes

Medical History

	Yes	No		Yes	No		Yes	No
Abdominal pain	☐	☐	Endometriosis	☐	☐	Osteoporosis	☐	☐
Abnormal uterine bleeding	☐	☐	Fibrocystic breast	☐	☐	Ovarian Cyst	☐	☐
Anemia or low hemoglobin	☐	☐	Fibroids	☐	☐	Pelvic pain	☐	☐
Anxiety	☐	☐	Gonorrhea	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Headaches, recurrent	☐	☐	Polycystic ovarian syndrome (PCOS)	☐	☐
Bleeding or clotting problems	☐	☐	Heart disease	☐	☐	Rectocele	☐	☐
Breast mass	☐	☐	Heartburn or reflux	☐	☐	Seasonal or environmental allergies	☐	☐
Cancer	☐	☐	Heavy periods	☐	☐	Seizures or epilepsy	☐	☐
Cancer, breast	☐	☐	Hepatitis	☐	☐	Sexual dysfunction	☐	☐
Cancer, cervical	☐	☐	Herpes	☐	☐	Shingles	☐	☐
Cancer, endometrial	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Cancer, ovarian	☐	☐	Hirsutism	☐	☐	Substance abuse	☐	☐
Cancer, vaginal	☐	☐	HPV	☐	☐	Syphilis	☐	☐
Cancer, vulvar	☐	☐	Infertility	☐	☐	Thyroid problems	☐	☐
Chlamydia	☐	☐	Inflammatory Bowel Disease (IBS)	☐	☐	Trichomonas	☐	☐
Cholesterol or lipid problems	☐	☐	Kidney disease	☐	☐	Tuberculoisis	☐	☐
Depression	☐	☐	Liver disease	☐	☐	Urinary Incontinence	☐	☐
Diabetes	☐	☐	Menopause	☐	☐	Uterine prolapse	☐	☐
Eating Disorder	☐	☐	MRSA			Vaginal infection (recurrent)	☐	☐
Ectopic pregnancy	☐	☐	Obesity or overweight	☐	☐	Vancomycin-Resistant Enterococcus (VRE)	☐	☐
Chicken pox	☐	☐	ParvoVirus B19 or Fifth's Disease	☐	☐			

Surgical History

	Yes	No		Yes	No		Yes	No
Appendectomy	☐	☐	Cholecystectomy	☐	☐	Hysterectomy	☐	☐
Bladder suspension	☐	☐	Colposcopy	☐	☐	Hysteroscopy	☐	☐
Breast augmentation	☐	☐	Cystocele repair	☐	☐	Laparoscopy	☐	☐
Breast biopsy	☐	☐	Dilate and curettage	☐	☐	LEEP	☐	☐
Breast lumpectomy	☐	☐	Endometrial ablation	☐	☐	Oophorectomy	☐	☐
Breast reconstruction	☐	☐	Fibroid removal (myomectomy)	☐	☐	Rectocele repair	☐	☐
Cervical conization	☐	☐	Genital wart removal	☐	☐	Tubal ligation or ESSURE	☐	☐
Cesarean section	☐	☐						

Please list your surgical history, if not listed on previous page. ☐ Never had surgery

Procedure or Surgery	Date of procedure	Where was the surgery done?	Any complications?

Any problems with anesthesia? ☐ No ☐ Yes, please explain: ______________________________

Family History

Do any of your parents, grandparents, siblings, or children have any of the following?	**Yes**	**No**
Alcohol or Drug problems	☐	☐
Anesthesia problems	☐	☐
Blood or Bleeding disorders	☐	☐
Cancer, Breast	☐	☐
Cancer, Ovarian	☐	☐
Cancer, Colon	☐	☐
Cancer, other	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Mental Health Problems	☐	☐
Obesity	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Other	☐	☐

Eating Habits & Safety Information

Do you need support with healthy eating? ❑ Yes ❑ No
Are you on a special food plan? ❑ Yes ❑ No
Do you feel you have a weight problem? ❑ Yes ❑ No
Do you exercise less than 3-4 days a week? ❑ Yes ❑ No
Do you often get sleepy during the day? ❑ Yes ❑ No
Do you **not** routinely wear your seat belt. ❑ Yes ❑ No
Do you have unlocked weapons in your home? ❑ Yes ❑ No
Are you having major stress? ❑ Yes ❑ No

Partner and Family Information

Significant other/spouse's name ______________________________ Age: ______________
Partner's job/employer: ______________________________
How many children do you have in your home? ______________

Prenatal Genetic Assessment

Are you worried about any medications or drugs that you used during this pregnancy? ❑ Yes, ___________________________________
❑ No

Are you worried about any exposures during this pregnancy? (ex: Rubella, CMV, other viral illnesses, X-rays, solvents, unsafe materials, etc)?
❑ Yes, ___________________________________
❑ No

Baby's Father's History:

Does the baby's father have any ongoing health problems? ❑ Yes ❑ No
Was the father of the baby age 40 or older when the baby was conceived? ❑ Yes ❑ No
Are you a blood relative to the father of the baby? ❑ Yes ❑ No

Race: Some ethnicities can increase your risk for certain illness that can suggest the need for more testing in pregnancy.

Are you or the father of the baby one of these ethnicities?

- ❑ Jewish
- ❑ Mediterranean (from Middle East, Greece, Italy, Spain, etc)
- ❑ Asian (from Southeast Asia, China, Taiwan, Philippines, India, etc)
- ❑ Latino/Hispanic
- ❑ Black or African
- ❑ French Canadian

Family History (you and the baby's father's family)
Are any of these health issues in your family history? If so, please write in the specific health problem:

- ❑ History of stillbirth or more than one miscarriage in your immediate family? ____
- ❑ Birth Defects (ex: Neural tube defects, heart, cleft palate/lip, limb defect, etc.)_______________________________________
- ❑ Mental retardation, autism or learning disabilities ____
- ❑ Chromosome problems (ex: Down syndrome, Klinefelter syndrome, Trisomy 13 or 18, Turner)_________________________
- ❑ Other genetic problems (ex: Cystic fibrosis, Marfan syndrome, Sickle cell anemia, PKU, Tay Sach's, hearing loss, bleeding disorders, etc.)____

Workplace assessment:
At work, are you exposed to chemicals, radiation or significant infections? ❑ Yes ❑ No
If so, what are you exposed to? _________________________________
At work, do you often lift heavy objects? ❑ Yes ❑ No
If so, how many pounds? _________________________________
Do you work with children? ❑ Yes ❑ No If yes, have you ever tested immune to Parvo Virus B19/Fifth's Disease? ❑ Yes ❑ No

Eating habits

Do you often skip meals?	❑ Yes ❑ No
Do you drink caffeinated coffee, soda or tea?	❑ Yes ❑ No
If yes, how much daily? ______________________________	
Do you eat less than five servings of fruits and vegetables daily?	❑ Yes ❑ No
Do you have concerns about toxoplasmosis (caused by eating contaminated meat or by cleaning a cat's litter box)	❑ Yes ❑ No
Do you have a history of an eating disorder?	❑ Yes ❑ No
Do you exercise regularly? Type(s), how much per week. _____________________________________	❑ Yes ❑ No

Early Pregnancy History

Since your last menstrual period, have you:	Experienced nausea?	❑ Yes ❑ No
	Thrown up?	❑ Yes ❑ No
	Had continued or worsening stomach pain?	❑ Yes ❑ No
	Had any vaginal bleeding?	❑ Yes ❑ No

Social History

Was this pregnancy planned?	❑ Yes ❑ No
Plans for newborn: ❑ Plan to parent ❑ Plan to place baby for adoption ❑ Unsure of plans	
Do you need extra support in this pregnancy?	❑ Yes ❑ No
Do you feel unsafe in any current relationship or have a history of abuse?	❑ Yes ❑ No
Do you have any money concerns?	❑ Yes ❑ No
Are you in a relationship? Partner or significant other's name _____________________________	❑ Yes ❑ No

Pregnancy history

Have you had any previous pelvic surgery? What kind? __________________________________	❑ Yes ❑ No
Have you had any miscarriages? At how many weeks? __________________________________	❑ Yes ❑ No
Have you ever delivered any pregnancies prior to 37 weeks?	❑ Yes ❑ No
Were you ever treated for preterm labor?	❑ Yes ❑ No
Have you ever had a stillborn baby?	❑ Yes ❑ No
Have you had any illness/infection during this pregnancy?	❑ Yes ❑ No
Do you have any chronic medical conditions?	❑ Yes ❑ No
Have you had gestational hypertension or preeclampsia in any previous pregnancy?	❑ Yes ❑ No

Tuberculosis Exposure Assessment

Have you been in close contact with people with known or suspected tuberculosis (TB)?	❑ Yes ❑ No
Are you an immigrant from Africa, Asia or Latin America?	❑ Yes ❑ No
Are you now or have you completed refugee status?	❑ Yes ❑ No
Have you even been treated for tuberculosis (TB) before?	❑ Yes ❑ No
If yes, when did your complete treatment? ___________________	
Are you now or have you been homeless or incarcerated in the last 5 years?	❑ Yes ❑ No
Have you ever been diagnosed with HIV?	❑ Yes ❑ No

Lead Exposure Assessment

Do you or others in your household have a job or hobbies that involve possible lead exposure?	❑ Yes ❑ No
Sometimes pregnant women feel the urge to eat things that are not food, such as clay, soil, or paint chips.	
Do you ever have these feelings or eat these things?	❑ Yes ❑ No
Do you live in a home built before 1978 that has required updates that made dust?	❑ Yes ❑ No
To your knowledge, has your home been tested for lead? ❑ Yes ❑ No If so, was it high?	❑ Yes ❑ No
Do you use any homemade remedies or cosmetics that are not sold in a store?	❑ Yes ❑ No
Do you use homemade pottery or leaded crystal?	❑ Yes ❑ No

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