AWC
Anchorage Women's Clinic
ANCHORAGE AND EAGLE RIVER

Name: _____ Date of Birth: _____ Today's Date: _____
Phone Numbers Home: _____ Work: _____ Cell: _____
Primary Care Provider: _____ Referred By: _____ Primary Language: _____
Insurance Preferred Hospital: Providence ☐ Alaska Regional ☐

Medication List/Pharmacy Information:

Please list all medications, vitamins & supplements you are currently taking or have been prescribed.

Name of Medication	Dose/Strength	How often do you take it?
1.		
2.		
3.		
4.		
5.		
6.		

Please list additional medications on the back of this form if needed

Allergies: List allergies to medications, food or environment including reaction:

_____

_____

Directives:

1. Any medical care limits due to religion or beliefs? ☐ Yes ☐ No
2. Are you an organ donor? ☐ Yes ☐ No
3. Do you have any other medical providers? ☐ Yes ☐ No
    a. If yes, who: _____
4. Do you already have a pediatrician? ☐ Yes ☐ No
    a. If yes, who: _____

Pregnancy Info:

1. First Day of Last Menstrual Period: _____
2. Was this a planned pregnancy? ☐ Yes ☐ No
3. Pre-pregnancy Weight: _____

Travel:

1. Have you or your partner traveled outside of Alaska in the last 6 months? _____
2. Do you have any travel plans during this pregnancy? _____

Current Weight: _____ Height: _____ AWC Only

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Past Medical & Family History:

For yourself, provide details and dates. For family members, please check if yes. In the "other" column, please specify who the family member is, such as: Maternal Grandmother (MGM), Maternal Grandfather (MGF), Paternal Grandmother (PMG), or Paternal Grandfather (PGF).

☐ **Check here if you were adopted** ***(Please put N/A if any of the following do NOT apply to you)***

	Self	Mother	Father	Sibling	Child	Other
Cancer: Type						
Diabetes						
High Cholesterol						
High Blood Pressure						
Stroke						
Osteoporosis						
Heart Disease						
Asthma/Emphysema						
Thyroid Disease						
Liver Disease						
Drug Abuse						
Arthritis						
Heartburn/Ulcer						
Bowel Problems						
Depression						
Anxiety						
Hepatitis						
Eating Disorder						
Infertility						
Varicose Veins						
Uterine Anomaly						
Phlebitis						

History of Anesthesia Problems? ☐ Yes ☐ No **History of Blood Transfusions?** ☐ Yes ☐ No When: _____

Surgical History:

List any surgeries you have had	Date

Social History:

Tobacco Use:

Do you smoke cigarettes? ☐ Yes ☐ No ☐ Never Past Use: ☐ Yes ☐ No Quit Date: _____

If yes, _____ pack(s) per day for _____ years.

Other tobacco use: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ E Cigarettes ☐ Never

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No # of drinks per week: _____ Quit for pregnancy? _____

Drug Use:

Do you use marijuana or other recreational drugs? ☐ Yes ☐ No If Yes, Frequency: _____

Have you ever used needles to inject drugs? ☐ Yes ☐ No If Yes, type and last use: _____

Have you ever been tested for Hepatitis C? ☐ Yes ☐ No If Yes, When: _____

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Social History:

1. Caffeine Use→ how many drinks daily? _____
2. Exercise → how often a week and what activity do you engage in? _____
3. Seatbelt Use → how often do you wear a seatbelt? _____%
4. Sun Exposure → do you wear sunscreen? _____ Do you use tanning beds? _____
5. Are you treated respectfully by your spouse/partner, family and friends? _____

Obstetric History: ☐ ***Check here if you have never been pregnant***

Please list type of delivery: Term= 37+ weeks Pre Term= <37 weeks, Spontaneous Miscarriage (SAB), Elected Abortion (EAB) or Ectopic Pregnancy.

Date of Delivery	# of Weeks	Labor Length	Baby's Weight	Sex (M/F)	Delivery Type (Vag or C/S)	Epidural/ Pain Med/ None	Name of Baby	Comments/Complications

Obstetric Initial Intake Information:

1. Positive home pregnancy test? ☐ Yes ☐ No
2. Occupation: _____
3. Type of work: _____
4. Education (Last Grade completed): _____
5. Number of children at home: _____
6. Father of Baby Name: _____ Birthdate:_____ Race: _____
7. Father of Baby Occupation: _____
8. Same father as your last pregnancy? ☐ Yes ☐ No

Pregnancy Dating:

First day of last menstrual period: _____ Certain or Approximate? **(Circle One)**

How often do you get your period: Every _____ Days.

How many days do you bleed: _____ Days. Are your periods regular? ☐Yes ☐ No

Were you on birth control when you became pregnant? ☐ Yes ☐ No Which Method? _____

Date of positive home pregnancy test: _____

Age of your first period: _____

Genetic History: *Genetic Screening includes Patient, Father of the Baby, or anyone in either family.*

	Yes	If Yes, Who		Yes	If Yes, Who
Will you be 35 years of age when baby is born?			Muscular Dystrophy		
Thalassemia: MVC <80			Cystic Fibrosis		
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			Huntington Disease		
Congenital Heart Defect			Mental Retardation/ Autism		
Down Syndrome			*If yes, was person tested for fragile X?*		
Tay-Sachs (EG, Jewish, Cajun, French Canadian)			Other inherited genetic or chromosomal disorder?		
Canavan Disease			Patient or Father of Baby have child with other birth defects?		
Familial Dysautonomia			History of recurrent pregnancy loss?		
Sickle Cell Disease or Trait (African)			History of stillbirth?		
Hemophilia			History of multiple births?		

Infection History:

	Yes		Yes
Do you live with someone with TB or exposed to TB?		High Risk Hepatitis C?	
History of sexually transmitted infections?		History of Group B Strep?	
Have you or your partner ever been diagnosed with genital herpes?		Do you live in a house with cats? *If so, who changes litter box?* _____	
Rash or viral illness since last menstrual period?		Do you eat moose meat?	
Exposure to chemicals, X-rays and/or drug or alcohol use since LMP?		History of Parvovirus (Fifth Disease)	
High Risk Hepatitis B?		Have you had chicken pox or the vaccine?	
Immunized against Hepatitis B?			

Other Patient History:

	Yes	Provide details if appropriate:
History of Major Accident?		
History of Blood Transfusion?		
Do you have any tattoos? *If yes, was it done in a professional setting?*		
Do you have any piercings? *If yes, was it done in a professional setting?*		
Date of last pap smear?		
History of abnormal pap smear? *If yes, list date and treatment: Colposcopy, Cryotherapy, LEEP, repeat Pap smear, etc.*		
History of Uterine anomaly?		
History of Infertility?		
History of In Utero Des Exposure?		
History of liver disease?		
History of varicosities?		
History of Phlebitis?		
History of thyroid dysfunction?		

Do you have a history of physical abuse? ☐ Yes ☐ No
Do you have a history of sexual abuse? ☐ Yes ☐ No

Vaccines:	**Dates**	**Where was it administered?**
Tetanus		
Gardasil		
Flu Shot		
Pneumococcal		
Covid Vaccine 1st		
Covid Vaccine 2nd		
Covid Vaccine Booster		