Circle of Life
Women's Center

1525 E. 6000 S. Suite A
South Ogden, UT 84405
Phone: (801) 337-5800
Fax: (801) 337-5809
www.colwc.com

Prenatal History

Please complete all sections below and bring this form to your first prenatal appointment.

PATIENT INFORMATION

Hospital for delivery: McKay Dee Hospital Ogden Regional Medical Center

Pediatrician: _____

Mother of Baby:
Name: _____ Age: _____ Race: _____
Primary Language: _____ Religion: _____
Occupation: _____

Father of Baby:
Name: _____ Age: _____ Race: _____
Primary Language: _____ Religion: _____
Occupation: _____

PREGNANCY HISTORY

Total Pregnancies: _____ Full Term: _____ Premature: _____ Abortions: _____
Miscarriages: _____ Ectopics: _____ Multiple Births: _____ Living: _____

	Birth Year	Place of Birth	Sex	Birth Weight	Gestational Age (in weeks)	Delivery Type: Vaginal C-Section VBAC	Anesthesia Type: Epidural Cervical Block None Other	Length of Labor (in hours)
1								
2								
3								
4								
5								
6								
7								
8								

If you had any complications and/or would like to list any additional comments, please list which pregnancy & explain details below:

_____
_____
_____

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MEDICAL RISK FACTORS

Do you have a personal history of:

	Yes	No	Details/Comments
Seizure Disorder	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Disease	☐	☐	_____
Diabetes (if yes, Type 1 or Type 2)	☐	☐	_____
Cardiac Disease	☐	☐	_____
Hypertension	☐	☐	_____
Lung Disease	☐	☐	_____
Gastrointestinal Disease	☐	☐	_____
Surgeries	☐	☐	_____
Liver Disease	☐	☐	_____
Renal Disease	☐	☐	_____
Venous Thromb/Pulmonary Embolism	☐	☐	_____
Blood Disease/Transfusions	☐	☐	_____
Cancer	☐	☐	_____
Organ Transplant	☐	☐	_____
Psychiatric	☐	☐	_____
HIV	☐	☐	_____
Prior Abnormal PAP	☐	☐	_____

GENETIC RISK FACTORS

	Yes	No	Details/Comments
Drug, med, radiation exposure in 1st trimester	☐	☐	_____
Family history of birth defects	☐	☐	_____
Previous fetus/infant with birth defect	☐	☐	_____

Do you have a personal or family history of:

Tay-Sachs	☐	☐	_____
Sickle Cell Disease/Trait	☐	☐	_____
Thalassemia	☐	☐	_____
Huntington Chorea	☐	☐	_____
Cystic Fibrosis	☐	☐	_____
Muscular Dystrophy	☐	☐	_____
Hemophilia	☐	☐	_____
Spina Bifida/Anencephaly	☐	☐	_____
Down's Syndrome	☐	☐	_____
Hydroencephaly	☐	☐	_____

ALLERGIES

Please list all of your current allergies:

_____

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MEDICATIONS

Please list all of your current medications (prescribed & over the counter). We also ask that you bring your medication bottles with you to your appointment. If you need additional space, please attach a separate sheet.

Name	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OBSTETIC RISK FACTORS

	Yes	No	Details/Comments
Previous stillbirth/neonatal death	▫	▫	_____
Previous infant admitted to NICU	▫	▫	_____
Previous infant with IUGR	▫	▫	_____
Abruption in prior pregnancy	▫	▫	_____
Placenta previa in prior pregnancy	▫	▫	_____
Previous cesarean section	▫	▫	_____
Previous infant > 9 pounds	▫	▫	_____
History of fetal distress in labor	▫	▫	_____
History of preeclampsia	▫	▫	_____
History of poly/oligohydramnios	▫	▫	_____
History of recurrent UTI	▫	▫	_____
Antibody sensitization	▫	▫	_____
Multiple gestation	▫	▫	_____

RISK FACTORS FOR PRETERM BIRTH

Do you have a personal history of:

	Yes	No	Details/Comments
Age < 18 or > 35	▫	▫	_____
Black race	▫	▫	_____
Weight < 121 pounds (or < 55 kg)	▫	▫	_____
History of STD's	▫	▫	_____
Previous uterine surgery	▫	▫	_____
Known uterine malformation	▫	▫	_____
Prior preterm birth (37 weeks or less)	▫	▫	_____
Incompetent cervix	▫	▫	_____
DES exposure	▫	▫	_____
2 or more miscarriages requiring D&C	▫	▫	_____
Drug abuse (including alcohol)	▫	▫	_____
Smoking	▫	▫	_____
Psychosocial/Physical Abuse	▫	▫	_____