

**Labor & Delivery**

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| **Admission Questions**  |
| YOUR DUE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Baby’s Ped: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Name on driver’s license\*: \_\_\_\_\_\_\_\_\_\_\_\_\_ Partner/Support Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***\*NOTE: the name on your license will be the name on your medical records –and- your baby’s name during the*** |
| ***hospital stay. For example, if your license says Jane Doe Jones, your baby will be Baby Girl/Boy Jane Doe Jones.*** |
| **Pro-Tip- If you want to a different name on your medical records, please change your driver’s license name before** |
| **arriving to the hospital.** |
| Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pre-pregnancy weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Traveled outside of Alabama or the USA within last 30 days: Yes | No If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Girl / Boy If boy, would you like him circumcised? Yes | No |
| What pharmacy do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you taking any RX or non-prescription medications at home? Yes | No  |
|  Prescriptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Over the counter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| House/Apt/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many stories? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have adequate access to electricity, heat, refrigeration, running water, phone, and transportation? Yes | No |
| Who lives with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a living will or advanced medical directive? Yes | No |
| Have you had the flu vaccine? (OCT – MAR ONLY) Yes | No If no, do you want it while here? Yes | NoIf not, would you like it? |
| Have you have the TDAP vaccine? Yes | No |
| Have you had Covid? Yes | No If yes, date? \_\_\_\_\_\_\_\_\_\_\_ Where were you tested?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you had the Covid vaccine? Yes | No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which one? Pfizer Moderna J&JIf so, which one and when? |
| Number of total pregnancies including this one? \_\_\_\_\_\_  |
| Number of babies born term (at or greater than 37 weeks) \_\_\_\_\_ Number of babies born at < 37 weeks \_\_\_\_\_\_ |
| Have you had any miscarriages or losses? Yes | No Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever had an abortion? Yes | No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever been a smoker? Yes | No Have you stopped? Yes | No If not, how many PPD? \_\_\_\_\_\_\_\_\_\_\_\_If yes, how much? What type? |
| Do you currently drink alcohol? Yes | No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a history of alcohol abuse within the two years? Yes | No  |
| Do you currently use any illicit drugs, including marijuana? Yes | No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a history of drug abuse within the last two years? Yes | No  |
| Are you taking or have you taken Methadone or Suboxone prescriptions? Yes | No  |
| Any history of infectious diseases? Yes | No  |
| Any history of STDs? Yes | No Details? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your partner know? Yes | No  |
| Check if any apply: MRSA \_\_\_\_ HIV\_\_\_\_ Hepatitis \_\_\_\_HPV\_\_\_\_ Tuberculosis\_\_\_\_ |
| HSV (Herpes)? Yes | No Type- Oral/ Vaginal/ Both/ Unk. Was your first outbreak during this pregnancy? Yes | No When was your last outbreak? \_\_\_\_\_\_\_\_ Or I have never had an outbreak, only + labwork? Yes | No  |
| Any history of physical, sexual, verbal, or emotional abuse? Yes | No Anything you would like to share? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any current thoughts of suicide or harm to yourself or others? Yes | No Anything you would like to share?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you safe at home now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Weight of largest child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Age of youngest child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did you have any genetic testing done with this pregnancy? Yes | No  |
| Any details you would like to share about the testing above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many ultrasounds have you had this pregnancy ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did you see Dr. Gonzalez or go to UAB Maternal Fetal medicine doctor? Yes | No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If you saw an MFM, why? 1st trimester screening, Special Ultrasounds or Doppler studies? Diabetes teaching?  |
| Or Other Reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you been told all of your ultrasounds been normal? Yes | No If no, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a support person? Yes | No If yes, relationship to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Marital status? Married\_\_\_\_\_\_ Divorced\_\_\_\_\_\_ Single \_\_\_\_\_\_ |
| Is the father of the baby involved? Yes | No If yes, name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does the baby have the same last name as you? Yes | No |
| Did you attend any prenatal classes this pregnancy or ever? Yes | No |
| Pain management/Anesthesia plan? Yes | No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a birth plan? Yes | No If yes, bring a copy with you and make sure to discuss your thoughts with your doctor before you come to the hospital. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If you do not have anything in writing, do you have any special requests you would like to discuss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Were you planning to DONATE or BANK your babies cord blood? Yes|No |
| Any cultural, spiritual, or dietary practices that would affect your care? Yes | No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any questions about breastfeeding? Yes | No  |
| Who is taking you home from the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Who will be helping you after discharge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Who will be helping you in the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a safe place for baby to sleep at home? Yes | No |
| Is this baby up for adoption? Yes | No If yes, Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Obstetrical History with previous pregnancies (NOT current pregnancy)*****(check box if applies to you)*** |
| * + Gestational diabetes
	+ Incompetent cervix (did you have a cerclage?)
	+ Infertility
	+ IUGR (was your baby small for its gestational age, less than 5lbs, 8oz at term)
	+ Macrosomia (greater than 8lbs, 13ozs)
	+ Gestational hypertension or eclampsia
	+ Placenta previa or placental abruption
	+ Preterm labor or premature rupture of membranes
 | * + Rh sensitization
	+ Uterine anomaly
	+ Birth defects
	+ Previous c-section
	+ Stillborn
	+ Neonatal death
	+ Post-partum depression
	+ Post-partum hemorrhage
	+ NICU admission
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Details you would like to share about any of the above?

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| **Medical History** ***(check box if applies to you)*** |
| * + Asthma
	+ Diabetes
	+ Hypertension
	+ Heart Disease
	+ Mitral Valve Prolapse
	+ Neurological Disorders
	+ Seizures
	+ Kidney Disease
	+ Liver Disease
	+ Phlebitis
	+ Thyroid Dysfunction
	+ Psychiatric Disorders
	+ Depression
 | * + Anxiety
	+ Major Trauma
	+ Abnormal Pap Smear
	+ GYN surgery
	+ Hospitalization or other surgeries
	+ Anesthesia complications
	+ Blood Transfusion
	+ Myomectomy or other uterine surgery
	+ Family history of anesthesia
		- Unexplained high fever
		- Difficulty waking up
	+ Any other medical diseases
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Details you would like to share about any of the above?

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| **Current Complications with this Pregnancy*****(check box if applies to you)*** |
| * + Diabetes
	+ Preterm labor
	+ Hypertension – chronic or gestational
	+ Did you receive any steroids?
	+ Placenta previa
	+ Hyperemesis
 | * + Polyhydramnios (too much amniotic fluid)
	+ Oligohydramnios (too little amniotic fluid)
	+ Heart disease
	+ Anemia
	+ Pyelonephritis
	+ Major Surgery during this pregnancy
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Details you would like to share about any of the above?

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| **Nutritional History*****(check box if applies to you)*** |
| * + Problems with appetite >3 days
	+ Chewing or swallowing difficulties
	+ Unexpected weight gain or loss
	+ Diabetes
	+ Eating Disorder
	+ Chron’s Disease
 | * + Ulcerative Colitis
	+ Pancreatitis
	+ Hepatitis
	+ Gastric Bypass Surgery
	+ Sprue
	+ Renal Failure
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Details you would like to share about any of the above?