VANDERBILT UNIVERSITY MEDICAL CENTER

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

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

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? _____

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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.										

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Personal Medical History

Please check the boxes below as they apply

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

□ Bipolar disorder _____
□ Breast Cancer : _____
□ Colon Cancer : _____
□ Ovarian Cancer : _____
□ Other Cancer : _____
□ Osteoporosis : _____
□ Crohn's disease _____
□ Celiac disease _____
□ Alzheimers, other dementia
_____
□ Addiction (alcohol, drugs)
_____
□Depression_____
□ Diabetes _____
□ Heart disease_____
□ Hypo or Hyperthyroidism (circle)
_____
□ Parkinson's : _____
□ High Blood Pressure
_____
□ Blood Clotting Disorder
_____
□ Kidney disease _____
□ Schizophrenia _____
□ Stroke _____
□ Preeclampsia_____
□ Heart Attack _____
□ Blood Clot _____
□ Other _____

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.

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

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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

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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