

McLaren Print System Order

Order No: 5866
 Order Date: 2014-09-18
 User: Jenny Fogelsonger
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Ship Location: McLaren Flint Community Med. Center
 1314 S. Linden Rd. Suite B
 Flint, MI 48532

Forms

Quantity: 500
 Paragon Dept No: 63550
 Dept Name: McLaren Flint Community Med. Center
 Company Number: 810

Order Total Price: 0.00

Form Number: M-34420
 Form Description: Pregnancy Patient Checklist
 Revision Date: 5/2012
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None



Your Name _____ Date _____

<p>GENERAL HEALTH YES NO</p> <p>DO YOU HAVE:</p> <p>High blood pressure? _____ Y/N</p> <p>Diabetes? _____ Y/N</p> <p>Medical Problems? _____ Y/N</p> <p>Have you been hospitalized in the past five years? _____ Y/N</p> <p>Are your menstrual periods regular? _____ Y/N</p> <p>Are you over 34 years old? _____ Y/N</p> <p>Remember some religions have ceremonies, beliefs, dietary restrictions which might affect your pregnancy and delivery are you:</p> <p><input type="checkbox"/> Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Jewish <input type="checkbox"/> Other _____</p> <p>OBSTETRIC HISTORY YES NO</p> <p>HAVE YOU HAD:</p> <p>A prior miscarriage, a stillborn, or an abortion? _____ Y/N</p> <p>Please describe the procedure(s) you have had: _____</p> <p>Abnormally delivered or a stillborn (SAB) delivery? _____ Y/N</p> <p>Problems with your pregnancies/deliveries? _____ Y/N</p> <p>Abnormally weighing over 9 pounds at birth? _____ Y/N</p> <p>Are you or your spouse Jewish, Italian, Greek or Irish? _____ Y/N</p> <p>Do you have any problems with miscarriage? _____ Y/N</p>	<p>CONTRACEPTION YES NO</p> <p>DO YOU EVER:</p> <p>Use Condoms? _____ Y/N</p> <p>Inject/Insert/Inject? _____ Y/N</p> <p>Take birth control pills? _____ Y/N</p> <p>When did you stop taking birth? _____</p> <p>Have an intrauterine device? _____ Y/N</p> <p>If so, how often removed? _____ Y/N</p> <p>INFECTIOUS DISEASE YES NO</p> <p>HAVE YOU EVER HAD OR BEEN EXPOSED TO:</p> <p>Hepatitis or cold sores? _____ Y/N</p> <p>Blood/bloodborne? _____ Y/N</p> <p>Conjunctiva, niphthia, VLS, AIDS, or genital herpes (check on rubella, HIV, Chlamydia, etc)? _____ Y/N</p> <p>German measles or "chicken" pox? _____ Y/N</p> <p>MEDICATIONS OR DRUGS YES NO</p> <p>DO YOU:</p> <p>Take any prescription medicines (whether applied to the skin, injected or swallowed)? _____ Y/N</p> <p>Drink beer, wine or alcohol more than twice a week? _____ Y/N</p> <p>Use over-the-counter medications (aspirin, ibuprofen, pain killers like Tylenol or naprox, etc)? _____ Y/N</p> <p>Use marijuana, cocaine, hallucinators, sleeping pills? _____ Y/N</p> <p>Drink more than 4 cups of coffee, tea or soda daily? _____ Y/N</p> <p>Smoke more than 3 cigarettes a day? _____ Y/N</p> <p>WORK AND PLAY YES NO</p> <p>DO YOU:</p> <p>Work around chemicals or drugs? _____ Y/N</p> <p>Lift more than 10 miles a week? _____ Y/N</p> <p>Do outside chores or exercise more than twice a week? _____ Y/N</p>
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IF YOU HAVE HAD A PREVIOUS C-SECTION SURGERY, PLEASE OBTAIN A COPY OF THE OPERATIVE REPORT AND BRING WITH YOU.

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