Health History Form

Please complete this form in preparation for your initial visit. Your responses will be kept confidential. This information assists us in optimizing your care. If you need more spaces, please use the area provided on the back.

Name First Middle Last Maiden					Date	Phone (home) (work)
Race	Religion	Yrs. Educ.	Marital Status	Occupation/Type of Business	Date of Birth	State of Birth
Address: Street City Zip					Inside City Limits Yes No	How long at this address?
Father of Baby: First Middle Last			Race	Yrs. Educ.	Date of Birth	State of Birth
Address (if different from above- if the same write "Same")					Phone (work) (home)	Occupation/Type of business
Partner/Husband (if different from Father)			Another person to contact in emergency Name:		Phone: Relationship:	
			E-Mail:			
Social Security #:		Father's Social Security #:		Social Security Number requested for baby? Circle YES or NO		How did you hear about our services?

Yes No Have you or the father of the baby (FOB) ever had a baby with birth genetic anomolies?
Yes No Are you and the FOB related by blood? (e.g. cousins)
Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)
Jewish Black/African Asian Mediterranean
Yes No Have you or the FOB ever had hepatitis or jaundice?
Yes No Do you think you are at an increased risk for AIDS/HIV or STD's?
Yes No Have you ever experienced dramatic fluctuations in your weight?
Yes No Have you ever had anorexia, bulimia or other eating problems?
Yes No Have you ever been in an abusive relationship or been abused ?
Yes No Have you ever had severe emotional problems?
Yes No Have you ever been on any medication for psychological problems?
Yes No Has anyone ever told you, or do you think you have ever used alcohol or drugs excessively?
Yes No Have you ever had a blood transfusion?

Height:_____

Pre-Pregnancy Weight:_____ **Current Weight:**_____

Do you know your blood type? Yes No If yes, what is your blood type?_____

MEDICAL HISTORY –
Please indicate if you have ever had any of these issues? When?

Severe headaches	Bowel problems/colitis
Eye vision problems	Blood in stool
Ear/hearing problems	Gall bladder problems
Dental problems	Liver problems
Thyroid	Hepatitis
Rheumatic fever	Diabetes
Blood clotting problems	Hypoglycemia
Anemia	Bladder infection
Hemorrhage	Kidney infection
High Blood Pressure	Urinary surgery
Varicose veins	Urethral dilation
Hemorrhoids	Aching joints
Tuberculosis	Pelvic/back injuries
Asthma	Seizures
Skin disorders	Cancer
Stomach problems	Hospitalizations
Ulcers	**Surgeries**
Chicken Pox	Fifth's Disease
Trauma	Fractures
Depression	Psychiatric Drugs
Toxic Exposure	Occupational Hazards
Blood transfusion	**Immunizations**

Current Pregnancy

Last Menstrual Period (1st day) _____ Normal? Yes No

Conception Date _____

Did you take a pregnancy test? Yes No Date_____

Planned pregnancy? Yes No

Feelings about this pregnancy _____

Father's feelings _____

Most recent birth control used _____

Contraception used in past; what, when, any problems? _____

Do you plan to have more children? Yes No Would you like information on Natural Family Planning? Yes No

Please indicate if you've had any of the following problems prior to pregnancy, during this pregnancy or in previous pregnancies:

Nausea	Yeast
Heartburn	Vaginal Infections (other)
Fatigue	Group B Strep
Urinary Tract Infections	Cervical Surgery
Herpes	Syphilis
Gonorrhea	Chlamydia
Pelvis Infections	Abortion
Fibroid	Uterine Surgery
Breast Surgery	Ovarian Cysts
HIV/AIDS	STD (other)
Headache	Vomiting
Abdominal Pain	Vaginal Bleeding
Fever	Depression
Constipation	Vaginal discharge
Other	Other

Gynecological History

Age of first period cycle_____ Cycle length_____ Are your cycles regular? Yes No
Do you have pain during menstruation? Yes No
When was your last clinical breast exam?_____
When was your last PAP smear?_____ Have you ever had an abnormal PAP? Yes No

Have you been pregnant before? Yes No How many pregnancies have you had?
Have you ever had a miscarriage? Yes No If yes, when? _____
Have you had a C-Section? Yes No If yes, when_____
Have you had a VBAC? Yes No If yes, when _____
How many babies did your mother have?_____ Vaginal or C-Section?_____

# Pregnancy and Date of Pregnancy	Length of Gestation	Length of Labor	Male or Female Single or Twin	Comments on Pregnancy

Sexual History

Do you have pain with intercourse? Yes No

How many sexual partners have you had?_____

Are you in a monogamous relationship? Yes No

Has your partner had previous sexual relationships or current ones other than you?

What is your activity level?_____

Tell me about your nutrition:_____

_____

_____

_____

_____

_____

Do you have any allergies to medications? Yes No If yes, please list_____
Do you have any allergies to latex? Yes No

Are you taking any medications? Yes No
If yes, please list the medication, the dosage and the reason for each medication: _____

_____

_____

Are you currently taking any herbs ? Yes No If yes, please list: _____

_____

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

Tobacco	Herbs
Alcohol	Fumes or Sprays
Caffeine	X-ray
Ultrasound	Cocaine
Marijuana	Measles
Street Drugs	Vaccinations
Cats	Other

Is there anything about yourself you think I should know or that you would like me to know so that I might serve you and your family better?

Midwife Date Reviewed/Date