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.
***Before being taken to our Registration area, this document will need to be completed in its entirety.**

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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Is this pregnancy a surrogacy agreement? Yes No

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	☐	☐	_____

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ALLERGIES

Please list all of your current allergies:

_____
_____
_____

MEDICATIONS

Please list all of your current medications (prescribed & over the counter). Many medications have similar spelling so please confirm the list below with your actual medication bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SUPPLEMENTS

Please list all of your current supplements. Many supplements have similar spelling so please confirm the list below with your actual supplement bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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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	☐	☐	_____