

<b>Member Information</b>	
Last Name: _____ First Name: _____ DOB: _____ ID#: _____	
Address: _____ City: _____ Zip: _____ Phone #: _____	
Date of Initial Prenatal Visit: _____ Completion date of Pregnancy Form: _____	
<b>Current Pregnancy</b>	
Gravida _____ Para _____ LMP _____ EDC _____ Blood Type _____	
<input type="checkbox"/> Multiple Gestation this pregnancy <input type="checkbox"/> Maternal age $\leq 16$ years <input type="checkbox"/> Maternal age $\geq 35$ years of age	
<b>Previous Pregnancies</b>	
<input type="checkbox"/> Multiple Gestations previous pregnancy <input type="checkbox"/> Previous C-Section <input type="checkbox"/> Hx of Placenta Previa	
<input type="checkbox"/> Hx of SAB/TAB/Fetal Demise <input type="checkbox"/> Preterm Labor/Delivery <input type="checkbox"/> Hx of Post Partum Depression	
Week of demise _____ Week of delivery _____	
<b>Medical History</b> (Check all that apply)	
<input type="checkbox"/> Cardiac Disease(Current/Past) <input type="checkbox"/> Clotting Disorders(Current/Past) <input type="checkbox"/> Diabetes/Gestational Diabetes(Current/Past)	
<input type="checkbox"/> HIV Testing (Current/Past) <input type="checkbox"/> Hypertension or PIH(Current/Past) <input type="checkbox"/> Incompetent cervix(Current/Past)	
<input type="checkbox"/> Mental Illness(Current/Past) <input type="checkbox"/> Neurologic Disorders(Current/Past) <input type="checkbox"/> Respiratory Conditions(Current/Past)	
<input type="checkbox"/> Sickle Cell Anemia(Current/Past) <input type="checkbox"/> STD(Current/Past)	
<b>Psycho/Social Issues</b> (check all that apply)	
<input type="checkbox"/> Drug Abuse(Current/Past) <input type="checkbox"/> Alcohol Abuse(Current/Past) <input type="checkbox"/> Smoker (Current/Past) <input type="checkbox"/> Domestic Abuse (Current/Past)	
<input type="checkbox"/> Housing Issues <input type="checkbox"/> Lack of Support System	
<b>Prenatal Care and Nutrition</b> (Check all that apply)	
<input type="checkbox"/> Missed several medical appointments <input type="checkbox"/> Currently Enrolled in WIC	
Description of above or other unlisted conditions: _____	
List of Medications: _____	
<b>Provider Information</b>	
_____ Provider Signature	_____ Provider Printed Name
_____ Provider Address	_____ Provider Phone #
_____ Delivery Hospital	_____ Provider Fax #