Antenatal Booking Form

Brighton and Sussex University Hospitals NHS Trust

Welcome to the Department of Women's Health.
We look forward to caring for you in your pregnancy.

Have you attended the Hospital before? Yes / No

Do you require an interpreter? Yes / No If YES Language required_____

Do you have any speech, hearing, visual or mobility disability that may affect the delivery of our care?
Please give details:

Please complete **ALL** of this form by ticking the relevant boxes to the best of your abilities

Section 1

Title_____

Surname _____

First Names _____

Previous Surname_____

Date of Birth_____

Address _____

_____

Town _____

County _____ **Post Code**_____

Is this your permanent UK address? YES / NO

Contact Telephone Numbers:

Home _____

Mobile _____

Work _____

NHS Number _____

Trust I.D Number _____

Intended place of delivery ☐ RSCH ☐ PRH ☐ Home

☐ Other Please specify_____

May we contact you via SMS Text if necessary?

YES / NO

Are you: **Married** ☐ **Cohabiting** ☐ **Single** ☐ **Divorced** ☐ **Civil partnership** ☐ **Widowed** ☐

One or two parent family _____ **Your occupation** _____

Religion _____ **Country of Birth** _____

Your Ethnic Group: This information is defined by the Dept. of Health; based on the 2001 Census and is only used for Healthcare Planning Purposes:

Asian Bangladeshi	☐	**Black Caribbean**	☐	**White British**	☐	**Other Ethnic Group**	☐
Asian Indian	☐	**Black African**	☐	**White Irish**	☐	**Other Mixed Group**	☐
Asian Pakistani	☐	**Black Other**	☐	**White Other**	☐	**Mixed White/Asian**	☐
Asian Other	☐	**Chinese**	☐			**Mixed White/Black African**	☐
						Mixed White/Black Caribbean	☐

Your GP's Name and Surgery_____ **Tel. No.**_____

Partner's name_____

Partner's DOB _____

Partner's Contact No. _____

Baby's Father's Ethnic Group _____

Next of Kin_____
(Next of Kin if not partner)
Relationship to you _____

Contact No. (Home) _____

(Mobile) _____

Section 2.
Your Medical History
Please include details of any current treatment/care

Are you allergic to anything e.g. Latex, Medications, Food or other Allergies ☐ Y ☐ N
Details:_____

Anaesthetic Reaction ☐ Y ☐ N_____

Autoimmune Disease ☐ Y ☐ N_____

Skin Conditions ☐ Y ☐ N_____
(Eczema, psoriasis)

Respiratory Disease ☐ Y ☐ N_____
(Severe asthma/TB/Chest Problems)

Asthma requiring medications ☐ Y ☐ N_____

Cystic Fibrosis ☐ Y ☐ N_____

Back/Limb/Pelvic Problems ☐ Y ☐ N_____

Blood Disorders ☐ Y ☐ N_____
e.g. Thalassaemia or Sickle Cell or Anaemia _____

Have you ever had a Blood Transfusion? ☐ Y ☐ N

Would you accept blood/blood products? ☐ Y ☐ N

Section 2 cont. Your Medical History

Cardiac Conditions or Problems/Surgery ☐Y ☐N_____

Cancer ☐Y ☐N_____

Diabetes ☐Y ☐N_____

Epilepsy (Folic Acid) ☐Y ☐N_____
Are you on epileptic drugs ☐Y ☐N_____

Central Nevous System Conditions ☐Y ☐N_____
(Under the care of a neurologist)

Genital Infections (Syphilis) ☐Y ☐N_____
(Group B Strep. in previous pregnancy) ☐Y ☐N_____

Hypertension ☐Y ☐N_____
(High Blood Pressure)

Infertility/Gynae Problems ☐Y ☐N_____
Have you had fertility treatment in this pregnancy, if so what

_____

_____

Kidney Disease ☐Y ☐N_____

Urine Problems ☐Y ☐N_____
(Inc cystitis/UTI)

Liver Disease ☐Y ☐N_____
(including Hepatitis/Jaundice)

Mental Health ☐Y ☐N_____
(including depression)

Other relevant conditions or problems ☐Y ☐N_____

FGM/Circumcision/Cutting ☐Y ☐N_____

Previous Surgery ☐Y ☐N_____

Previous Organ Transplant ☐Y ☐N_____

Previous Uterine Surgery ☐Y ☐N_____
(including Caesarean)

Thrombosis (blood clot) ☐Y ☐N_____

Thyroid/other endocrine disorders ☐Y ☐N_____

Gastrointestinal Conditions ☐Y ☐N_____
(Crohn's, colitis, gastric ulcer)

Section 3. Family History

The following questions only apply to your immediate family.

Has any member of your family had:

Diabetes ☐Y ☐N Type: **Insulin dependent** ☐
Diet controlled ☐
What relation to you _____

Hypertension ☐Y ☐N **What relation to you** _____
(incl. PIH/Eclampsia)

Sickle Disease ☐Y ☐N **What relation to you**_____

Thalassaemia ☐Y ☐N **What relation to you**_____

Postnatal Depression ☐Y ☐N
What relation to you_____

Are you Adopted? ☐ Yes ☐ No

The following questions apply to **both you and your partner's family**. Has any member of your family had:

History of learning difficulties ☐Y ☐N
Congenital disorder ☐Y ☐N
Congenital dislocation of hips ☐Y ☐N
History of twins ☐Y ☐N
Genetic inherited condition (incl McADD) ☐Y ☐N

If yes to any please specify _____

_____

_____

Are you and your partner blood relatives? YES / NO

Section 4. Previous Other Pregnancy Conditions

Previous gestational diabetes ☐Y ☐N_____

Previous pregnancy induced hypertension ☐Y ☐N_____
(including PIH/HELLP/Pre eclampsia/Eclampsia)

Previous fetal congenital anomaly (please specify) ☐Y ☐N_____

Required specialist input ☐Y ☐N

Previous history of postnatal depression ☐Y ☐N

Puerperal psychosis ☐Y ☐N

_____

_____

_____

Previous requirement for fetal medicine (please specify) ☐Y ☐N_____

Required specialist input ☐Y ☐N

Previous pre term birth before 34 weeks ☐Y ☐N_____

Previous growth restriction/ small baby (IUGR) ☐Y ☐N_____

Placental Problems ☐Y ☐N_____
(including IUGR/Placenta Accreta/ Manual removal of placenta)

Section 5. PREVIOUS PREGNANCY DETAILS

See medical notes ☐

This section is to record details of your previous pregnancies, including miscarriages and terminations. If this information needs to be treated in confidence please discuss this with the midwife as alternative arrangements can be made.

Date	Gest	Place of Birth	Sex M / F	Antenatal problems	Labour details: Complications	Type of birth (include relevant details)	Outcome (Misc/ Live SB/ NND)	Name (first last)	Feeding (If BF give duration)	Birth weight	Present health
				Y ☐ N ☐ ______	Y ☐ N ☐ ______	SVD ☐ Forceps ☐ Ventouse ☐ Caesarian ☐ Breech ☐	Live ☐ SB ☐ NND ☐				
				Y ☐ N ☐ ______	Y ☐ N ☐ ______	SVD ☐ Forceps ☐ Ventouse ☐ Caesarian ☐ Breech ☐	Live ☐ SB ☐ NND ☐				
				Y ☐ N ☐ ______	Y ☐ N ☐ ______	SVD ☐ Forceps ☐ Ventouse ☐ Caesarian ☐ Breech ☐	Live ☐ SB ☐ NND ☐				
				Y ☐ N ☐ ______	Y ☐ N ☐ ______	SVD ☐ Forceps ☐ Ventouse ☐ Caesarian ☐ Breech ☐	Live ☐ SB ☐ NND ☐				
				Y ☐ N ☐ ______	Y ☐ N ☐ ______	SVD ☐ Forceps ☐ Ventouse ☐ Caesarian ☐ Breech ☐	Live ☐ SB ☐ NND ☐				

Early Pregnancy Losses

Year	Gestation	Nature of loss	Comments

Section 6.
Health in This Pregnancy

First day of last period _____

Are you taking folic acid ☐Y ☐N
If YES date commenced_____

Vit D ☐Y ☐N
If YES date commenced_____

Are you currently taking any medication ☐Y ☐N
If YES date commenced _____
Have you taken illicit drugs in the past ☐Y ☐N _____

_____

Have you taken any substances or illicit drugs in this pregnancy, if so what _____

_____

Alcohol Intake: Pre pregnancy units _____
Current Units_____

Does your partner drink alcohol: ☐Y ☐N
Current Units_____

Your Smoking: Never ☐
Current ☐ How many per day _____
Given up ☐ Date stopped _____
Partner Smoking: ☐Y ☐N

Any other information that you think is relevant
_____
_____

Is this a multiple pregnancy ☐Y ☐N ☐Unknown

Have you ever had a smear YES / NO
Have you had a smear test within the last 3 years YES / NO
Always Negative YES / NO
Have you ever had a Colposcopy YES / NO

Your Height _____ **Booking Weight**_____
at booking

BMI _____

Section 7.
Social Factors

Have you, your children or your partner ever had a named social worker	YES ☐	NO ☐	if **YES,** Child ☐ Mother ☐ Partner ☐
Are you, your children or your partner on the child protection register	YES ☐	NO ☐	if **YES,** Child ☐ Mother ☐ Partner ☐
Are your children living with you	YES ☐	NO ☐	
Are you homeless / temp. accommodation	YES ☐	NO ☐	if **YES,** Child ☐ Mother ☐ Partner ☐
Are you a refugee or asylum seeker	YES ☐	NO ☐	if **YES,** Child ☐ Mother ☐ Partner ☐
Are you a recent migrant (within last 12 months)	YES ☐	NO ☐	if **YES,** Child ☐ Mother ☐ Partner ☐
Are you under 20 years old	YES ☐	NO ☐	if **YES,** Child ☐ Mother ☐ Partner ☐

Section 8.
FOR COMPLETION BY MIDWIFE/HOSPITAL

Date of booking _____ Booked by_____Named Midwife_____ LMP_____
EDD_____
If booking later than 12 weeks, reason why: _____ No. of weeks at Booking _____
Has a booking taken place elsewhere: _____ If Yes - which hospital _____
Consultant appointment required ☐ Yes ☐ No. If YES, date_____ BP _____
Reason for appointment _____
Model of care: Midwifery ☐ Maternity team care ☐ Hospital team ☐
☐ NHS ☐ Private ☐ Overseas visitor for the last 12 months Yes / No

Reason for Referral	Were referral questions asked?	Was referral made? If so to whom?
VTE	YES ☐ NO ☐	☐ Low ☐ Intermediate ☐ High ☐ N/A To whom:
BMI	YES ☐ NO ☐	☐ Yes ☐ Declined ☐ N/A BMI Measurement: To whom:
Smoking	YES ☐ NO ☐	☐ Yes ☐ Declined ☐ N/A CO_2 Reading: ☐ Declined To whom:
Worth/Rise	YES ☐ NO ☐	☐ Yes ☐ Declined ☐ N/A To whom:
Whooley	YES ☐ NO ☐	☐ Yes ☐ Declined ☐ N/A To whom:
Teenage	YES ☐ NO ☐	☐ Yes ☐ Declined ☐ N/A To whom: Teenage Midwife ☐ Yes ☐ No
BCG	YES ☐ NO ☐	Is BCG recommended for Infant? ☐ Yes ☐ No Details