Patient Name: ____ **DOB**: ____________________

In order to provide accurate prenatal care and complete coordination of your care, please read over and sign the authorization for care below.

Authorization for Prenatal Care

Please Initial:

_____ I authorize Greater Seacoast Community Health to assign staff as deemed necessary to provide services to me, while I am a patient in the Prenatal Program, according to program policies of Greater Seacoast Community Health.

Such care may include:

- Medical Supervision
- Medication Administration
- Medical Testing
- Education
- Social Services
- Nutritional Services
- Drug Screening as deemed necessary by your provider
- Monitor/ Check NH State Drug Monitoring system, as necessary
- Treatment prescribed by the Program Medical Staff

_____ I also authorize the sharing of medical record information between physicians, hospital staff *and* delivering practices. (**Maternal Fetal Medicine, Garrison Women's Health, Harbour Women's Health, OB/GYN & Infertility)**

Please Initial Next to Delivering Hospital:

______ **Wentworth-Douglass Hospital** (*Goodwin* / *Families First*)
______ **Frisbie Memorial Hospital** (*Goodwin*)
______ **Portsmouth Regional Hospital** (Families First)

______ I authorize staff to share information with the Visiting Nurse Association, Community Action Program of Strafford County, and Maine Families Home Visiting programs for complete coordination of prenatal care, consistent with HIPAA privacy guidelines.

In order to improve maternity care services in the state of NH, the NH Div. of Public Health Services is requesting permission to collect some information about your pregnancy. All information provided would be kept confidential and used for statistical purposes only (Name not included).

This consent expires 60 days after delivery, unless otherwise revoked by patient.

By signing below, you are stating that you have read and understand the above details about the prenatal program and given the opportunity to have any questions addressed regarding the above.

Patient Signature: ____ **Date**: _______________

Staff Signature: ____ **Date**: _______________

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GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Patient Name:____ **DOB**: ________________

Who is your emergency contact? ______________________________ **Phone #:** _________________

What is their relationship to you? ____________________________________

Do you have any other children? Yes No **Do they live with you?** Yes No

Please tell us their names and ages: ____

____

Who do you expect to be helpful with the baby? ____

Are you close with your immediate family? Yes No

Please explain: ____

____

What is your highest level of education completed?

Last Grade Completed _________ GED # of years Completed in College__________

What do you do for work? ____

Full Time or Part-Time

What are your plans for working after the baby is born?

____

What have you used for birth control in the past? ____

Do you plan to use birth control after the birth? Yes No Unsure

If yes, what method would like to use? (*If known*) ____________________________________

Was this a planned pregnancy? Yes No Unknown

If no or unknown: *(Circle One)*

Contraception failure
Contraception not used
Other: ______________________________________

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GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Behavioral Health Questionnaire

Patient Name:____ **DOB**:________________

This questionnaire will help us identify people who may need extra support or services during pregnancy or postpartum.

1. **Have you ever had any of the following problems? (*circle all that apply*)**

   Premenstrual Disorder   Depression and/or Anxiety   Substance Misuse

   Manic-Depressive Disorder   Difficult Labor or Delivery   Postpartum Depression

2. **Have you ever been sexually abused or sexually assaulted? *(circle one)*** Yes No

3. **Have you been in treatment for any of the above problems? (*circle one*)** Yes No

   If yes, when? _____________ Where?________________________________

4. **Have you been prescribed any of the following medications? (please circle)**

   Prozac Zoloft Effexor Pamelor Elavil Valium Ativan Klonopin

   Any other medications for **behavioral health**? _________________________________

5. **Do you have any pressing concerns or feel you may be suffering from depression? (*circle one*)**

   Yes No

   If yes, please briefly describe:

   ____

   ____

   ____

   ____

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Father of the Baby____ **DOB**__________________

Address ____ **Phone #:** ____________________

How do you describe their race/ethnicity? ________________________

Do they smoke cigarettes? Yes No **Are there any concerns about their alcohol use?** Yes No

Please explain____

____

Do they use any illicit substances or non-prescribed medication? Yes No

Please explain ____

____

Are you still together? Yes No

If you and the baby's other parent were, or are, in a relationship, for how long? _____________

Do you have, <u>or have you ever had</u>, any concerns about your safety in your relationship?

Yes No

What is the highest level of education the baby's other parent has completed?

Last grade completed_________ GED # of years completed in college _____________

Are they employed? Yes No **If yes, what do they do?** ___________________

Do they have any children? Yes No **If so, do the children live with them?** Yes No

Children's names and ages ____

____

Is their immediate family helpful? Yes No

Please explain ____

____

Do they have any mental health issues? Yes No

If yes, what is the diagnosis and treatment? ____

____

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GREATER SEACOAST COMMUNITY HEALTH

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Medication History

Patient Name:________________________________ **DOB:**__________________________________

Since your last menstrual period, have you used <u>any</u> of the following? Please be as accurate as possible.

Medication	Yes or No	Brand of Medication	Last Time Taken
Aspirin (acetylsalicylic acid)			
Acetaminophen (i.e. Tylenol)			
Ibuprofen (i.e. Motrin)			
Prescription narcotics (Morphine, Darvocet, Percocet, Oxycodone)			
Cold, Flu, or Cough Medicine			
Allergy Medicine			
Birth Control (all methods)			
Acne Medication			
Anti-Seizure or Anti-Convulsive			
Sleeping Pills/ Tranquilizers			
Diet Pills, Laxatives, or Anti –Diarrheal			
Vitamins			
Any Other (including prescription medications)			

If you have any other comments regarding the above questions, please write them below:

____

____

____

____

____

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GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Prenatal Substance Use Screening Health History

Patient Name:___________________________________ **DOB:**_________________________________

Have you **EVER used ANY** of the following, be as accurate as possible. This includes anything used in the past or presently.

Medication/ Drug Type	Yes or No	Last time used & How much
Cigarette/ Smokeless Tobacco		
Alcohol		
Sleeping Pills, Barbiturates, Tranquilizers (non-prescription use)		
Marijuana		
Cocaine/ Crack		
Amphetamines (non-prescription use)		
Narcotics/ Heroin		
PCP		
Inhalants		
LSD, Mushrooms, Hallucinogens		
Bath Salts		
Methadone, Suboxone (street use)		
Other		

Have you ever participated in a substance use recovery program?

Please check one of the following:

_______Currently ________ Previously ________No

If so, please describe treatment below:

____

____

____

____

Would you like help accessing substance use recovery supports? Yes No

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GREATER SEACOAST COMMUNITY HEALTH

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Genetic History – Risk Factors

The following questions will help in the care of you pregnancy. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health of your unborn baby. Please answer all of the questions to the best of your ability. All information will be kept confidential.

Please place a check mark ✓ in the box stating either **Yes, No,** or **Unknown** under the appropriate column indicating **Patient** or **Father of Baby (FOB)**. If you have additional information you think we need to know, please write it in the space provided below.

Patient Name:____ **DOB**: ____________________

History Of	Patient			FOB			Comments
	Yes	No	Unknown	Yes	No	Unknown	
Thalassemia							
Neural Tube Defect							
Down Syndrome							
Tay-Sachs							
Sickle Cell Disease/Trait							
Hemophilia							
Muscular Dystrophy							
Cystic Fibrosis							
Huntington Chorea							
Mental Retardation							
Fragile X							
Other Genetic/ Chromosomal							
Child w/ Other Birth Defect							
Other							

Do you have any additional information you would like to address with the provider?

____

____

____

____

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GREATER SEACOAST COMMUNITY HEALTH

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Tuberculosis Risk Assessment

Name:____ DOB:________________________

1. Is there a family history of tuberculosis or is a family member on medication for the disease?
2. Do you or any household members have an immune deficiency disease such as HIV/AIDS or Hodgkin's Lymphoma?
3. Or chronic diseases like diabetes or chronic kidney failure?
4. Or taking chemotherapy?
5. Or suffering from malnutrition?
6. Have you, any family members or close contacts recently been in jail, prison, a nursing home, a homeless shelter, or considered homeless?
7. Are you or any family member's immigrants from a foreign country?
8. Are any family members or close contacts IV drug users?
9. Is tuberculosis active in your neighborhood?
10. Have you had a TB test done in the past year?

Patient Signature: ____________________________________ **Date**: _______________

Staff Signature: ______________________________________ **Date**: _______________

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

COVID-19 Risk Assessment

Name: ______________________________________ DOB: _____________________________

Have you tested positive for COVID-19 since your last menstrual period? Yes No

If yes, date of positive test: ____________ **Type of test?** Rapid or PCR

Have you received a COVID-19 Vaccine? Yes No

If yes, which vaccine did you receive? Moderna Pfizer J&J

Date(s) received: 1st Dose: ________ **2nd Dose:** ________ **Booster:** _______