Women’s Services Prenatal Clinic

Congratulations on your pregnancy!

We have scheduled your first prenatal visit at the Durham County Department of Public Health Prenatal Clinic. Your first visit is a busy one and will include the following activities:

- Review your Medical History with a clinic nurse
- Sign consent forms for medical tests and screenings
- Prenatal lab work
- Enroll into additional prenatal services that include:
  - Duke Family Care Program
  - WIC - Women, Infant and Children (WIC)
  - Dental Services for Pregnant women
  - Childbirth (Lamaze) classes
  - Pregnancy Management Care Program
- Schedule your next appointment that will include a physical exam by a nurse—midwife, or physician

IMPORTANTA:
Please arrive on time and complete the attached medical history form and BRING IT WITH YOU for this visit. If you arrive late or have not completed the form you will be asked to reschedule your appointment for another appointment.

Discontinuing Services/Provider Transfer
If you do NOT plan to continue prenatal care services at this clinic and you need to apply for Medicaid, please ask for a pregnancy verification form. You can apply for Medicaid at the Department of Social Services. Once you have your Medicaid card you can be seen by any OB provider that accepts Medicaid.

If you have additional questions, please call our Prenatal clinic Monday - Friday at (919) 560-7732
CCNC Pregnancy Home Risk Screening Form

Complete this side of the form and give it to the nurse or doctor. Please answer as honestly as possible so we can provide the best care for you and your baby. The care team will keep this information private.

Name: _________________________ Date of birth: ____________ Today’s date: ____________

Physical Address: __________________________________________ City: _______________ ZIP: ____________

Mailing Address (if different): __________________________________ City: _______________ ZIP: ____________

County: ________________ Home phone number: ________________ Work phone number: ________________

Cell phone number: __________________ Social security number: __________________

Race: □ American-Indian or Alaska Native □ Asian □ Black/African-American
□ Pacific Islander/Native Hawaiian □ White □ Other ( specify): ________________

Ethnicity: □ Not Hispanic □ Cuban □ Mexican American □ Puerto Rican □ Other Hispanic

1. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
   □ I wanted to be pregnant sooner.
   □ I wanted to be pregnant now.
   □ I wanted to be pregnant later.
   □ I did not want to be pregnant then or any time in the future.
   □ I don’t know.

2. *Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
   □ Yes □ No

3. *Are you in a relationship with a person who threatens or physically hurts you?
   □ Yes □ No

4. *Has anyone forced you to have sexual activities that made you feel uncomfortable?
   □ Yes □ No

5. In the last 12 months were you ever hungry but didn’t eat because you couldn’t afford enough food?
   □ Yes □ No

6. *Is your living situation unsafe or unstable?
   □ Yes □ No

   □ A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
   □ B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
   □ C. *I stopped smoking AFTER I found out I was pregnant and am not smoking now.
   □ D. *I smoke now but have cut down some since I found out I was pregnant.
   □ E. *I smoke about the same amount now as I did before I found out I was pregnant.

8. Did any of your parents have a problem with alcohol or other drug use? □ Yes □ No

9. Do any of your friends have a problem with alcohol or other drug use? □ Yes □ No

10. Does your partner have a problem with alcohol or other drug use? □ Yes □ No

11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? □ Yes □ No

12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs? □ Not at all □ Rarely □ Sometimes □ Frequently

13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?
   □ Not at all □ Rarely □ Sometimes □ Frequently

(For Pregnancy Care Management use only) Date risk screening form was received: ___/___/_____

PMH Risk Screening Form v1.7 September 2013
Durham County Health Department
Prenatal Clinic Patient History Form

Name (First, Middle, Last)

Duke History number

Social Security Number

Birth Date __________/________/_______

Place of Birth

Address: Street Address

Apt. or Building Number ______ City ________ State ______ Zip Code ______

Home Phone ( ) ______-______ Work phone ( ) ______-______ Cell ( ) ______-______

Marital Status: Single Married Divorced Widowed Separated

Religion or spiritual belief:

Race/Ethnicity: Asian/Pacific Island Black Hispanic Native American White Unknown

Highest level of education completed ________ Occupation ________________

Employer __________________ Work Phone Number: _______________________

Type of Insurance: (circle any that apply)

Presumptive Medicaid
Baby Love (Medicaid for Pregnancy Women)
NC Medicaid
Private Insurance
Self Pay (no insurance)

Name of Husband/Father of this baby ________________ His race ________________

His Daytime phone number ________________ Occupation ________________

Emergency Contact person and phone number ____________________________
CURRENT PREGNANCY

What is the first day of your last normal menstrual period? (mm/dd/yy)? ___/___/___

Are you sure about the date? Is it definite, approximate, or unsure? □ yes □ no

Was it a normal period? □ yes □ no  Are your periods usually regular? □ yes □ no

How often do you have a period? Every _____ days  How many days do they last? ___

How old were you when you got your first period? _____

Was this a planned pregnancy? □ Yes □ No

Were you using any birth control when you got pregnant? □ Yes □ No

If you were using birth control what were you using? ____________________________

When did you stop using this birth control (mm/dd/yy)? ___/___/___

Have you had an ultrasound during this pregnancy? □ Yes □ No If yes, when: ____________________________

PREGNANCY HISTORY

Have you ever been pregnant before? □ yes □ no

How many times (count this pregnancy) have you been pregnant? ______

How many of these pregnancies were Full Term (no more than 3 weeks early) ______

How many of these pregnancies were preterm (more than 3 weeks early)? ______

How many were miscarriages? _____  How many were abortions? _____

How many were pregnancies in your tubes (ectopic)? ______

How many of the babies you delivered are living? ______

Have you ever had twins, triplets etc. (which?) _____ twins _____ triplets

How much did you weigh before you were pregnant? _______ pounds

Please use pages 7 and 8 to tell us about each of your pregnancies.
MEDICAL HISTORY
Please put an X by any condition or statements that apply to you

Pulmonary
______ Asthma
______ I have been treated for tuberculosis (other)
______ I have had a +PPD (TB test)

Blood or Cardiac
______ I have Mitral Valve Prolapse
______ I have a history of an arrhythmia
______ I have a heart murmur
______ I have had congestive heart failure
______ I have Sickle Cell Anemia

High Blood Pressure (Hypertension)
______ I had high blood pressure in pregnancy (PIH)
______ I have high blood pressure now

Thromboembolism (blood clots)
______ I have had a clot in my leg (DVT)
______ I have had a clot in my lung (PE)
______ Other

Liver Disease
______ I have had yellow jaundice or Hepatitis
______ Other

Gastrointestinal Conditions
______ I have had Morning sickness during this pregnancy (nausea and vomiting)
______ I have had severe vomiting requiring IV’s & medications in this pregnancy (Hyperemesis)
______ I have an eating disorder (anorexia/bulimia)
______ I have gallbladder disease
______ I have had my gallbladder removed
______ I have frequent bladder infections (UTI’s)
______ I have been diagnosed wit Lupus
______ I have had an Infection in my kidneys (pyelo)
______ I have had Kidney stones (renal calculi)
______ I have been diagnosed with a back-up in my kidneys (renal reflux)
______ I have had a Kidney Transplant

Neurological Conditions
______ I have been diagnosed with Migraines
______ I have a Seizure disorder
______ I have Multiple Sclerosis
______ Other

Mental Health (Psychological)
______ I have a history of anxiety
______ I have a history of depression
______ I have bipolar disorder
______ I have been diagnosed with schizophrenia

Autoimmune Disorders
______ I have Diabetes

Thyroid Disorders
______ I have Hyperthyroidism
______ I have Hypothyroidism
______ I have had a Goiter

Gynecologic Conditions
______ I have a history of infertility
______ I have had an abnormal pap smear
______ I have had gonorrhea before
______ I have had Chlamydia before
______ I have had trichomonas before
______ I have had bacterial vaginosis (BV) before
______ I have had breast cancer
______ I have had a lump or cyst in my breast

Gynecologic surgery
______ I had an ectopic pregnancy requiring surgery
______ I have had surgery to remove fibroids (myomectomy)

Blood Transfusions
______ I have had a blood transfusion
______ I had a reaction to a blood transfusion

Immunizations
______ I have had the chicken pox vaccine
______ My immunizations are up to date

Headaches
______ I have been treated for headaches

Respiratory
______ I have pulmonary hypertension
______ I have cystic fibrosis

Urological
______ I need to urinate a lot (frequency)
______ I have burning when I urinate
______ Sometimes I have to urinate so bad that I barely make it to the bathroom (urgency)

Other
______ I have had surgery before that is not listed
______ I have other health condition(s):
IMMUNIZATIONS

☐ yes ☐ no Have you ever had a positive test for Tuberculosis? (ppd or chest xray)
☐ yes ☐ no Have you ever had Chicken Pox?
☐ yes ☐ no Have you ever had the vaccine for Chicken Pox?
☐ yes ☐ no Have you ever been exposed to or had hepatitis? (yellow jaundice)
☐ yes ☐ no Have you received the Hepatitis B Vaccine series?
☐ yes ☐ no Have you ever been vaccinated against Rubella?
☐ yes ☐ no Have you been vaccinated for HPV? (human papilloma virus)
☐ yes ☐ no Have you lived in the United States less than 5 years?
☐ yes ☐ no Do you work in Day Care?
When did you receive your last tetanus shot? _______________________

GENETIC and ENVIRONMENTAL SCREENING

Put an X by any condition or statements that apply to you and your family OR the father of the baby and his family

☐ I will be 35 or greater when my baby is born
☐ I am related by blood to the father of this baby
☐ I have had more than 2 miscarriages
☐ There is a history of mental retardation
☐ There is a history of a chromosome abnormality or birth defect; please list: ______________________
☐ Someone has muscular dystrophy
☐ I have been exposed to x-rays (radiation) during this pregnancy
☐ I have been exposed to medications during this pregnancy; Please list: ______________________
☐ I have had alcohol during this pregnancy
☐ I have used tobacco products (cigarettes, chewing) during this pregnancy
☐ I have used marijuana, cocaine, or other drugs during this pregnancy; Please list: ______________
☐ Someone has Sickle Cell Disease, Sickle Cell Trait, Beta Thalassemia Disease or trait or other problems with red blood cells (hemoglobinopathy)
☐ Someone was born with a neural tube defect (spina bifida, myelomeningocele)
☐ Someone has a bleeding disorder (hemophilia)
☐ Someone has a clotting disorder (thrombophilia disorder)
☐ Someone is from Jewish, French, Canadian, or Creole descent
☐ Someone has Huntington disease
☐ Someone has cystic fibrosis
☐ I have or my baby's father has been exposed to any harmful chemicals, gases, paints, fumes, etc. at work or at home during this pregnancy? Please describe: ______________________
☐ I am exposed to cat feces because I empty cat litter or do gardening
☐ I eat uncooked meat or fish
Prenatal Record Continued: **NURSE SCREENING FORMS**

**ALLERGIES**

Do you have any allergies to foods or medications or materials?  □ yes  □ no

If you do have allergies what reactions do you have?

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<td>Seafood</td>
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<td>Tape/Band-Aids</td>
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<td>Codeine</td>
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<td>Penicillin</td>
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<td>Sulfa Drugs</td>
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<td>Xray Dye</td>
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<td>Other</td>
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**Medications**

Please list all vitamins, over the counter medications, or herbal supplements that you have used since you have been pregnant. This would include medications you took before you knew you were pregnant.

1. prenatal vitamins  □ yes/no  3.  
2.  
4.

**Alcohol, Tobacco, and Depression**

□ yes  □ no  Did you smoke cigarettes before you knew you were pregnant?
If yes: About how many cigarettes per day did you smoke?

- □ 1-5 cigarettes
- □ ½ pack
- □ 1 pack
- □ 2 or more packs

□ yes  □ no  Have you smoked cigarettes since you found out you were pregnant?
If yes: About how many cigarettes per day have you smoked?

- □ 1-5 cigarettes
- □ ½ pack
- □ 1 pack
- □ 2 or more packs

□ yes  □ no  Did you drink alcohol before you knew you were pregnant?

□ yes  □ no  Have you drank alcohol since you found out you were pregnant?
If yes: What is the most drinks you had in any single day since you became pregnant?

- □ 1 or 2 drinks
- □ 3 to 5 drinks
- □ More than 5 drinks

□ yes  □ no  Did you use drugs before you knew you were pregnant?
If yes: What drugs did you use? (Check all that apply)

- □ Prescription drugs
- □ Marijuana
- □ Cocaine
- □ Heroin
- □ Other

□ yes  □ no  Have you used drugs since you found out you were pregnant?
If yes: What drugs have you used? (Check all that apply)

- □ Prescription drugs (without a prescription)
- □ Cocaine
- □ Heroin
- □ Other

□ yes  □ no  Have you ever received treatment for alcohol or drug problems?
If yes: Please describe treatment

Version: 1/25/08
Psychosocial and Behavioral History

☐ yes  ☐ no  Was this a planned pregnancy?

How do you feel about your pregnancy? ________________________________

Do you have any Religious or Spiritual Preferences? If yes, please list: _____________________________

☐ yes  ☐ no  Would you accept a blood transfusion in an emergency situation?

Do you have concerns or need resources or information about any of the following?

Please put a check next to those concerns that apply to you

___ None  ___ Family Support

___ Adjustment to illness  ___ Father of the baby

___ Baby Supplies  ___ Finances

___ Car seat  ___ Food

___ Child Care  ___ Housing

___ Clothing  ___ Homelessness

___ Daily activities  ___ Incarceration

___ DSS involvement  ___ Legal Problems

___ Emotional Abuse  ___ Major Life Change

___ Physical Abuse  ___ Psychiatric history

___ Sexual Abuse  ___ Transportation

☐ yes  ☐ no  Do you have any problems with hearing, reading, speech or vision?

☐ yes  ☐ no  Do you have other concerns? ________________________________

☐ yes  ☐ no  During the past 12 months, was there ever a time when you felt sad, blue, really down, or depressed for two weeks or more in a row?

☐ yes  ☐ no  During the past 12 months, was there ever a time lasting two weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

☐ yes  ☐ no  During the past 12 months, was there ever a time lasting one month or longer when most of the time you felt really stressed, worried, tense, or like your nerves were getting bad?

☐ yes  ☐ no  Have you ever been on medication to help you feel less sad, bad, or worried, or to calm your nerves? If yes, name of medication(s): ________________________

☐ yes  ☐ no  Have you experienced any other mental health problems or treatment?

If yes, describe ________________________________

When did these occur? year(s): ________________________________
| Delivery Date  
(Month/Day/Year) | ____ weeks | ____ weeks | ____ weeks | ____ weeks |
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<td>Miscarriage</td>
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<tr>
<td>IF you had a Miscarriage STOP after this question</td>
<td>Live born infant</td>
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<tr>
<td>Type of birth</td>
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<td>How did your labor start?</td>
<td>Induced</td>
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<td>How many hours were you in labor?</td>
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<td>If you had a cesarean, what was the reason?</td>
<td>Cervix didn’t dilate</td>
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<td>How much did the baby weigh?</td>
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<td>Where did you deliver?</td>
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<td>Did you have any complications during this pregnancy?</td>
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<td>Did you have any problems after the birth of this baby?</td>
<td>Heavy bleeding</td>
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<td>Did you breastfeed this baby?</td>
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<td>If you did, for how long?</td>
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Fill in the blanks and circle the answers that apply to you.

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<td>Duration of pregnancy</td>
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<td>Other:</td>
</tr>
<tr>
<td>What type of medicine or anesthesia did you have?</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</tr>
<tr>
<td>Shot</td>
<td>Shot</td>
<td>Shot</td>
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</tr>
<tr>
<td>Epidural/Spinal</td>
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</tr>
<tr>
<td>General Anesthesia</td>
<td>General Anesthesia</td>
<td>General Anesthesia</td>
<td>General Anesthesia</td>
<td>General Anesthesia</td>
</tr>
<tr>
<td>How much did the baby weigh?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where did you deliver?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have any complications during this pregnancy?</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes</td>
<td>Diabetes</td>
<td>Diabetes</td>
<td>Diabetes</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>High Blood Pressure</td>
<td>High Blood Pressure</td>
<td>High Blood Pressure</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>Preterm Labor</td>
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<tr>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
</tr>
<tr>
<td>Did you have any problems after the birth of this baby?</td>
<td>Heavy bleeding</td>
<td>Heavy bleeding</td>
<td>Heavy bleeding</td>
<td>Heavy bleeding</td>
</tr>
<tr>
<td>Depression</td>
<td>Depression</td>
<td>Depression</td>
<td>Depression</td>
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</tr>
<tr>
<td>Infection</td>
<td>Infection</td>
<td>Infection</td>
<td>Infection</td>
<td>Infection</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
</tr>
<tr>
<td>Did you breastfeed this baby?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you did, for how long?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>