



Medical/Health History

Please fill out this medical and personal history very carefully. When you come for your next visit we will go over the history together and discuss any questions that you might have. Just leave blank any questions you cannot answer.

PERSONAL INFORMATION

Your Name _____
Address _____
Phone _____ Cell _____
Occupation _____ Email _____
Date of Birth _____ Height _____ Usual Weight _____
Marital Status _____ Ethnicity _____ SSI# _____
Last grade of High School completed _____ Years of post-secondary formal education _____
Partner's Name _____ Birth date _____
Address _____
Occupation _____ Ethnicity _____ SSI# _____
Last grade of High School completed _____ Years of post-secondary formal education _____
How did you hear about our practice? _____
Insurance _____ Family Doctor/Pediatrician _____

MENSTRUAL HISTORY

When do you think you may have conceived? _____
How long is your menstrual cycle? _____ Last Menstrual Period (LMP) _____
Was it normal in length and heaviness of flow? _____
Did you have a pregnancy test? _____ Was this a planned pregnancy? _____
Previous Menstrual Period (PMP) _____
How old were you when you began menstruating? _____
Were you using birth control when you conceived? _____
If yes, what type? _____

OBSTETRICAL HISTORY

Total Pregnancies _____ Full Term _____ Premature _____
Abortion _____ Ectopic _____ Miscarriage _____
Living Children _____ Twins _____ Cesarean _____ VBAC _____



Please list information about your previous births: (starting with your first birth)

Date: Mo/Yr _____ # of weeks at delivery _____ Length of labor _____
Birth Weight _____ Sex: M/F _____ Place of Birth _____
Complications: _____

Date: Mo/Yr _____ # of weeks at delivery _____ Length of labor _____
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Birth Weight _____ Sex: M/F _____ Place of Birth _____
Complications: _____

Date: Mo/Yr _____ # of weeks at delivery _____ Length of labor _____
Birth Weight _____ Sex: M/F _____ Place of Birth _____
Complications: _____

Describe anything else you would like us to know about your previous births.

Did you nurse any of your babies? _____ If yes, how long? _____
If no, why didn't you nurse and/or what problems did you experience with nursing? _____



MEDICAL HISTORY

Please check if you have had any of the following conditions. In the space below record date, treatment, and any follow-up you received. Also feel free to list any other important conditions and/or concerns.

- | | | |
|--|---|--|
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Eye/vision problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pelvic/back injuries | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Ear/hearing problems | <input type="checkbox"/> Phlebitis/varicosities | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Urinary Tract Surgery | <input type="checkbox"/> Asthma |

Are there any hereditary diseases or conditions in your family such as diabetes, cancer, heart disease, hypertension, phenylketonuria, neural tube defects, or chromosomal disorders? (List and indicate which relative.)

YES NO Do you have any drug sensitivities or allergies?

If yes, list _____

YES NO Have you or the father of your baby ever had a baby with a birth defect or mental retardation?

YES NO Do you or the father of your baby have any family members with birth defects or conditions diagnosed as genetic or inherited?

YES NO Are you or the father of your baby from any of these ethnic/racial groups?

(please check) Ashkenazi Jew Black/African Asian Aleutian Mediterranean

How many times was your mother pregnant? _____

How many children did she have? _____ Did she have any miscarriages? _____

Were there any complications with her pregnancies? _____

How long were her labors? _____ How much did you weigh at birth? _____



- YES NO Have you had or now have mental health problems?
- YES NO Have you ever used drugs/alcohol excessively?
- YES NO Have you ever experienced dramatic fluctuations in your weight?
- YES NO Have you ever had anorexia, bulimia, or eating problems?
- YES NO Have you ever been in an abusive relationship, including now, or been abused in the past (physically and emotionally intimidated, beaten, or injured)?
- YES NO Have you ever been raped?
- YES NO Have you ever had a blood transfusion?

Do you have any special dietary considerations, such as vegetarianism, lactose intolerance, or phenylketonuria? _____

What do you generally do for exercise? _____

When was the date of your last dental visit? _____

Do you have any untreated dental problems? _____

GYNECOLOGICAL/CONTRACEPTIVE HISTORY

When was your last Pap smear? _____

Have you ever had an abnormal Pap? YES NO If so, when? _____

Do you do self breast exams? YES NO

Please check if you have ever had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Yeast | <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Gardnerella |
| <input type="checkbox"/> Condyloma (genital warts) | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> PID | <input type="checkbox"/> Genital sores |
| <input type="checkbox"/> Human Papilloma Virus (HPV) | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Oral herpes |
| <input type="checkbox"/> Cervicitis | <input type="checkbox"/> Cervical surgery | <input type="checkbox"/> Cervical polyp |
| <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Uterine surgery | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Other reproductive problems/conditions _____ | | |

Have you ever used any method of birth control YES NO If so, what kind? _____

Problems/complications?



CURRENT PREGNANCY

What prenatal care have you had up to the present? Please list doctors, clinics, and hospitals where you have had care, what was done, and especially if you have had any lab work or special testing done.

Please check if you have had any of the following problems during this pregnancy:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Rash | <input type="checkbox"/> Backache |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Abdominal/pelvic pain | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Vaginal bleeding/spotting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Family problems | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Work problems |

Have you used or been exposed to any of the following during this pregnancy?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Viruses | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cats | <input type="checkbox"/> Non-prescription drugs |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Prescription drugs |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Fumes/sprays |
| <input type="checkbox"/> Street drugs | <input type="checkbox"/> X-Rays | <input type="checkbox"/> Other environmental hazards |
| <input type="checkbox"/> Measles or other infectious diseases | | |

What herbs, vitamins and/or supplements are you currently taking?

Do you regularly visit a chiropractor? If so, how frequently? _____

Do you regularly visit a homeopath or naturopath? If so, how frequently? _____

Do you plan to breast feed this baby? If so, how long would you like to nurse? _____

Are there any particular ethnic, cultural, or religious preferences for your care that you would like to discuss? _____



Do you feel you have adequate resources, i.e. food, shelter, money, for this pregnancy? _____

Please list the people you plan to invite to your birth _____

Have you faced any opposition to your plans for home birth? _____

Please give some thought to the following questions and write your ideas. If you and your partner are together, each of you should answer. Read all questions before answering.

Why do you want to have this baby at home _____

Partner: _____

What do you see as the duties or responsibilities of your midwives? _____

Partner: _____



In choosing home birth and licensed midwifery care, you are going against current cultural birth norms. Only about 1% of all births in the United States each year occur at home. Many people consider home birth irresponsible and some have even likened it to child abuse. For example, if the birth results in damage or death in the hospital, no one will come to you and say, "See what happens when you have your baby in the hospital." However if a problem arises at home, you will invariably be asked this question regarding home birth again and again. What risks do you think there are with home birth?

Partner: _____

How do you feel about going to hospital to deliver if your midwives feel that complications are arising? _____

Partner _____

How do you think you might deal with the problem of a baby or mother who suffered permanent injury or died at home? _____

Partner: _____

