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

2. Do you have children? How many? _____ Miscarriage? How many? _____
Caesarean's? How many? _____ Termination? How many? _____
Ectopic pregnancy? How many? _____

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

Ms ☐ Mrs ☐ Miss ☐ FAMILY NAME GIVEN NAME | PATIENT NO.

ADDRESS

DATE OF BIRTH | TELEPHONE Home Work Mobile

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

MATERNITY BOOKING

☐ TAURANGA ☐ WHAKATANE

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

BREASTFEEDING
- ☐ Breastfeeding history
- ☐ Breastfeeding education
- ☐ Leaflets
- ☐ To discuss follow-up at 32 weeks

Ethnicity

ALCOHOL
(Glasses a week)
- ☐ Nil
- ☐ 1-4
- ☐ 5-10
- ☐ 10 or more

SUBSTANCES
- ☐ No
- ☐ Yes
- ☐ Not known
- ☐ Type

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