

Welcome to the Department of Women's Health.  
We look forward to caring for you in your pregnancy.

Have you attended the Hospital before? Yes / No

Do you require an interpreter? Yes / No If YES Language required \_\_\_\_\_

Do you have any speech, hearing, visual or mobility disability that may affect the delivery of our care?

Please give details:

Please complete **ALL** of this form by ticking the relevant boxes to the best of your abilities

### Section 1

Title \_\_\_\_\_

Surname \_\_\_\_\_

First Names \_\_\_\_\_

Previous Surname \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Town \_\_\_\_\_

County \_\_\_\_\_ Post Code \_\_\_\_\_

Is this your permanent UK address? YES / NO

Contact Telephone Numbers:

Home \_\_\_\_\_

Mobile \_\_\_\_\_

Work \_\_\_\_\_

NHS Number \_\_\_\_\_

Trust I.D Number \_\_\_\_\_

Intended place of delivery ☐ RSCH ☐ PRH ☐ Home

☐ Other Please specify \_\_\_\_\_

May we contact you via SMS Text if necessary?

YES / NO

Are you: Married ☐ Cohabiting ☐ Single ☐ Divorced ☐ Civil partnership ☐ Widowed ☐

One or two parent family \_\_\_\_\_

Your occupation \_\_\_\_\_

Religion \_\_\_\_\_

Country of Birth \_\_\_\_\_

**Your Ethnic Group:** This information is defined by the Dept. of Health; based on the 2001 Census and is only used for Healthcare Planning Purposes:

Asian Bangladeshi <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>	White British <input type="checkbox"/>	Other Ethnic Group <input type="checkbox"/>
Asian Indian <input type="checkbox"/>	Black African <input type="checkbox"/>	White Irish <input type="checkbox"/>	Other Mixed Group <input type="checkbox"/>
Asian Pakistani <input type="checkbox"/>	Black Other <input type="checkbox"/>	White Other <input type="checkbox"/>	Mixed White/Asian <input type="checkbox"/>
Asian Other <input type="checkbox"/>	Chinese <input type="checkbox"/>		Mixed White/Black African <input type="checkbox"/>
			Mixed White/Black Caribbean <input type="checkbox"/>

Your GP's Name and Surgery \_\_\_\_\_ Tel. No. \_\_\_\_\_

Partner's name \_\_\_\_\_

Next of Kin \_\_\_\_\_

(Next of Kin if not partner)

Partner's DOB \_\_\_\_\_

Relationship to you \_\_\_\_\_

Partner's Contact No. \_\_\_\_\_

Contact No. (Home) \_\_\_\_\_

Baby's Father's Ethnic Group \_\_\_\_\_

(Mobile) \_\_\_\_\_

### Section 2.

#### Your Medical History

Please include details of any current treatment/care

Are you allergic to anything e.g. Latex, Medications, Food or other Allergies ☐ Y ☐ N

Details: \_\_\_\_\_

Anaesthetic Reaction ☐ Y ☐ N \_\_\_\_\_

Autoimmune Disease ☐ Y ☐ N \_\_\_\_\_

Skin Conditions (Eczema, psoriasis) ☐ Y ☐ N \_\_\_\_\_

Respiratory Disease ☐ Y ☐ N \_\_\_\_\_  
(Severe asthma/TB/Chest Problems)

Asthma requiring medications ☐ Y ☐ N \_\_\_\_\_

Cystic Fibrosis ☐ Y ☐ N \_\_\_\_\_

Back/Limb/Pelvic Problems ☐ Y ☐ N \_\_\_\_\_

Blood Disorders e.g. Thalassaemia or Sickle Cell or Anaemia ☐ Y ☐ N \_\_\_\_\_

Have you ever had a Blood Transfusion? ☐ Y ☐ N

Would you accept blood/blood products? ☐ Y ☐ N

**Section 2 cont. Your Medical History****Cardiac Conditions or Problems/Surgery** ☐ Y ☐ N \_\_\_\_\_**Cancer** ☐ Y ☐ N \_\_\_\_\_**Diabetes** ☐ Y ☐ N \_\_\_\_\_**Epilepsy (Folic Acid)** ☐ Y ☐ N \_\_\_\_\_**Are you on epileptic drugs** ☐ Y ☐ N \_\_\_\_\_**Central Nervous System Conditions** ☐ Y ☐ N \_\_\_\_\_  
(Under the care of a neurologist)**Genital Infections (Syphilis)** ☐ Y ☐ N \_\_\_\_\_  
(Group B Strep. in previous pregnancy) ☐ Y ☐ N \_\_\_\_\_**Hypertension** ☐ Y ☐ N \_\_\_\_\_  
(High Blood Pressure)**Infertility/Gynae Problems** ☐ Y ☐ N \_\_\_\_\_  
**Have you had fertility treatment in this pregnancy, if so what**  
\_\_\_\_\_  
\_\_\_\_\_**Kidney Disease** ☐ Y ☐ N \_\_\_\_\_**Urine Problems** ☐ Y ☐ N \_\_\_\_\_  
(Inc cystitis/UTI)**Liver Disease** ☐ Y ☐ N \_\_\_\_\_  
(including Hepatitis/Jaundice)**Mental Health** ☐ Y ☐ N \_\_\_\_\_  
(including depression)**Other relevant conditions or problems** ☐ Y ☐ N \_\_\_\_\_**FGM/Circumcision/Cutting** ☐ Y ☐ N \_\_\_\_\_**Previous Surgery** ☐ Y ☐ N \_\_\_\_\_**Previous Organ Transplant** ☐ Y ☐ N \_\_\_\_\_**Previous Uterine Surgery** ☐ Y ☐ N \_\_\_\_\_  
(including Caesarean)**Thrombosis (blood clot)** ☐ Y ☐ N \_\_\_\_\_**Thyroid/other endocrine disorders** ☐ Y ☐ N \_\_\_\_\_**Gastrointestinal Conditions** ☐ Y ☐ N \_\_\_\_\_  
(Crohn's, colitis, gastric ulcer)**Section 3.  
Family History**The following questions only apply to your immediate family.**Has any member of your family had:****Diabetes** ☐ Y ☐ N Type: Insulin dependent ☐  
Diet controlled ☐  
What relation to you \_\_\_\_\_**Hypertension** ☐ Y ☐ N What relation to you \_\_\_\_\_  
(incl. PIH/Eclampsia)**Sickle Disease** ☐ Y ☐ N What relation to you \_\_\_\_\_**Thalassaemia** ☐ Y ☐ N What relation to you \_\_\_\_\_**Postnatal Depression** ☐ Y ☐ N  
What relation to you \_\_\_\_\_**Are you Adopted?** ☐ Yes ☐ NoThe following questions apply to **both you and your partner's family**. Has any member of your family had:**History of learning difficulties** ☐ Y ☐ N  
**Congenital disorder** ☐ Y ☐ N  
**Congenital dislocation of hips** ☐ Y ☐ N  
**History of twins** ☐ Y ☐ N  
**Genetic inherited condition (incl McADD)** ☐ Y ☐ N**If yes to any please specify** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Are you and your partner blood relatives? YES / NO****Section 4.  
Previous Other Pregnancy Conditions****Previous gestational diabetes** ☐ Y ☐ N \_\_\_\_\_**Previous pregnancy induced hypertension** ☐ Y ☐ N \_\_\_\_\_  
(including PIH/HELLP/Pre eclampsia/Eclampsia)**Previous fetal congenital anomaly (please specify)** ☐ Y ☐ N \_\_\_\_\_**Required specialist input** ☐ Y ☐ N**Previous history of postnatal depression** ☐ Y ☐ N**Puerperal psychosis** ☐ Y ☐ N  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Previous requirement for fetal medicine (please specify)** ☐ Y ☐ N \_\_\_\_\_**Required specialist input** ☐ Y ☐ N**Previous pre term birth before 34 weeks** ☐ Y ☐ N \_\_\_\_\_**Previous growth restriction/ small baby (IUGR)** ☐ Y ☐ N \_\_\_\_\_**Placental Problems** ☐ Y ☐ N \_\_\_\_\_  
(including IUGR/Placenta Accreta/ Manual removal of placenta)

This section is to record details of your previous pregnancies, including miscarriages and terminations. If this information needs to be treated in confidence please discuss this with the midwife as alternative arrangements can be made.

Date	Gest	Place of Birth	Sex M / F	Antenatal problems	Labour details: Complications	Type of birth (include relevant details)	Outcome (Misc/ Live SB/ NND)	Name (first last)	Feeding (If BF give duration)	Birth weight	Present health
				Y <input type="checkbox"/> N <input type="checkbox"/> _____	Y <input type="checkbox"/> N <input type="checkbox"/> _____	SVD <input type="checkbox"/> Forceps <input type="checkbox"/> Ventouse <input type="checkbox"/> Caesarian <input type="checkbox"/> Breech <input type="checkbox"/>	Live <input type="checkbox"/> SB <input type="checkbox"/> NND <input type="checkbox"/>				
				Y <input type="checkbox"/> N <input type="checkbox"/> _____	Y <input type="checkbox"/> N <input type="checkbox"/> _____	SVD <input type="checkbox"/> Forceps <input type="checkbox"/> Ventouse <input type="checkbox"/> Caesarian <input type="checkbox"/> Breech <input type="checkbox"/>	Live <input type="checkbox"/> SB <input type="checkbox"/> NND <input type="checkbox"/>				
				Y <input type="checkbox"/> N <input type="checkbox"/> _____	Y <input type="checkbox"/> N <input type="checkbox"/> _____	SVD <input type="checkbox"/> Forceps <input type="checkbox"/> Ventouse <input type="checkbox"/> Caesarian <input type="checkbox"/> Breech <input type="checkbox"/>	Live <input type="checkbox"/> SB <input type="checkbox"/> NND <input type="checkbox"/>				
				Y <input type="checkbox"/> N <input type="checkbox"/> _____	Y <input type="checkbox"/> N <input type="checkbox"/> _____	SVD <input type="checkbox"/> Forceps <input type="checkbox"/> Ventouse <input type="checkbox"/> Caesarian <input type="checkbox"/> Breech <input type="checkbox"/>	Live <input type="checkbox"/> SB <input type="checkbox"/> NND <input type="checkbox"/>				
				Y <input type="checkbox"/> N <input type="checkbox"/> _____	Y <input type="checkbox"/> N <input type="checkbox"/> _____	SVD <input type="checkbox"/> Forceps <input type="checkbox"/> Ventouse <input type="checkbox"/> Caesarian <input type="checkbox"/> Breech <input type="checkbox"/>	Live <input type="checkbox"/> SB <input type="checkbox"/> NND <input type="checkbox"/>				
Early Pregnancy Losses											
Year	Gestation	Nature of loss	Comments								

## Section 6. Health in This Pregnancy

First day of last period \_\_\_\_\_

Are you taking folic acid ☐ Y ☐ N

If YES date commenced \_\_\_\_\_

Vit D ☐ Y ☐ N

If YES date commenced \_\_\_\_\_

Are you currently taking any medication ☐ Y ☐ N

If YES date commenced \_\_\_\_\_

Have you taken illicit drugs in the past ☐ Y ☐ N \_\_\_\_\_

Have you taken any substances or illicit drugs in this pregnancy, if so what \_\_\_\_\_

Alcohol Intake: Pre pregnancy units \_\_\_\_\_  
Current Units \_\_\_\_\_

Does your partner drink alcohol: ☐ Y ☐ N

Current Units \_\_\_\_\_

Your Smoking: Never ☐

Current ☐ How many per day \_\_\_\_\_

Given up ☐ Date stopped \_\_\_\_\_

Partner Smoking: ☐ Y ☐ N

Any other information that you think is relevant \_\_\_\_\_

Is this a multiple pregnancy ☐ Y ☐ N ☐ Unknown

Have you ever had a smear YES / NO

Have you had a smear test within the last 3 years YES / NO

Always Negative YES / NO

Have you ever had a Colposcopy YES / NO

Your Height \_\_\_\_\_ Booking Weight \_\_\_\_\_  
at booking

BMI \_\_\_\_\_

## Section 7. Social Factors

Have you, your children or your partner ever had a named social worker YES ☐ NO ☐ if YES, Child ☐ Mother ☐ Partner ☐

Are you, your children or your partner on the child protection register YES ☐ NO ☐ if YES, Child ☐ Mother ☐ Partner ☐

Are your children living with you YES ☐ NO ☐

Are you homeless / temp. accommodation YES ☐ NO ☐ if YES, Child ☐ Mother ☐ Partner ☐

Are you a refugee or asylum seeker YES ☐ NO ☐ if YES, Child ☐ Mother ☐ Partner ☐

Are you a recent migrant (within last 12 months) YES ☐ NO ☐ if YES, Child ☐ Mother ☐ Partner ☐

Are you under 20 years old YES ☐ NO ☐ if YES, Child ☐ Mother ☐ Partner ☐

## Section 8. FOR COMPLETION BY MIDWIFE/HOSPITAL

Date of booking \_\_\_\_\_ Booked by \_\_\_\_\_ Named Midwife \_\_\_\_\_ LMP \_\_\_\_\_

If booking later than 12 weeks, reason why: \_\_\_\_\_ EDD \_\_\_\_\_

Has a booking taken place elsewhere: \_\_\_\_\_ No. of weeks at Booking \_\_\_\_\_

Consultant appointment required ☐ Yes ☐ No. If YES, date \_\_\_\_\_ If Yes - which hospital \_\_\_\_\_

Reason for appointment \_\_\_\_\_ BP \_\_\_\_\_

Model of care: Midwifery ☐ Maternity team care ☐ Hospital team ☐

☐ NHS ☐ Private ☐ Overseas visitor for the last 12 months Yes / No

Reason for Referral	Were referral questions asked?	Was referral made? If so to whom?
VTE	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Low <input type="checkbox"/> Intermediate <input type="checkbox"/> High <input type="checkbox"/> N/A To whom: _____
BMI	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Declined <input type="checkbox"/> N/A BMI Measurement: _____ To whom: _____
Smoking	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Declined <input type="checkbox"/> N/A CO <sub>2</sub> Reading: <input type="checkbox"/> Declined To whom: _____
Worth/Rise	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Declined <input type="checkbox"/> N/A To whom: _____
Whooley	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Declined <input type="checkbox"/> N/A To whom: _____
Teenage	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Declined <input type="checkbox"/> N/A To whom: Teenage Midwife <input type="checkbox"/> Yes <input type="checkbox"/> No
BCG	YES <input type="checkbox"/> NO <input type="checkbox"/>	Is BCG recommended for Infant? <input type="checkbox"/> Yes <input type="checkbox"/> No Details _____