



Member Information

Member ID:		Today's Date:		Initial Prenatal Visit: Date:	
Member Name:					
Member Phone Number:		Date of Birth:		Primary Language Spoken:	
EDD	LMP	GRAVIDA	FULL-TERM	PRE-TERM	PARA AB LIVE

OB Provider Information

OB Tax ID:	
Provider Last Name:	Provider First Name:
Phone Number:	Fax Number:

Current Pregnancy Risks (Check All That Apply)

<input type="checkbox"/> Preterm Labor	<input type="checkbox"/> Fetal Anomaly	Specify:
<input type="checkbox"/> Incompetent Cervix	<input type="checkbox"/> Psychiatric/Emotional Disorder	Specify:
<input type="checkbox"/> Twins <input type="checkbox"/> Triplets	<input type="checkbox"/> Other Social Challenges	Specify:
<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Substance Abuse	Specify:
<input type="checkbox"/> Placenta Previa or Vaginal Bleeding	<input type="checkbox"/> Tobacco Use	Specify:
<input type="checkbox"/> Preeclampsia or P.I.H.	<input type="checkbox"/> Alcohol Use	Specify:
<input type="checkbox"/> Under age 16	<input type="checkbox"/> Nutritional Deficit	Specify:
<input type="checkbox"/> Over age 35	<input type="checkbox"/> Other Risk	Specify:
<input type="checkbox"/> Domestic Violence		
<input type="checkbox"/> I.U.G.R.		

Previous Pregnancies (Check All that Apply)

<input type="checkbox"/> Preterm Labor	# Weeks:	<input type="checkbox"/> Previous Low Birth Weight	Weight:
<input type="checkbox"/> Preterm Delivery	# Weeks:	<input type="checkbox"/> Congenital Anomaly	Specify:
<input type="checkbox"/> PROM or PPRM	# Weeks:	<input type="checkbox"/> Placenta Previa	<input type="checkbox"/> Abruption
<input type="checkbox"/> Incompetent Cervix		<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> P.I.H.
<input type="checkbox"/> Spont. AB or Fetal Demise	# Weeks:	<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Insulin
<input type="checkbox"/> Previous C-Section	Reason:	<input type="checkbox"/> Other	Specify:

Current Medical Conditions (Check All that Apply)

<input type="checkbox"/> HIV or AIDs	Specify:	<input type="checkbox"/> STD	Specify:
<input type="checkbox"/> Asthma	Specify:	<input type="checkbox"/> Mental/Emotional Illness	Specify:
<input type="checkbox"/> Substance Abuse Rehab	Specify:	<input type="checkbox"/> Cardiac Condition	Specify:
<input type="checkbox"/> Chronic Hypertension	Specify:	<input type="checkbox"/> Neurological Condition	Specify:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Insulin Dependent	<input type="checkbox"/> Other	Specify:

Health Screening

Current Medications	Specify:	Specify:	Specify:
Domestic Violence Screening?	Specify:		
HIV Tested <input type="checkbox"/> YES <input type="checkbox"/> NO	Test Declined <input type="checkbox"/> YES <input type="checkbox"/> NO	WIC Referral Given <input type="checkbox"/> YES <input type="checkbox"/> NO	

Date

Completed By

****NOTE to OB Provider:** This form generates a pregnancy notification and should be submitted to 'Ohana within 30 days of the initial prenatal visit.