LEBANON FAMILY HEALTH SERVICES
PREGNANCY TEST FORM

Name: _____ Date: _____

Date of Birth: _____ Age: _____ CHART #: _____
Fecha de nacimiento *Edad*

First day of last normal period:
El primer dia de su period normal _____

Do you get regular periods every month? Yes No
Recibe sue flujo menstrual cada mes *Si* *No*

Have you had any irregular or abnormal bleeding since your last period? Yes No
ha tenido algun sangrado irregular o anormal desde sue ultima mensturacion? *Si* *No*

Were you planning a pregnancy? Yes No
Estas tratando de quedar embarazada *Si* *No*

Are you on a birth control method at present? Yes No
Esta's usando un metodo anticonceptivo? *Si* *No*

If yes, what birth control method?
Que metodo de anticonceptivo?

Please circle any pregnancy symptoms you may be having:
Por favor circulo sintomas de embarazo que usted tiene:

Breast tenderness *El dolor en sue seno*	Nausea *Nauseas*	Frequent urination *Orinar con mas frecuencia*	Weight gain *El aumento de peso*
Cramping *Colicos*	Tiredness *Cansancio*	Vomiting *Vomitando*	Spotting *Manchado/Sangrado*

Some drugs can change the urine pregnancy test results. Please list present medications or drugs that you have used in the last 48 hours. Include over the counter medications such as aspirin or durgs such as marijuana.
Algunas drogas pueden cambiar los resultados de la prueba de embarazo de orina. Por favor escriba todos los medicamentos o drogas que ha utilizado en las ultimas 48 horas. Incluya todos los medicamentos como la aspirina o drogas como la marihuana.

Please Provide Information On Other Side

I understand that I will be getting a URINE pregnancy test today. I also understand that a urine pregnancy test may not be able to detect all pregnancies and that I may be asked to have a blood pregnancy test or to return to the office at a later date for further follow-up.

_____ _____

Patient Signature Date

Yo entiendo que tendra una prueba de embarazo de orina. Tambien entiendo que una prueba de embarazo de orina no podra mostrar todos los embarazos. Tambien entiendo que me puede pedir para tener una prueba de sangre o para volver a la oficina mas tarde para otra visita.

_____ _____

Firma de paciente *Feche*

CLINIC NOTES: **WT** _____ **HT** _____ **BMI** _____ **BP** _____

NON DIRECTIVE COUNSELING PROVIDED? **Yes** **No**

PREG TEST RESULTS **POSITIVE EDC** _____ **WKS** _____ **NEGATIVE**

_____ Folic acid info given GC _____ CT _____

_____ _____

STAFF SIGNATURE **DATE**

KD 11/14

LEBANON FAMILY HEALTH SERVICES
PRECONCEPTIONAL HEALTH APPRAISAL

Name: _____ Date: _____

Directions: Place an "X" mark next to any item in sections I-VI that is true for you.

I. NUTRITION: Do you:/

____ Eat less than three meals some days/
____ Practice vegetarianism (east few or no meats)/
____ Practice fasting (avoid eating for 24 hours or longer)/
____ Eat laundry starch, clay or dirt on occasion/
____ Vomit more than once a month/
____ Eat a special diet

II. LIFESTYLE HISTORY: Do you:/

____ Smoke cigarettes/
____ Drink beer, wine or hard liquor/
____ Use lead or chemicals at home or at work/
____ Worry that your parents, partner, or husband might hurt you in some way/
____ Work with radiation or ever have X-rays/
____ Own a cat/
____ Have questions about blood relatives having children/

ARE YOU:

____ Less than 18 years old/
____ More than 34 years old/

III. FAMILY HISTORY: Does anyone in your family have:/

____ High Blood Pressure/
____ Diabetes ("Sugar" Diabetes)/
____ Hemophilia ("Free Bleeders")/
____ Jewish Background (or have Tay Sachs disease or trait)/
____ Sickle Cell Disease or Trait/
____ Birth Defects (such as heart, spine or other problems)/
____ Mental Retardation/
____ Cystic Fibrosis/

IV. MEDICAL HISTORY: Do you now or have you ever had:/

____ Genital Herpes/
____ Gnorrhea or Chlamydia (infections of the pelvic organs)/
____ Syphilis/
____ Epilepsy (seizures or spells)/
____ Diabetes ("Sugar" Diabetes)/
____ High Blood Pressure/
____ Heart Disease/
____ Other (such as PKU, Kidney Disease, Veneral Warts)/
____ Questions about HIV, the AIDS virus/

V. REPORDUCTIVE HISOTRY: Have you had any of the following:/

___ History of "female" surgery (ovaries, tubes, uterus, cervix) or problems with your uterus or cervix

___ History of your mother receiving DES (a drug to stop miscarriages) when she was pregnant with you

___ Two or more abortions after 14 weeks of pregnancy

___ Three or more miscarriages/
___ Five or more pregnancies/
___ Less than 12 months since last birth/
___ One or more infants weighing more than 9 pounds at birth

___ One or more infants weighing 5 ½ pounds or less at birth

___ One or more fetal deaths (stillborn)/
___ One or more neonatal deaths (baby died before one month old)

___ One or more infants with a birth defect/
___ One or more infants requiring a stay in an intensive care nursery

___ History of vaginal bleeding late in pregnancy/

VI. DRUG HISTORY: Do you ever use:

___ Prescription Drugs/
___ Drugs that do not need a prescription/
___ "Street" Drugs (examples include marijuana, cocaine, crack, heroin, etc.)

___ Vitamins/
___ Birth Control Pills/