Health History for Pregnant/ Breastfeeding/Postpartum Women

Today's Date: _____

Name: _____

DOB: _____ Age: _____

Health History for Women

1. Where do you get health care?_____
2. How long has it been since your last health-care visit? _____
3. Have you been to the hospital in the last 12 months?
   ❑ Yes ❑ No
4. Have you ever had any health problems, surgery, or serious injury?
   ❑ Yes ❑ No

   If yes, please list them._____
5. Do you have dental problems, including pain or white spots on your teeth?
   ❑ Yes ❑ No

   If yes, please list your problems. _____
6. Are you taking any medications, including vitamins?
   ❑ Yes ❑ No

   If yes, please list them. _____
7. How long has it been since your last dental-care visit? _____
8. Are you on a special diet?
   ❑ Yes ❑ No

   If yes, please describe the diet. _____
9. Are there any foods that you limit or do not eat?
   ❑ Yes ❑ No

   If yes, please list them. _____
10. Do you have difficulty chewing or swallowing?
    ❑ Yes ❑ No

    If yes, please list your problems. _____
11. Do you have any of these?
    a. a working stove ❑ Yes ❑ No
    b. a working refrigerator ❑ Yes ❑ No
    c. running water ❑ Yes ❑ No
12. Is there anyone living in your household who currently smokes inside the home?
    ❑ Yes ❑ No
13. Have you had a cigarette — even a puff — in the last 30 days?
    ❑ Yes ❑ No
14. Are you afraid someone you know may injure or harm you or your children?
    ❑ Yes ❑ No

    National Domestic Violence Hotline 1-800-799-7233
15. Are you ever concerned you won't be able to buy enough food to feed your family?
    ❑ Yes ❑ No

    The Texas Information and Referral network can be reached by dialing 211 or online http://www.211Texas.org.
16. Would you like a referral to family planning (birth control)?
    ❑ Yes ❑ No

Answer the following questions *only* if this is your first time at this clinic:
How many previous pregnancies have you had? _____ Please list them in the chart below.

No.	Birth Date or Date Pregnancy Ended	Outcome L = Live S = Stillbirth M = Miscarriage T = Terminated (aborted) N = Neonatal Death	Birth Weight	Premature		List any problems you had during the pregnancy or delivery.	CA: Make sure the chart contains all previous and most recent pregnancy outcomes.
				Yes	No		

Staff Comments

Health History Updates for Breastfeeding/Postpartum Women

Name: _____

DOB: _____

Staff Instructions

For continuity of care, review all previous health history documentation before asking these update questions. Document current pregnancy outcome on the reverse side (see chart). Complete new health history for all pregnant and initial clients.

Update # 1

Today's Date _____

1. Have you been seen by a doctor or other health professional in the last six months?
   ❑ Yes ❑ No
2. Do you have any new or ongoing health problems or concerns?
   ❑ Yes ❑ No
3. Are you afraid someone you know may injure or harm you or your children?
   ❑ Yes ❑ No

National Domestic Violence Hotline 1-800-799-7233

Staff Comments

Update # 2

Today's Date _____

1. Have you been seen by a doctor or other health professional in the last six months?
   ❑ Yes ❑ No
2. Do you have any new or ongoing health problems or concerns?
   ❑ Yes ❑ No
3. Are you afraid someone you know may injure or harm you or your children?
   ❑ Yes ❑ No

National Domestic Violence Hotline 1-800-799-7233

Staff Comments