

## 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 EDD _____ To be determined by provider	<b>For Genetic/Teratology, Infection/Immunization histories refer to DHHS form #4156; Initial Psychosocial history DHHS forms #4158 or 4159; Nutrition refer to DHHS forms #4161 or 4162.</b>
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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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<b>CONTRACEPTIVE HISTORY</b> <input type="checkbox"/> Never used <input type="checkbox"/> Has used: <input type="checkbox"/> Pill <input type="checkbox"/> Condoms <input type="checkbox"/> Vaginal Ring <input type="checkbox"/> Patch <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> Depo-Provera® injection <input type="checkbox"/> Others _____ Last Date Used _____	<b>Future BCM</b> _____ <b>Desires BTL</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <b>If yes – Referral Done</b> _____ <b>Date Consent signed</b> _____ <b>Funding Source</b> _____
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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.								

<b>SEXUAL HISTORY</b>	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
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HISTORY (see instructions)		Document Positive Findings Include Dates and Treatments Under Comments					
<b>Patient History Only:</b>	<b>Patient</b>	<b>Comments</b>	<b>Patient and Family History Only:</b>	<b>Patient</b>	<b>Family</b>	<b>Comments</b>	
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)			<b>Patient, Family and FOB History Only:</b>	<b>Patient</b>	<b>Family</b>	<b>FOB</b>	<b>Comments</b>
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				

26. Check off any of the following that you are using now or used in the past year

Now:  Alcohol  Marijuana  Cocaine/Crack Cocaine  Heroin  IV Drugs  Prescription Drugs  None  Other \_\_\_\_\_

Past:  Alcohol  Marijuana  Cocaine/Crack Cocaine  Heroin  IV Drugs  Prescription Drugs  None  Other \_\_\_\_\_

27. Check off any of the following that your partner is using now or used in the past year

Now:  Alcohol  Marijuana  Cocaine/Crack Cocaine  Heroin  IV Drugs  Prescription Drugs  None  Other \_\_\_\_\_

Past:  Alcohol  Marijuana  Cocaine/Crack Cocaine  Heroin  IV Drugs  Prescription Drugs  None  Other \_\_\_\_\_

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 <https://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:  
<https://whb.ncpublichealth.com/provPart/forms.htm>