

## Your Details

Single    Married / CP    Partner    Separated    Divorced    Widowed

Family name at birth

Country of birth  If not UK, year of entry

Faith / Religion  Citizenship status

Disability  No  Yes  Details

## Partner's Details

First name  Surname

Address if different

Postcode:

Date of birth

Employed  U/E  Occupation

UK citizenship status  If not born in UK, year of entry

Social Assessment-booking	No		Yes		2nd Assessment		Referred (Details: page 13)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No	Yes	
Has difficulty understanding English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any difficulties reading / writing English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needs help understanding Pregnancy Notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needs help completing forms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Employment status</b>							
Occupation <input type="text"/> Years in education <input type="text"/>							
F/T <input type="checkbox"/> P/T <input type="checkbox"/> Home <input type="checkbox"/> Student <input type="checkbox"/> Sick <input type="checkbox"/> U/E <input type="checkbox"/> Retired <input type="checkbox"/> Voluntary <input type="checkbox"/>							
Housing: Owns <input type="checkbox"/> Rents <input type="checkbox"/> With family/ friends <input type="checkbox"/> UKBA <input type="checkbox"/> NFA <input type="checkbox"/>							
Care services <input type="checkbox"/> Temporary accommodation <input type="checkbox"/> Other <input type="text"/>							
Entitled to claim benefits (income support, child tax credits, job seeker etc.) <input type="checkbox"/>							
Do you have support from partner / family / friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any household member had/has social services support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of social worker(s)/ Other Professionals (CAF)	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>
Does your partner have any other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>		<input type="text"/>

Tobacco use - booking	No		Yes		Record plan on p13			2nd		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No	Yes	No. per day	No	Yes	No. per day
Are you a smoker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Have you ever used tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Was this in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
When did you give up <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
If in pregnancy, how many weeks were you <input type="text"/> <input type="text"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Anyone else at home smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Do you:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Smoke cigarettes					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Smoke roll up's					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Smoke cannabis					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chew tobacco					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Use shisha					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
CO testing					<input type="checkbox"/>	<input type="checkbox"/>	Result <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Result <input type="text"/>
Smoking cessation referral					<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Drug use - booking	No		Yes		2nd		Alcohol - booking	No		Yes		2nd	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No	Yes		No	Yes	No	Yes	No	Yes
Have you ever used street drugs, gas or glue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Units per week	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Details <input type="text"/>					<input type="checkbox"/>	<input type="checkbox"/>	Pre-pregnancy	<input type="text"/>	Currently	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Are you receiving treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance misuse referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any drug or alcohol concerns in the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Details <input type="text"/>								

**Ethnic Origin** (If mixed, tick more than one box)

The term Ethnic Origin is to describe where your family originates from, as distinct from where you were born. This information will help us to support which blood screening tests you should be offered (see p6) and to produce a customised growth chart for your baby (see p16).

	You	Baby's father		You	Baby's father
<b>Africa</b>			<b>Caribbean</b> (eg Barbados, Jamaica, Trinidad & Tobago)	<input type="checkbox"/>	<input type="checkbox"/>
North Africa (eg Morocco, Algeria)	<input type="checkbox"/>	<input type="checkbox"/>	European (eg Britain, Ireland, Greece, Poland)	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Sahara (eg Somalia, Kenya, Nigeria)	<input type="checkbox"/>	<input type="checkbox"/>	Middle East (eg Egypt, Israel, Syria, Yemen)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Asia India</b>	<input type="checkbox"/>	<input type="checkbox"/>	Other <input type="text"/>	<input type="text"/>	<input type="text"/>
Pakistan	<input type="checkbox"/>	<input type="checkbox"/>	<b>Declined to give information</b>	<input type="checkbox"/>	<input type="checkbox"/>
Bangladesh	<input type="checkbox"/>	<input type="checkbox"/>			
Far East Asia (eg Japan, Korea, China)	<input type="checkbox"/>	<input type="checkbox"/>			
South East Asia (eg Malaysia, Thailand, Philippines)	<input type="checkbox"/>	<input type="checkbox"/>			

**Medical History** Complete risk assessment and management plan page 13, additional comments page 21.

<b>Do you have / have you had:</b>	No	Yes	<b>Details</b>
Admission to ITU/ HDU	<input type="checkbox"/>	<input type="checkbox"/>	
Admission to A & E in last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	
Anaesthetic problems	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (inc. latex)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or chest problems	<input type="checkbox"/>	<input type="checkbox"/>	
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical smear	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy /Neurological problems	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to toxic substances	<input type="checkbox"/>	<input type="checkbox"/>	
Fertility problems (this pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	
Female circumcision	<input type="checkbox"/>	<input type="checkbox"/>	
Gastro-intestinal problems (eg Crohns)	<input type="checkbox"/>	<input type="checkbox"/>	
Genital Infections (e.g. Chlamydia, Herpes)	<input type="checkbox"/>	<input type="checkbox"/>	
Gynae history /operations	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence (urinary / faecal)	<input type="checkbox"/>	<input type="checkbox"/>	
Infections (e.g. MRSA, GBS)	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney or urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease inc. hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine or severe headache	<input type="checkbox"/>	<input type="checkbox"/>	
Musculo-skeletal problems	<input type="checkbox"/>	<input type="checkbox"/>	
Operations	<input type="checkbox"/>	<input type="checkbox"/>	
Pelvic injury	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnancy problems (e.g. Cholestasis, HELLP)	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle cell / Thalassaemia	<input type="checkbox"/>	<input type="checkbox"/>	
TB exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	
Medication in the last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal bleeding in this pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	
Other (provide details)	<input type="checkbox"/>	<input type="checkbox"/>	
Folic acid tablets	<input type="checkbox"/>	<input type="checkbox"/>	

Date       Result \_\_\_\_\_

Start date       0.4mg  5mg  Dose changed? No  Yes

**Physical Examination** performed   **Details**

<b>Mental Health</b> <small>(Record plan on page 13)</small>	No	Yes	During the last month have you been bothered by:	No	Ist Yes	No	2nd Yes
Past or present mental illness	<input type="checkbox"/>	<input type="checkbox"/>	Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous treatment/In-patient care	<input type="checkbox"/>	<input type="checkbox"/>	Having little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history	<input type="checkbox"/>	<input type="checkbox"/>	Is this something you feel you need or want help with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your partner have any history	<input type="checkbox"/>	<input type="checkbox"/>	Referral required (record plan on page 13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Details <input type="text"/>							

**Family History** The term 'family' here means blood relatives only - e.g. your children, your parents, grandparents, brothers and sisters, uncles and aunts and their children (i.e. first cousins). Update management plan (page 13) if indicated

Has anyone in your family had:	No	Yes	Has anyone had:	in your family		in family of baby's father	
- diabetes Type <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	- a disease that runs in families	No	Yes	No	Yes
- thrombosis (blood clots)	<input type="checkbox"/>	<input type="checkbox"/>	- need for genetic counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- high blood pressure / eclampsia	<input type="checkbox"/>	<input type="checkbox"/>	- stillbirths or multiple miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- hip problems from birth	<input type="checkbox"/>	<input type="checkbox"/>	- a sudden infant death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your partner the baby's father	<input type="checkbox"/>	<input type="checkbox"/>	- learning difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the baby's father a blood relation	<input type="checkbox"/>	<input type="checkbox"/>	- hearing loss from childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First cousin <input type="checkbox"/> Second cousin <input type="checkbox"/> Other <input type="checkbox"/>			- heart problems from birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age of baby's father <input type="text"/>			- abnormalities present at birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Details <input type="text"/>							

Name

Unit No

\* Signatures must be listed on page 26 for identification