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).

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<thead>
<tr>
<th>Name of Medication/Supplement/Vitamin/Herb</th>
<th>Amount</th>
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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.