

MATERNAL HEALTH HISTORY — Part A

(See Instructions)

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month	Day Year
4. Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White		
5. Ethnic Origin <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported		
6. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
7. County of Residence		

Age	Education	Religion	Marital Status
Occupation			
Address			
Phone (H)	(C)		
(W)			
Emergency Contact:			
Relationship:	Phone (H)		
(W)	(C)		

Final EDC _____ To be determined by provider	For Genetics, Infectious Diseases and Immunizations refer to Part B (form DHHS 3963B); for Psychosocial & Nutrition History refer to Part C & D (forms DHHS 3963C-1 and DHHS 3963D).
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Allergies/drug reactions None Known PCN Others _____ Latex Allergy Yes No

MENSTRUAL HISTORY	Menarche Age	Frequency	Length Days	Amount	LNMP _____ Describe: LMP _____ Describe:
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CONTRACEPTIVE HISTORY <input type="checkbox"/> Never used Has used: <input type="checkbox"/> OCP <input type="checkbox"/> Depo <input type="checkbox"/> Mirena <input type="checkbox"/> Copper T <input type="checkbox"/> barrier method <input type="checkbox"/> Ring Last Date Used _____ <input type="checkbox"/> Implanon <input type="checkbox"/> Patch <input type="checkbox"/> Others _____	Future BCM _____ Desires BTL <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes – Referral Done _____ Date Consent signed _____ Funding Source _____
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OBSTETRICAL HISTORY	Gravida	Term	Preterm	Abortion Spon: Ind:	Multiple Births	Ectopic	Living
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No.	Month/Year	Sex	Birth Weight	Weeks Gest.	Hrs. Labor	Anesthesia	Delivery Type	Antepartum Intrapartum, Postpartum Complications (incl. preterm labor)
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

SEXUAL HISTORY Age of First Intercourse _____ History of forced sexual intercourse <input type="checkbox"/> Yes <input type="checkbox"/> No Lifetime number of partners _____ Number of current partners _____ Current FOB different than other FOB's <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

HISTORY (see instructions)

Document Positive Findings Include Dates and Treatments Under Comments

Patient History Only:	Patient	Comments	Patient and Family History Only:	Patient	Family	Comments	
1. Anemia			14. Hypertension				
2. Operations/hospitalizations			15. Diabetes/gestational diabetes				
3. Gastrointestinal disorders			16. Cardiac disorders/ rheumatic fever				
4. Eating disorders/ special diets/pica			17. Endocrine disorders/ thyroid				
5. Phlebitis/varicosities			18. Neurological/Seizure disorders				
6. Dental problems			19. Gynecological disorders				
7. Blood transfusions			20. Multiple births				
8. Td/Tdap Vaccine within last 10 yrs			21. Cancer				
9. Varicella (history of)			Patient, Family and FOB History Only:	Patient	Family	FOB	Comments
10. Prescription/OTC Meds			22. Accidents/physical trauma				
11. Home Remedies / Herbs			23. Pulmonary disorders/ tuberculosis				
12. Urinary tract disorders/ infections			24. Liver disorders/ hepatitis (A,B,C)				
13. History since last menstrual period (illness, meds, etc)			25. Psychiatric disorders/ depression				

Comments/Notes: _____

Signature: _____ Date: _____

Interpreter Used N/A No Yes Interpreter Name _____

MATERNAL HEALTH HISTORY — PART A

Instructions

Purpose: To assess and document patient's Allergy, Obstetrical, Menstrual, Contraceptive, Sexual, Medical, and Family history.

Instructions: Refer to link <http://whb.ncpublichealth.com/provPart/forms.htm> for a list of definitions pertaining to this form, use as needed.

This form is to be completed by the appropriate staff and reviewed by the clinical provider. Use agency policy approved codes. This form is not a mandatory form and may be used at the discretion of the health department.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
<http://whb.ncpublichealth.com/provPart/forms.htm>