N.C. Department of Health and Human Services
Division of Public Health
Women Infant and Community Wellness Section

MATERNAL HEALTH HISTORY — Part A

(See Instructions)

1. Last Name	First Name	MI

2. Patient Number

3. Date of Birth (MM/DD/YYYY) — Month / Day / Year

4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White

5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported

6. Gender ☐ Female ☐ Male

7. County of Residence

Age	Education	Religion	Marital Status
Occupation			
Address			
Phone (H)		(C)	
(W)			
Emergency Contact**:**			
Relationship:		Phone (H)	
(W)		(C)	

Final EDD_____
To be determined by provider

For Genetic/Teratology, Infection/Immunization histories refer to DHHS form #4156; Initial Psychosocial history DHHS forms #4158 or 4159; Nutrition refer to DHHS forms #4161 or 4162.

Allergies/drug reactions ☐ **None Known** ☐ **PCN** ☐ **Others**_____ **Latex Allergy** ☐ **Yes** ☐ **No**

MENSTRUAL HISTORY	Menarche Age	Frequency	Length Days	Amount	LNMP _____ Describe: LMP _____ Describe:

CONTRACEPTIVE HISTORY ☐ **Never used** ☐ **Has used:**
☐ Pill ☐ Condoms ☐ Vaginal Ring ☐ Patch ☐ Implant ☐ IUD
☐ Depo-Provera® injection ☐ Others_____ Last Date Used_____

Future BCM_____
Desires BTL ☐ **Yes** ☐ **No** ☐ **N/A**
If yes – Referral Done_____ **Date Consent signed**_____
Funding Source _____

OBSTETRICAL HISTORY	Gravida	Term	Preterm	Abortion Spon: Ind:	Multiple Births	Ectopic	Living

No.	Month/ Year	Sex	Birth Weight	Weeks Gest.	Hrs. Labor	Anesthesia	Delivery Type	Antepartum, Intrapartum, Postpartum Complications (incl. preterm labor)
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

SEXUAL HISTORY Age of First Intercourse____ **History of forced sexual intercourse** ☐ **Yes** ☐ **No**
Lifetime number of partners____ Number of current partners____ **Current FOB different than other FOB's** ☐ Yes ☐ No ☐ N/A

HISTORY (see instructions) Document Positive Findings Include Dates and Treatments Under Comments

Patient History Only:	**Patient**	**Comments**	**Patient and Family History Only:**	**Patient**	**Family**	**Comments**	
1. Anemia			14. Hypertension				
2. Operations/hospitalizations			15. Diabetes/gestational diabetes				
3. Gastrointestinal disorders			16. Cardiac disorders/ rheumatic fever				
4. Eating disorders/ special diets/pica			17. Endocrine disorders/ thyroid				
5. Phlebitis/varicosities			18. Neurological/Seizure disorders				
6. Dental problems			19. Gynecological disorders				
7. Blood transfusions			20. Multiple births				
8. Td/Tdap Vaccine within last 10 yrs			21. Cancer				
9. Varicella (history of)			**Patient, Family and FOB History Only:**	**Patient**	**Family**	**FOB**	**Comments**
10. Prescription/OTC Meds			22. Accidents/physical trauma				
11. Home Remedies / Herbs			23. Pulmonary disorders/ tuberculosis				
12. Urinary tract disorders/ infections			24. Liver disorders/ hepatitis (A,B,C)				
13. History since last menstrual period (illness, meds, etc)			25. Psychiatric disorders/ depression				

26. Check off any of the following that you are using now or used in the past year

Now: □ Alcohol □ Marijuana □ Cocaine/Crack Cocaine □ Heroin □ IV Drugs □ Prescription Drugs □ None □ Other_____

Past: □ Alcohol □ Marijuana □ Cocaine/Crack Cocaine □ Heroin □ IV Drugs □ Prescription Drugs □ None □ Other_____

27. Check off any of the following that your partner is using now or used in the past year

Now: □ Alcohol □ Marijuana □ Cocaine/Crack Cocaine □ Heroin □ IV Drugs □ Prescription Drugs □ None □ Other_____

Past: □ Alcohol □ Marijuana □ Cocaine/Crack Cocaine □ Heroin □ IV Drugs □ Prescription Drugs □ None □ Other

Comments/Notes: _____

Signature: _____ Date: _____

Interpreter Used ☐ N/A ☐ No ☐ Yes Interpreter Name _____

MATERNAL HEALTH HISTORY — PART A

Instructions

Purpose: To assess and document patient's Allergy, Obstetrical, Menstrual, Contraceptive, Sexual, Medical, and Family history.

Instructions: Refer to link https://wicws.dph.ncdhhs.gov/provpart/forms.htm for a list of definitions pertaining to this form, use as needed.

This form is to be completed by the appropriate staff and reviewed by the clinical provider. Use agency policy approved codes. This form is not a mandatory form and may be used at the discretion of the health department.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
https://wicws.dph.ncdhhs.gov/provpart/forms.htm