Papamoa Midwives

Congratulations on Your Pregnancy

To ensure you and your baby receive the best care in pregnancy please complete this checklist.

Full Name ____________________________________ Date of Birth / /

First Day of Last Period / / Unsure Height_______________cm

Expected Due Date: / / Weight_______________Kg

1. Is this your first pregnancy? Yes No

Do you have children? How many?______ Miscarriage? How many?___
Caesarean's? How many?______ Termination? How many?___
Ectopic pregnancy? How many?___

2.
3. Have you had any **blood tests** in this pregnancy? Yes No
   Where did you have your blood tests? Tauranga Other____________________

4. Have you had any **scans** in this pregnancy? Yes (How many?________) No
   Where did you have your scan(s)? Medex Bay Radiology Bethlehem Other_______________

5. Are you taking **Folic Acid**? Yes No
6. Are you taking **Iodine**? Yes No

7. Are you taking any other **medicines, vitamins or herbal remedies**? Yes No
   Please list____

8. Do you **smoke**? Yes (How many?___________) No

9. Have you had any **alcohol** in this pregnancy? Yes (How much/often?________________) No

10. Have you read the booklet on the importance of **food safety** in pregnancy? Yes No

11. Do you have any **medical conditions, operations, health problems** or a history of **gynaecology problems or treatment of your cervix?** Yes No

Please describe____

How is your pregnancy going so far?

Have you had any **bleeding**? Yes No (If yes, When?_______________________________)

Any **stomach pain**? Yes No (If yes, When?Where?_______________________________)

Do you have **severe vomiting**? Yes No (If yes, are you medicated for it? Yes No)

Other concerns?____

CLINIC NOTES Date seen: Gest: BP:

Booking Bloods: Y/N Folic/Iodine: Y/N Dating Scan: Y/N

Midwife: _____________ Registration Date: ______ DeregDate:______

File Transferred Y/N Reg Signed Y/N Claim Number:
Previous History:

7541 11/16

Patient Label

BAY OF PLENTY
DISTRICT HEALTH BOARD

CONFIDENTIAL PATIENT DETAILS

Patient or Representative — please complete ALL questions this side only.
Please PRINT legibly and please tell us if you need help to complete the form.

PATIENT DETAILS ☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Other:________

Last Name: ________ First Name/s: ________

Previous Family Name: ________ Also known as: ________

Date of birth: / / Age:______ Gender: ☐ Male ☐ Female

CONTACT DETAILS **Home** Ph: ________ Work Ph: ________ Mobile:________

Email address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address: *What is your usual New Zealand address?* No. ______ Street ________

Suburb: ________ Town /City ________ Post Code ________

Postal Address: *(if different from your usual NZ address OR Overseas Address)* No. ____ Street ________

Suburb: ________ Town /City ________ Post Code ________

FAMILY DOCTOR: ________ Practice Name: ________

COUNTRY OF BIRTH: ________

Are you a New Zealand citizen? ☐ YES ☐ NO If NO, do you have a NZ Residency Permit? ☐ YES ☐ NO

ETHNIC GROUP

☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori ☐ Tongan
☐ Niuean ☐ Chinese ☐ Indian ☐ Other *please state* ________

CONTACT PEOPLE: (eg. lead support person, parent/guardian (if under 16), caregiver, relative.

1. Name: ________ Relationship: ________
Mobile: ________ Home Ph: ( ) ________ Work Ph: ( ) ________

2. Name: ________ Relationship: ________
Mobile: ________ Home Ph: ( ) ________ Work Ph: ( ) ________

Would you like contact with:

Maori Health services for this visit? ☐ YES ☐ NO RSA Visitors ☐ YES ☐ NO

Chaplaincy Services? ☐ YES ☐ NO Official Church visitors? ☐ YES ☐ NO

Denomination: ________

SMOKING STATUS

Patient to complete ... tick box for YES

☐ Currently smoke ☐ Ex-smoker
☐ Never smoked
☐ Declined screening

Advice / Quit pack offered *(staff to complete)*

Cessation: ☐ GP referral on discharge
☐ Patient to contact community cessation
☐ Declined cessation Initial ☐

We collect information about you to provide you with safe, effective and efficient medical care. The information collected may be shared with other health care providers or be used for research and funding purposes. We may also access other health care providers' shared access information if necessary to provide you with health care. If you have any questions about this please contact the on-call Quality and Patient Safety Co-ordinator - Tga (021) 791 864 or Whk (021) 475 230.

DECLARATION... I declare that the above information is correct

________ DATE ________

Signature of Patient / Parent / Guardian / EPOA holder / Other

STAFF USE ONLY

Details updated in IBA : Point of Entry	Name Dept Date	Health records req'd: Y / N
Details updated in IBA : Subsequently	Name Dept Date	

136482 X7480 7/09

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

MATERNITY BOOKING

☐ TAURANGA ☐ WHAKATANE

Ms / Mrs / Miss	FAMILY NAME	GIVEN NAME	PATIENT NO.
ADDRESS			
DATE OF BIRTH	TELEPHONE Home	Work	Mobile

Smokefree Status

Definitions ...
- Never Smoked ☐
- Current Smoker ☐
- Quit > 12 months ☐
- Quit < 12 months ☐

Smokefree Screening:
Home ☐ Car ☐ Pregnancy ☐

Brief advice ☐ Referral ☐ NRT ☐
Declined ☐

Person responsible for this booking

Name

GP

Specialist

Hospital team

Midwife

Other

ALCOHOL

(Glasses a week)

- ☐ Nil
- ☐ 1-4
- ☐ 5-10
- ☐ 10 or more

SUBSTANCES

- ☐ No
- ☐ Yes
- ☐ Not known
- ☐ Type

BREASTFEEDING

☐ Breastfeeding history

☐ Breastfeeding education

☐ Leaflets

☐ To discuss follow-up at 32 weeks

Ethnicity

FATHER'S DETAILS

Family Name

Given Names

- ☐ NZ European ☐ Maori ☐ Samoan
- ☐ Cook Island ☐ Tongan ☐ Niuean
- ☐ Chinese ☐ Indian
- ☐ Other (such as Dutch, Japanese, Tokelauan) —*please state...*

GYNAE HISTORY

- ☐ No
- ☐ Yes (e.g. cong.abn, infertility, laparoscopy, surgery)

Year

PAST MED. HISTORY

- ☐ Rheumatic Fever
- ☐ Cardiac Disease
- ☐ Hypertension
- ☐ Asthma
- ☐ Epilepsy
- ☐ Diabetes
- ☐ UTI /Renal
- ☐ STD
- ☐ Psychiatric
- ☐ Thyroid
- ☐ Coagulation
- ☐ Autoimmune
- ☐ Other

BLOOD TRANSFUSIONS

☐ No ☐ Yes
☐ Not known

CURRENT MEDICATION

☐ No ☐ Yes
☐ Not known

DRUG ALLERGIES

☐ No ☐ Yes
☐ Not known

RECENT CONTRACEPTION

☐ No ☐ Yes
☐ Not known

FAMILY HISTORY

- ☐ Hypertension
- ☐ Diabetes
- ☐ TB
- ☐ Multi-Pregnancy
- ☐ Deafness
- ☐ Other (incl cong.abn)
- ☐ Adopted

MENSTRUAL CYCLE

☐ Reg. ☐ Irreg.

LMP

☐ Cert ☐ Uncert
☐ Not known

SCAN DATE

Foetuses:

Scan maturity weeks

CLINICAL EDD

REVISED EDD

Reason

OBSTETRIC HISTORY

Place of Delivery	Delivery date dd/mm/yy	Pregnancy		Labour & Puerperium		Infant				
		Dur.in weeks	Complications	Dur.in hours	Complications	Alive NND SB IFD	Sex	Birth weight (g)	Breast feeding months	Problems

BLOOD TESTS

Blood Group	______	Rhesus	☐	Hep B A'g	neg	pos	Smear	neg	pos
Antibodies	☐	Polycose	☐	Hep C A'g	neg	pos	Strep B	neg	pos
Rubella	☐	VDRL	☐	HIV	neg	pos	Chlamydia	neg	pos

DATE					
Hb /Ferritin					

OBSTETRIC COMMENTS

FIRST VISIT

Date	Maturity			Lie & Presentation	Eng.	F.H.R.	Wgt.	B/P	Oed.	Urine		Height	Sign
	Calc.	Clin.	Meas.							Prot.	Sugar		