

Name: <i>First</i> <i>Middle</i> <i>Last</i>		Phone: Home - Work / Cell -
Address: <i>Street</i> <i>City</i> <i>Zip</i>		
Occupation:	Date of Birth:	Social Sec #:
Partner: <i>First</i> <i>Middle</i> <i>Last</i>		Phone: Home - Work / Cell -
Occupation:	Date of Birth:	Social Sec #:
Method of Payment: <i>Insurance</i> <i>Cash</i>	Insurance Co:	Group #: Policy #:

Previous Pregnancies <i>Please complete this table regarding your own pregnancy history (from earliest to most recent).</i> <i>* Outcome refers to birth (cesarean or vaginal), miscarriage, or termination of pregnancy</i>						
Date	# Wks	Outcome * / Name	Labor Length	Weight	How did labor begin?	Breastfed? How Long?

How would you describe your previous birth experiences?

Is there anything about your past pregnancies / births that you WOULD like repeated?

- that you would NOT like repeated?

Please describe your feelings about this pregnancy and upcoming birth:

How does your partner feel about this pregnancy and birth?

Medical History

- | | | | |
|---------------------|--------------------------|------------------------------|----------------------------|
| 1. Severe headaches | 11. Stomach problems | 21. Blood clotting problems | 31. Seizures |
| 2. Vision problems | 12. Ulcers | 22. Bowel problems / colitis | 32. Cancer * |
| 3. Hearing problems | 13. Chicken pox | 23. High blood pressure * | 33. Hospitalizations |
| 4. Dental problems | 14. Hepatitis | 24. Hemorrhoids | 34. Surgeries |
| 5. Anemia | 15. Liver problems | 25. Blood in stool | 35. Multiple pregnancies * |
| 6. Hemorrhage | 16. Diabetes * | 26. Gall bladder problems | 36. Birth defects * |
| 7. Varicose veins * | 17. Bladder infection(s) | 27. Kidney infection(s) | 37. Severe depression * |
| 8. Tuberculosis | 18. Hypoglycemia | 28. Urinary surgery | 38. Other |
| 9. Asthma | 19. Thyroid problems | 29. Aching joints | |
| 10. Skin disorders | 20. Rheumatic Fever | 30. Pelvis / back injuries | |

Please indicate, using the above numbers, if you have ever had any of these and when:

Please indicate if anyone in your immediate family has ever had any of the starred (*) conditions above and when:

Father of Baby - Please indicate if the baby's father has or has ever had any of the following and when:

- | | | |
|-------------------------------------|------------------------------|-------------------------|
| 1. Sexually transmitted disease(s) | 2. Severe emotional problems | 3. Alcohol / drug abuse |
| 4. Tobacco use | 5. Hepatitis | 6. Tuberculosis |
| 7. Birth defects (immediate family) | | |

Gynecological History

Age at first period: Cycle length (days): Regular? Yes No Sometimes Duration of bleeding:

Last Pap smear: Have you ever had an abnormal Pap? Dates of Abnl Pap:

- | | | | |
|---------------------------|--------------------|-----------------------|-------------------------------------|
| 1. Yeast infection | 2. Trichomonas | 3. Group B Strep | 4. Chlamydia / Gonorrhea / Syphilis |
| 5. Bacterial Vaginosis | 6. Cervicitis | 7. Cervical Surgery | 8. Cervical polyp |
| 9. Ovarian cyst | 10. Fibroids | 11. Endometriosis | 12. Genital sores |
| 13. Herpes (oral/genital) | 14. Genital warts | 15. Abnormal bleeding | 16. Uterine surgery |
| 17. Breast lump(s) | 18. Breast surgery | 19. Infertility | |

Please indicate if you have ever had any of the following, and when:

Current Pregnancy Information

First day of last menstrual period: Was period normal? Yes No If no, explain:

Suspected date of conception: Date of positive preg test: Planned pregnancy? Yes No

If you are Rh-, have you received Rhogam with this pregnancy? Yes No If yes, when:

Please circle any of the following conditions you have experienced during this pregnancy:

Nausea	Vomiting	Fever	Headache	Vaginal Infection	Leg Cramps	Backache
Constipation	Swelling	Diarrhea	Rash	Bleeding Gums	Depression	Anxiety
Varicose Veins	Hemorrhoids	Bleeding	Work problems	Family problems	Abdominal Pain	

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

Tobacco	Alcohol	Caffeine	Fumes / sprays	Marijuana	Cocaine	Street Drugs
X-Rays	Ultrasound	Travel	Measles / Virus	Vaccinations	Cats	Medications

Some of the following questions are of a deep and personal nature and it may be difficult to share your response to them. They are optional. We feel your responses will enable us to better meet your physical and emotional needs during your pregnancy, birth and postpartum. Please feel free to voice any concerns you may have about these questions, or any feelings they make invoke. In addition, if there are any responses that you would NOT want discussed in front of your current partner, please let us know. Thank you!

Describe your current diet (vegan, vegetarian, omnivorous):

In your opinion, is your diet good, mediocre, or poor? Why?

Do you have an opportunity to rest or nap each day?

Do you sleep well at night?

Are you doing any special exercise, meditation, or yoga?

How do you feel about your sexual relationship since becoming pregnant?

Do you have any concerns about your relationship with your partner?

How do you feel about weight gain during pregnancy?

What childbirth related books have you read?

Describe your healthcare in the past five years. Do you use naturopathic physicians, chiropractors, acupuncturists, MDs, etc.?

Describe your occupation, how it affects your pregnancy, how long you plan to work, and if/when you plan to return to work postpartum:

How do you envision your ideal birth scenario? What sort of factors are important?

Do you trust your body to give birth?

Do you have any strong concerns about this pregnancy and birth?

Describe your personal strengths:

- Your personal weaknesses:

What increases your strength / courage?

What diminishes your strength / courage?

What are your concerns about birth and mothering?

What are your hopes about birth and mothering?

Have you ever felt unsafe in your home for any reason? Yes No

Has a partner ever threatened to hit you? Yes No

Have you ever undergone any personal, emotional, physical, or sexual abuse in your life? Yes No

Have you ever been on medication for emotional / psychological disorders? Yes No

Have you ever been forced to have sex without your consent? Yes No

Has anyone ever told you, or do you think, that you have an eating disorder? Yes No

Has anyone ever told you, or do you think, that you have ever used drugs or alcohol excessively? Yes No

If your parents are living, what is your relationship with them now?

What are your family's thoughts on your pregnancy and birth plans?