Trilogy
Homegrown Health Care

Notification of Pregnancy Form
Fax to: 414-771-1159

Member Information

Last Name:_____ First Name:_____ DOB:_____ID#: _____

Address:_____ City: _____ Zip: _____ Phone #: _____

Date of Initial Prenatal Visit:_____ Completion date of Pregnancy Form:_____

Current Pregnancy

Gravida _____ Para_____ LMP_____ EDC_____ Blood Type _____

☐ Multiple Gestation this pregnancy ☐ Maternal age < 16 years ☐Maternal age > 35 years of age

Previous Pregnancies

☐ Multiple Gestations previous pregnancy ☐ Previous C-Section ☐ Hx of Placenta Previa

☐ Hx of SAB/TAB/Fetal Demise ☐ Preterm Labor/Delivery ☐ Hx of Post Partum Depression

Week of demise _____ Week of delivery _____

Medical History (Check all that apply)

☐Cardiac Disease(Current/Past) ☐Clotting Disorders(Current/Past) ☐Diabetes/Gestational Diabetes

☐HIV Testing (Current/Past) ☐Hypertension or PIH(Current/Past) ☐Incompetent cervix(Current/Past)

☐Mental Illness(Current/Past) ☐Neurologic Disorders(Current/Past) ☐Respiratory Conditions(Current/Past)

☐Sickle Cell Anemia(Current/Past) ☐STD(Current/Past)

Psycho/Social Issues (check all that apply)

☐Drug Abuse(Current/Past) ☐Alcohol Abuse(Current/Past) ☐Smoker(Current/Past) ☐Domestic Abuse

☐Housing Issues ☐Lack of Support System

Prenatal Care and Nutrition (Check all that apply)

☐Missed several medical appointments ☐Currently Enrolled in WIC

Description of above or other unlisted conditions: _____

_____

List of Medications: _____

_____

Provider Information

_____ _____

Provider Signature Provider Printed Name

_____ _____

Provider Address Provider Phone #

_____ _____

Delivery Hospital Provider Fax #