MARTIN LUTHER KING JR. COMMUNITY HOSPITAL HIGH RISK SCREENING

This form will help us understand if you have a high risk pregnancy. Please fill out the form and talk to your nurse.

Name: ____

Phone Number: ____

1. Are you receiving prenatal care? YES NO

   If yes, where? ____

2. Are you taking medications other than prenatal vitamins and iron? YES NO

   If yes, what medications ____

3. Has your doctor told you that you have a high risk pregnancy? YES NO

   If yes, why ____

   ____

4. Have you ever received a blood transfusion? YES NO

5. Have you been admitted to a hospital for any reason other than childbirth? YES NO

   If yes, why ____

6. Have you ever had surgery on your uterus? YES NO

STAFF USE ONLY

Approved for delivery YES NO

Approved by __________

Martin Luther King, Jr.
Community Hospital