COBB & DOUGLAS PUBLIC HEALTH
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OB HEALTH HISTORY

(Worksheet)

OFFICE USE ONLY:
Ht. _____ Wt._____BP____/_____ P_____

Smoking ____Allergies_____ COVID _____

EDPS ___GA Hope ___Healthy Start_____

Instructions: Please fill out completely.

Name: _____

How well do you speak English? Excellent/ Good/ Need help Do you need a translator? Circle: Yes No
What language do you read/speak most at home? _____ What language do you write best in? _____
Education (Years completed) Circle one: <9th grade GED High School Tech Some college College
Do you have a job? Circle: Yes No
When is the best time to call you? _____
Do you receive food stamps, WIC? Circle: Yes No
Do you have any other health insurance? Circle: Yes No Other insurer? _____
Do you have family/friends who are helpful to you? Circle: Yes No
Will you have transportation to your appointments? Circle: Yes No
What is your current living situation? Circle: Homeless Live Alone Live with someone
Who do you live with? Circle all that apply: Husband Boyfriend Mother Father Children Other _____
Is any other assistance needed for the household? Circle: Yes No Please describe: _____

Medical / Social History:

Please check any of the following that you have personally had a history of:

- ☐ Lupus
- ☐ Sickle Cell
- ☐ Anemia
- ☐ Blood clot
- ☐ High blood pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Diabetes (Type 1 or 2)
- ☐ Ulcers
- ☐ Seizures
- ☐ Herpes
- ☐ Syphilis
- ☐ Chlamydia/ Gonorrhea
- ☐ Genital Warts
- ☐ HIV / AIDS
- ☐ Smoking
- ☐ Cancer
- ☐ Alcohol or Recreational Drugs
- ☐ Social Problems:
- ☐ Housing, Utilities, WIC
- ☐ Depression / Anxiety
- ☐ Uterine Fibroids
- ☐ Endometriosis
- ☐ Tubal or Ectopic pregnancy
- ☐ Early labor/ Delivery
- ☐ Repeated Miscarriage
- ☐ Vaginal bleeding after 20 weeks
- ☐ Diabetes with pregnancy
- ☐ Multiples births (twins, triplets, etc.)
- ☐ Preeclampsia/ Eclampsia
- ☐ Abnormal baby at birth
- ☐ Cancer Type: _____

Do you currently use recreational drugs? Circle: Yes No What drug(s)? _____ How often? _____
Are you currently in a relationship where you are physically or mentally hurt, threatened or made to feel afraid?
Circle: Yes No

OB History:

Have you been pregnant before? Circle one: Yes No
Date of your previous pregnancy end date: _____
Total # Living Children: _____ How many of your children are on Medicaid? _____
Total # of Pregnancies: _____ # Premature Births (before 37 weeks): _____ # of Abortions: _____
# of Miscarriages: _____ # of infants admitted to NICU: _____ # of Stillbirth: _____# of Children that died: _____
Have you had a C-section? Circle: Yes No
Please write the names and ages of the children who live with you: _____

_____

Current Pregnancy:

Please check any of the pregnancy symptoms you are currently having.

- ☐ Abdominal Cramping
- ☐ Anxiety
- ☐ Back pain
- ☐ Bloating/Gas/ Flatulence
- ☐ Breast tenderness
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headaches
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Increased appetite
- ☐ Increased Urination
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain (foot/leg)
- ☐ Swelling in Hands/Legs/Feet
- ☐ Vaginal spotting/ bleeding
- ☐ Varicose Veins

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REPRODUCTIVE LIFE PLAN

(Worksheet Discard after data entry in VHN, original template in PCM Manual, Appendex E)

Instructions: Please fill out completely.

Name _____ DOB _____ Medicaid Number _____

It is important to let your health care provider know what your plans are for having, or not having, children and for protecting yourself from sexually transmitted infections. Your health care provider can then better help you with your family planning or contraceptive needs, and better advise you about ways to protect your own health and the health of any children you desire to have.

Please tell us about your plans for having, or not having children and for protecting yourself from sexually transmitted infections by checking the box which is closest to your answer.

1. After this pregnancy, how would you describe your desire to have another child?
   - ☐ I DO NOT want to have a child ever (or ever again).
   - ☐ I DO want to have a child:
     - ☐ Now or in the next year
     - ☐ In 1 to 2 years
     - ☐ In 3 to 4 years
     - ☐ In 5 or more years
     - ☐ I am unsure about when.
   - ☐ I am unsure about whether I want to have a child now or in the future.

2. Do you (or your partner) do anything to prevent pregnancy or sexually transmitted infections?
   - ☐ I don't have a partner or I'm not sexually active right now.
   - ☐ I am sexually active with a partner of my same sex.
   - ☐ No, I (and my partner) do not do anything to prevent pregnancy or sexually transmitted infections.
   - ☐ Sometimes when we have sex, I (or my partner) do something to prevent pregnancy or sexually transmitted infections.
   - ☐ Every time we have sex, I (or my partner do) something to prevent pregnancy or sexually transmitted infections.

If you (or your partner) did something to prevent pregnancy or sexually transmitted infections 'Sometimes" or 'Every time' you have sex, what method did you use:

- ☐ Condoms
- ☐ Birth control pills
- ☐ Patch
- ☐ Depo-Provera
- ☐ Vaginal Ring
- ☐ Diaphragm
- ☐ Intrauterine device (IUD)
- ☐ My tubes are tied (tubal ligation)
- ☐ My partner had a vasectomy
- ☐ Other _____

3. Is there a method of birth control that you or your partner have thought about using or about which you would like to learn more? _____

4. Are you having (or have you had) problems with a birth control method that you would like to talk about with your provider today? _____

5. Are you concerned about any sexually transmitted infections?

   ☐ No ☐ Maybe ☐ Yes

Nurse electronic signature and date in patient system VHN.