Good Samaritan Hospital • Family Birth Center Pre-Admission Assessment

Please place a mark next to each question, or fill in the blank where needed.
All information is strictly confidential, and is only used to assist Family Birth Center staff in planning the best care for you.

General Information

Name: _____ Your date of birth: _____
Height: _____ Pre-pregnancy weight: _____ Your doctor: _____
Due date: _____ Your baby's doctor: _____
When did you first see the doctor about your pregnancy? _____
How do you plan to give birth: ☐ Vaginally ☐ Cesarean Are you expecting twins? ☐ Yes ☐ No
Have you attended or are you planning to attend:
Prenatal class? ☐ Yes ☐ No Breastfeeding class? ☐ Yes ☐ No Pharmacy Preference
Sibling class? ☐ Yes ☐ No Car seat check-up event? ☐ Yes ☐ No _____

Obstetrical History

Have you had problems with any of the following during this or any past pregnancies?

Condition	Pregnancy: Current	Pregnancy: Previous	Description
Gestational Diabetes	☐	☐	
Incompetent Cervix	☐	☐	
History of Infertility	☐	☐	
Baby measuring small for dates	☐	☐	
Baby measuring large for dates	☐	☐	
Pregnancy Induced Hypertension	☐	☐	
Placenta Previa	☐	☐	
Abruption	☐	☐	
Preterm Labor	☐	☐	
Premature Rupture of Membranes	☐	☐	
RH Sensitization	☐	☐	
Uterine Abnormality	☐	☐	
Prior C-Section	☐	☐	
Stillborn Birth	☐	☐	
Neonatal Death	☐	☐	
Postpartum Depression	☐	☐	
Postpartum Hemorrhage	☐	☐	
DES Exposure	☐	☐	

Did you receive a flu shot during this pregnancy? If yes – when?

Health Management

Medications you are currently taking: _____
Are you allergic to any medicines? ☐ Yes ☐ No Latex sensitive/allergy? ☐ Yes ☐ No
Foods or environmental allergens? ☐ Yes ☐ No
If yes to any of the above, please explain: _____
Have you ever had a blood transfusion? ☐ Yes ☐ No Have you had Chickenpox or received immunization? ☐ Yes ☐ No
History of MRSA? ☐ Yes ☐ No History of VRE? ☐ Yes ☐ No
Do you have or have you ever had any problems with:
☐ Diabetes ☐ Seizures ☐ Heart Disease/Mitral Valve Prolapse ☐ High BP ☐ Blood Clots
☐ Breathing (Asthma, TB) ☐ Bladder/Kidney ☐ Stomach/Bowel ☐ Eating Disorders ☐ Thyroid Disease
☐ Mental Health ☐ Abnormal Pap Smear ☐ Gynecologic Surgery ☐ Anesthesia Complications
☐ Crohn's Disease/Ulcerative colitis ☐ Pancreatitis ☐ Hepatitis ☐ Renal Failure
☐ Other _____
Have you ever been hospitalized for any surgeries, injuries or illnesses other than childbirth? ☐ Yes ☐ No
If yes, dates and explanation _____
_____
Do you have a history of, or have you been exposed to any sexually transmitted diseases? ☐ Yes ☐ No
If yes: _____
Do you smoke cigarettes? ☐ Yes ☐ No If yes, amount per day: _____
Does anyone in your home smoke cigarettes? ☐ Yes ☐ No If yes, amount per day: _____
Have you consumed alcohol during this pregnancy? ☐ Yes ☐ No
If yes, amount and when: _____
Have you ever used any street or recreational drugs? ☐ Yes ☐ No
If yes, type and when: _____
Did you receive a Tetanus shot? _____ Pneumonia shot? _____

Mothers Family Health History

Condition	Siblings	Father	Mother	Grandparents Father's side	Grandparents Mother's side
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Anesthesia Problems	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐

Any other family health concerns: _____

_____

Special Needs

Learn best by: ☐ 1:1 Instruction ☐ Reading ☐ Video ☐ Group Discussion ☐ Demonstration
Do you have any physical limitations Family Birth Center Staff should be aware of? ☐ Yes ☐ No
If yes, please explain: _____
Do you have a limitation in: Hearing ☐ Yes ☐ No If so, please explain: _____
Do you wear: ☐ glasses ☐ contacts
Primary language spoken in the home if other than English: _____
Do you need an interpreter when you have your baby? ☐ Yes ☐ No
Do you have an interpreter who will come to the hospital with you? ☐ Yes ☐ No If yes, name: _____
Are there religious or cultural practices we can incorporate into your care? ☐ Yes ☐ No
If yes, please describe: _____
Do you have an advanced directive? ☐ Yes ☐ No *If yes, please bring a copy to the hospital with you.*
If no, would you like more information about advanced directives? ☐ Yes ☐ No
Do you have a living will? ☐ Yes ☐ No *If yes, please bring a copy to the hospital with you.*
Do you have a durable power of attorney? ☐ Yes ☐ No If yes, name: _____
Are you an organ donor? ☐ Yes ☐ No

Nutrition

Are there any special dietary needs we can incorporate into your care? ☐ Yes ☐ No
If yes, please describe: _____
Have you had any problem with your appetite in the last 5 days? ☐ Yes ☐ No
Do you have any chewing or swallowing difficulties? ☐ Yes ☐ No
Have you had inappropriate weight gain or loss? ☐ Yes ☐ No
Do you have any presence of skin breakdown? ☐ Yes ☐ No
Would you like to visit with a dietitian? ☐ Yes ☐ No
Do you plan to: ☐ Breast feed ☐ Bottle feed ☐ Undecided Do you need more information? ☐ Yes ☐ No
Have you breastfed before? ☐ Yes ☐ No Any problems with feeding? ☐ Yes ☐ No
Did you quit breastfeeding before you wanted to? ☐ Yes ☐ No

Relationship Information

Are you: ☐ Married ☐ Cohabitate ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Are you in a relationship where you have been physically or emotionally hurt or threatened? ☐ Yes ☐ No
If yes, please explain: _____
History of physical, sexual or verbal abuse or neglect? ☐ Yes ☐ No
If yes, please explain: _____
Do you feel unsafe returning home? ☐ Yes ☐ No
If yes, please explain: _____

Infant Care Information

Do you have concerns about your role or responsibilities at home in being able to care for you and your baby? ☐ Yes ☐ No
Who do you currently live with? _____
Who will help at home after the baby is born? ☐ Partner ☐ Family ☐ Friends ☐ No outside help anticipated
Is this a: ☐ Planned pregnancy ☐ Unexpected pregnancy Is the baby's father involved with the pregnancy? ☐ Yes ☐ No
Do you have a car seat available for discharge? ☐ Yes ☐ No If male, is circumcision desired? ☐ Yes ☐ No
Are you currently using any of the following community resources? ☐ Medicaid ☐ WIC ☐ Other _____
Name of outside case worker if working with an agency: _____
Have you chosen adoption? ☐ Yes ☐ No ☐ Undecided
If yes, are you using an agency, attorney, case worker or contact person: _____