Indiana University Health

Pre-Admission Questionnaire

The staff of Women and Children's Services want to give you the opportunity to make your labor and delivery admission easier. By filling out and bringing this questionnaire to the hospital when you come to have your baby, your nurse will be able to quickly enter the information into the computer. Your nurse can complete your admission, activate your healthcare provider's orders and begin taking care of you.

You may pre-register your insurance information online at iuhealth.org/Bloomington. Click on "pre-register", complete the form and submit. Another option is to call 812.353.9101 or toll free at 877.353.9101. Thank you for assisting us in the admission process.

Please complete this form and place in your bag to bring to the hospital. Give the completed form to the nurse when you arrive.

General Admission Information:

Name: ____

Your age: ______________

Name of Doctor/Certified Nurse Midwife: _____________________________________

If someone asks for you, is it okay for us to tell them you are here? ☐ Yes ☐ No

What is your due date? ____

How many times have you been pregnant? ___________ Given birth? ____________

How many babies were born term (>38 weeks)? _____ Preterm? _____ Still living? ______

How were your babies born? ☐ Vaginal births (#)_______ ☐ Cesarean births (#)________

If by Cesarean, are you planning a vaginal birth after Cesarean (VBAC)? ☐ Yes ☐ No

What was the month of your first prenatal visit? ______________________________

Complications – Previous Pregnancy/Delivery:

Did you have any complications during any pregnancy, delivery or after giving birth? ☐ Yes ☐ No

If yes, explain: ____

Did you have any pregnancy losses (miscarriage, abortion, ectopic pregnancy or stillbirth)?

☐ Yes ☐ No If yes, explain: ____

What is your weight? Pre-pregnancy: ____________lbs. At last office visit: __________lbs.

How tall are you? ________ft. _______in.

Allergies:

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, explain: ____

Do you have any allergies to latex, food or anything in the environment? ☐Yes ☐ No

If yes, explain: ____

Communication and Cultural Needs Assessment:

What primary language do you speak? ____________________________________

Do you have any special learning needs or difficulties (language barrier, hearing, visual or learning deficit)? ☐ Yes ☐ No

If yes, explain: ____

Drug and Alcohol Use:

Have you consumed alcohol during your pregnancy? ☐ Yes ☐ No

If yes, how often and how much do you drink? ______________________________

Do you smoke? ☐ Yes ☐ No

If no, have you ever smoked? ☐ Yes ☐ No If yes, how much/day? __________

Have you ever used "street" drugs? ☐ Yes ☐ No

If yes, please list which drugs, how much, how often, and for how many years you have used the drugs, and if you have ever had treatment for any drug use. ***This information will help keep you and your baby safe and help us treat your baby, as he/she may go through withdrawal and have seizures***: ____

____

Vaccine History:

Have you had your flu shot? ☐ Yes ☐ No Date: ____________

Please indicate if you have had the following vaccinations:

Tdap (Tetanus/Diphtheria/Pertussis (whooping cough) ☐ Yes ☐ No Date: __________

Pneumococcal (pneumonia)? ☐ Yes ☐ No Date: ___________

Infant Information:

Pediatrician:

Who is your pediatrician? ____________________

Will you have a different baby doctor after you leave the hospital? ☐ Yes ☐ No

If yes, name of doctor: ____________________

Feeding Preference:

Please check all that apply: I am planning on ☐ Breastfeeding ☐ Bottle feeding ☐ Both

Circumcision (if applicable):

If you have a boy, are you planning to have him circumcised? ☐ Yes ☐ No ☐ Undecided

Labor and Delivery Plans

Pain Management:

What are your pain management plans for labor and delivery? ____________________

Birth Plan:

Do you have a birth plan? ☐ Yes ☐ No If yes, please attach to this questionnaire.

Are you planning to have a tubal ligation? ☐ Yes ☐ No

General Info:

Who is (are) your support person(s)? ____________________

What relationship is (are) your support person(s) to you? ____________________

What is your marital status? ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

What will your baby's last name be (if different from yours)? ____________________

Name of baby's father: ____________________

If single, do you plan to sign a paternity affidavit? ☐ Yes ☐ No

Is the baby's father involved? ☐ Yes ☐ No

Is an adoption planned? ☐ Yes ☐ No

What pharmacy do you use for prescriptions? ____________________

Did you take prenatal classes? ☐ Yes ☐ No

If yes, please check: ☐ Childbirth Preparation ☐ Baby Basics ☐ Breastfeeding

Classes taken at: ☐ BABS ☐ IU Health Bloomington ☐ Other ____________________

Do you go to WIC? ☐ Yes ☐ No

Are you planning a 24-hour release? ☐ Yes ☐ No

Cultural / Spiritual Practices:

Do you have spiritual or cultural practices to incorporate in your care? ☐ Yes ☐ No

If yes, please describe: ____________________

Do you have spiritual or cultural dietary needs to incorporate in your care? ☐ Yes ☐ No

If yes, please describe: ____________________

Patient Medical History:

Do you have, or have you ever had, any of the following medical problems?

Diabetes? ☐ Yes ☐ No If yes: ☐ Type I ☐ Gestational (during pregnancy)

Hypertension (High Blood Pressure)? ☐ Yes ☐ No If yes, for how long?____________________

Heart disease? ☐ Yes ☐ No If yes, describe:____________________

Autoimmune disorder? ☐ Yes ☐ No If yes, what?____________________

Kidney disease or bladder infections? ☐ Yes ☐ No If yes, how often?____________________

Neurological problem or Epilepsy? ☐ Yes ☐ No If yes, describe:____________________

Hepatitis/Liver disease? ☐ Yes ☐ No If yes, what kind?____________________

Varicosities/Phlebitis? ☐ Yes ☐ No If yes, where?____________________

Thyroid Dysfunction? ☐ Yes ☐ No If yes, explain:____________________

Been a victim of trauma or violence? ☐ Yes ☐ No If yes, explain:____________________

Blood transfusion? ☐ Yes ☐ No Date, if known: ____________________

Is your Blood Type Negative? ☐ Yes ☐ No If yes, when did you receive RhoGam?____________________

Lung Problems: Asthma? ☐ Yes ☐ No Tuberculosis? ☐ Yes ☐ No

Have you had a prior hospitalization and/or surgery? ☐ Yes ☐ No

If yes, please explain: ____________________

Have any gynecological problems or infertility? ☐ Yes ☐ No

If yes, explain: ____________________

Abnormal Pap Smear? ☐ Yes ☐ No Date, if known: ____________________

Uterine Anomaly? ☐ Yes ☐ No If yes, explain:____________________

Have you or your partner had or currently have a sexually transmitted infection? ☐ Yes ☐ No

If yes, check: ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ HPV (warts) ☐ HIV

☐ Hepatitis (if yes: ☐ A ☐ B ☐ C) ☐ Herpes (if yes, when treated? ________)

Assessment:

Did you get tested for Group Beta Strep? ☐ Yes ☐ No

If yes, were your results: ☐ Positive ☐ Negative

Have you had any infections or viral Illness recently? ☐ Yes ☐ No

If yes, explain: ______ ____

Do you have any skin rashes, open sores, piercings or tattoos? ☐ Yes ☐ No

If yes, describe:____

Have you been exposed to anyone who:

Is sick? ☐ Yes ☐ No If yes, describe:________________________________

Has Lice, scabies or bedbugs? ☐ Yes ☐ No If yes, describe?____________________

Do you have any other medical problems? ☐ Yes ☐ No

If yes, describe:____

____

Family History

Do you or the father of the baby, any of your children, siblings or parents have any:

Reaction to an anesthetic? ☐ Yes ☐ No

If yes, explain:____

History of hearing loss at birth? ☐ Yes ☐ No If yes, who? ____________________

Birth defects or genetic problems? ☐ Yes ☐ No

If yes, who and what was the birth defect?________________________________

Other significant family history? ☐ Yes ☐ No

Who/what? ____

Ultrasound

Did you have an ultrasound during your pregnancy? ☐ Yes ☐ No

If yes, where was it done? ______________________________

Were any problems identified? ☐ Yes ☐ No

If yes, explain? ______________________________

Please check any of the following that you wish to have on file:

☐ Advanced Directives ☐ Living Will ☐ Durable Power of Attorney

Emotional Wellness:

Do you now or have you had in the past any concerns about your emotional health (depression, anxiety, scary thoughts, etc.)? ☐ Yes ☐ No If yes, explain:______________________________

____

Do you now or have you in the past considered attempting suicide or personal harm?

☐ Yes ☐ No If yes, explain: ______________________________

Are you in a relationship where you have been physically or emotionally hurt or threatened?

☐ Yes ☐ No If yes, explain: ______________________________

Is there a history of physical, sexual or verbal abuse or neglect within the last 2 years?

☐ Yes ☐ No If yes, explain: ______________________________

Do you feel unsafe returning home?

☐ Yes ☐ No If yes, explain: ______________________________

Medication List:

What medications (including prescription or over-the-counter medications, pain pills, supplements, vitamins, herbs) do you take? (Use separate sheet if more space is needed).

Name of Medication/Supplement/Vitamin/Herb	Amount	Frequency Taken

I verify that the above information is correct, to the best of my knowledge.

______________________________ ______________________________

Signature Date

When completed, place with your packed bag to bring to the hospital.

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