Please complete prior to your first appointment.

date. _____

DEMOGRAPHICS.
name. _____ birth date. _____ age. ____ social security #. _____
address. _____ city. _____ state. ___ zip. _____
mobile #. _____ home #. _____
email. _____
race/ethnicity: _____ primary language. _____

marital status: married. partnered. single. widowed.
spouse/partner name. _____ spouse/partner #. _____

emergency contact person. _____ emergency contact phone #. _____

employer. _____ type of work. _____
work #. _____

primary insurance. _____ billing address. _____
phone #. _____ policy #. _____ group #. _____
policy holders name. _____ dob. _____
secondary insurance. _____ billing address. _____
phone #. _____ policy #. _____ group #. _____
policy holders name. _____ dob. _____

authorization to provide medical information via phone #_____ email_____
signature. _____

What brought you to the birth center?

How did you find out about us? Friend/Referral Google Other: _____

CLIENT HISTORY.
Thank you for taking the time to complete our paperwork. We acknowledge that it will take a bit of time - so sit down, pour yourself a cup of tea, and pull out your favorite pen! The information you provide will help us get to know you and individualize your care.

PREGNANCY.
How are you feeling about this pregnancy?

Was this pregnancy planned? Yes No

What are your hopes for this pregnancy?

What are your biggest fears about pregnancy, birth, and parenting?

Do you have any cultural/religious beliefs about pregnancy/birth that you want supported?

Who is the father of the baby? _____ Age. ____
Occupation. _____
Do you live together? Yes No For how long? _____
Level of involvement in the pregnancy: Very. Somewhat. Not at all.
Does your partner have any other children? Yes _____ No

How do you feel about your relationship?

How does your partner feel about this pregnancy?

Does your partner have genital herpes? Yes No

SOCIAL HISTORY.
Your level of education: High School. Some College. Associate's Degree.
Bachelor's Degree. Master's Degree. Doctoral Degree.

What is your occupation? If you are now staying home with your children, what work did you do previously?

How much do you work? Full Time. Part Time. Days. Nights.

Do you plan to return to work or school after your baby is born? Yes No
When? _____ How many hours per week? _____

Who can you count on for support during your pregnancy, labor, birth, and postpartum?
Partner. Family. Friends. School. Co-Workers. Neighbors.

Do you feel connected to/supported by your community? Yes No

Are you planning to take childbirth preparation classes, or have you previously taken any?
Yes, I have taken or plan to take the following class: _____
My partner will attend/has attended classes with me: Yes No

What kind of relationship do you have?
____ Long-term relationship with one partner.
____ More than one partner in past year.
____ No current partner.

How safe do you feel in your home?
____ Very safe. No concerns with domestic violence.
____ Safe now, but have had concerns with domestic violence in the past.
____ I do not feel safe at home.

Have you ever or are you currently feeling abused physically, emotionally, sexually, or financially?
____ Never. ___
____ I have felt abused in the past but not currently.
____ Yes, I am currently feeling abused.

ACTIVITY. REST.
How often do you exercise? None. Daily. 3-5 d/week. 1-2 d/week.
Do you have any physical limitations? Yes No
What types of exercise do you enjoy? _____
How hours of sleep do you get per night? 4. 5. 6. 7. 8. 9. 10.
Do you have any trouble sleeping? Yes No
If yes, please elaborate:

CAFFEINE. ALCOHOL. DRUGS.
How many 8 oz. servings of caffeine do you drink per day?
None. 1. 2. 3. 4.
What kind? Coffee. Tea.

How many alcoholic drinks have you had per week over the past 3 months?
None. 1. 2. 3. 4. 5. 6.
What kind? Wine. Beer. Liquor.

Has anyone close to you complained about your drinking in the past year? Yes No
Do the drinking habits of anyone in your household worry you? Yes No

Have you ever smoked?
___ Never
___ In past. When did you quit and how much did you smoke? _____
___ Currently. How many cigarettes per day? ____ Do you want to quit? Yes No

Have you ever used the following drugs: marijuana, cocaine, LSD, heroine, methamphetamines, ecstasy?
___ Never.
___ In past. What type and how much/how often? _____
___ Currently. What type and how much/how often? _____

Does anyone in your household use drugs?
____ No.
____ Yes. What ype and how much/how often?_____

Do you take prescription pain medications?
____ No.
____ Yes. What type and how much/how often? _____

RESOURCE/NEEDS ASSESSMENT.
What type of housing do you currently live in? Home. Apartment/Condo. Trailer
Do you feel it is adequate for your needs? Yes No

Do you receive food program assistance (WIC or food stamps)? Yes No

How often do you use a seatbelt when driving? Always. Often. Never.

Do you have difficulty with reading, seeing, hearing, or following instructions? Yes No

Do you have other needs you need help with? Yes No If yes, please elaborate:

NUTRITIONAL HISTORY.
Do you follow any special diet? Vegetarian. Vegan. Gluten Free. Paleo.
Other: Please specify _____
Do you have any food allergies or intolerances? Yes No
Please specify _____
How many times do you eat per day? Meals_____ Snacks _____
How many servings of protein per day? 0. 1. 2. 3. 4.
What types of protein? Meat. Eggs. Beans. Tofu. Nuts.

How many servings of vegetables per day? 0. 1. 2. 3. 4.
How many servings of fruit per day? 0. 1. 2. 3. 4.
How many servings of grains per day? 0. 1. 2. 3. 4.
How many servings of dairy products per day? 0. 1. 2. 3. 4.
How many sweets per day? 0. 1. 2. 3. 4.
How many liters of fluids do you drink per day? 1. 2. 3. 4. 5. 6.

Have you eaten or had cravings for any of the following: dirt/clay, laundry starch, corn starch, baking soda, plaster, refrigerator ice? Yes No

GYNECOLOGICAL HISTORY.
When was your last menstrual period? _____
This date is: Certain. Week Known. Guess.
That period was: Normal. Lighter. Earlier. Later.
Do you know when you conceived? _____
When did you get a positive Home Pregnancy Test? _____

Tell us about your typical menstrual pattern:
How old were you got your first period? _____
How regular are your cycles? <28 d. 28-30 d. >30 d. Irregular.
Duration of flow? 2-3 d. 3-5 d. 5-7 d.
Amount? Heavy. Normal. Light.
Character? Painless. Clots. Cramping. Other: _____
Do you experience PMS symptoms? Yes No
If yes, describe _____

Who do you have sex with? Men only. Men and Women. Women only.

Are you satisfied with sex? Yes No: elaborate _____

Do you experience any pain with sex? Yes No

When was the date of your last pap? _____ Was it normal? Yes No

If age > 40, have you had a baseline mammogram? Yes No

PREGNANCY HISTORY.
Total Pregnancies (including current): ____ Full Term Births: ____ Preterm Births: ____
Twin Births: ____ Ectopic Pregnancies: ____ Miscarriages: ____
Therapeutic or Induced Abortions: ____ Living Children: ____

List All Pregnancies from first to last, including miscarriages or abortions.

Date	# Weeks	Type of Birth	Gender	Hours of Labor	Weight	Place of Birth	Pain Mgmt	Child's Name

Were you happy with your birth experience(s)?

Did you have any complications with any pregnancy, birth, or postpartum? Yes No
If yes, please elaborate:

Did any of your babies have any problems after birth, and do any of them have health issues now? Yes or No
If yes, please elaborate:

How do you plan to feed your baby? Breast. Bottle. Both.
If breastfeeding, for how long? 3-6 mo. 6-9 mo. 9-12 mo. >12 mo.
If you have breastfed before, did you experience any problems?

CONTRACEPTION. What birth control have you used in the past? For how long? Were you satisfied with the method?
___Oral Contraceptives _____
___Condoms _____
___Withdrawal_____
___Natural Family Planning _____

___ ParaGard_____
___ Mirena/Skyla_____
___ Diaphragm/Cervical Cap_____
___ DepoProvera _____
___ NuvaRing _____
___ Nexplanon/Implanon _____

GYNECOLOGIC DISORDERS.

Note the date(s) that you had any of the following.

____ I Have No History of Gynecological Problems
____ Abnormal Mammogram _____
____ Abnormal Paps _____
____ Cryo / LEEP / Conization of the Cervix _____
____ Endometriosis _____
____ Fibroids _____
____ Genital Warts _____
____ Genital Herpes _____
____ Gonorrhea or Chlamydia _____
____ Infertility _____
____ Ovarian Cysts _____
____ Pelvic Inflammatory Disease _____
____ Trichomoniasis or Syphilis _____
____ Uterine Abnormalitis_____
____Vaginal Infections: Yeast, Bacterial Vaginosis _____
____ Other_____

MEDICAL HISTORY.

Height _____ Pre-pregnancy Weight _____

Date of last Tetanus/Diptheria/Pertussis (TDAP) booster: _____

Date of last Flu shot: _____

Did you have Chicken Pox as a child or have you received the vaccine? Yes No

Do you have cats? Yes No If yes, do you change the litter box? Yes No

When was your last visit to the dentist? _____

Have you had any viral illnesses or fevers since becoming pregnant? Yes No
If yes, please elaborate:

ALLERGIES. Please list any allergies you have (medications, iodine, shellfish, tape, and seasonal allergies) and the reaction.

____ I Have No Known Drug Allergies

_____

_____

PERSONAL HISTORY. Please indicate dates of applicable items.

____ I Have No Personal History of Medical Problems
____ Anemia_____
____ Anxiety/Depression/Mental Illness _____
____ Postpartum Anxiety/Depression_____
____ Autoimmune Disorders: Lupus, MS _____
____ Bleeding Disorders_____
____ Blood Clots _____
____ Cancer_____
____ Diabetes: Type 1, 2, or Gestational _____
____ Eating Disorder: Anorexia, Bulimia _____
____ Headaches/Migraines_____
____ Heart Disease _____
____ High Blood Pressure: Chronic or in Pregnancy _____
____ Intestinal Disease: Crohns, IBS _____
____ Kidney or Bladder Infections _____
____ Liver Disease: Hepatitis _____
____ Lung Disease: Asthma, Tuberculosis, Pneumonia _____
____ Periodontal Disease _____
____ Rh negative blood type_____
____ Seizures_____
____ Thyroid Dysfunction_____
____ Varicose Veins _____
____ Other _____

SUPPLEMENTS. HERBS.

Please list all supplements/herbs you are taking, brand and dosage.

____ I am not taking any supplements or herbs

_____

_____

_____

MEDICATIONS.

Please list all medications / dosage / reason and for how long you have been taking.

____ I am not taking any medications

_____

_____

_____

HOSPITALIZATION AND SURGICAL HISTORY.
List all past hospitalizations/surgeries other than childbirth: Dates, Reason, Complications
____ I have not had any past hospitalizations or surgeries
_____
_____
_____

Have you ever had any complications with anesthesia? Yes No
If yes, please list. _____

Have you ever received a blood transfusion? Yes No
If yes, when and why? _____

In the event of an emergency would you accept blood products? Yes No

Do you have an Advanced Directive on file? Yes No

Do you have a Power of Attorney on file? Yes No

FAMILY MEDICAL HISTORY.
Mother: Living ____ How is her health?:_____
Deceased ____ Age and cause of death: _____
Father: Living ____ How is his health?:_____
Deceased ____ Age and cause of death: _____
Number of Sisters? Living____ How is their health? _____
Deceased____ Age and cause of death: _____
Number of Brothers? Living ____ How is their health? _____
Deceased ____ Age and cause of death: _____

Does anyone in **your family** have a history of the following? List relation.
____ No Family History of Medical Problems
____ Cancer_____
____ Anxiety/Depression/Mental Illness_____
____ Diabetes_____
____ Heart Disease_____
____ High Blood Pressure_____
____ Hepatitis/ Liver Disease_____
____ Kidney Disease _____
____Thyroid Disease_____
____Other:_____

HEREDITARY BREAST AND OVARIAN CANCER SCREEN.

1. You or a family member (mother or fathers side) were diagnosed with breast cancer at age 50 or younger. Yes No
2. You or a family member were diagnosed with ovarian cancer at any age. Yes No
3. Male family member with breast cancer at any age. Yes No
4. Ashkenazi Jewish ancestry and a personal or family history of breast or ovarian cancer at any age. Yes No
5. There are two breast cancers in the same person or two family members with breast cancer on the same side of the family, one under age 50. Yes No
6. Family member were diagnosed with triple negative breast cancer at any age. Yes No
7. There is a pancreatic cancer and a breast or ovarian cancer in the same person or on the same side of the family at any age. Yes No
8. There are three family members with breast cancer in the same side of the family. Yes No
9. You have a previously identified BRCA1 or BRCA2 mutation in your family. Yes No

Does anyone in **your family or the father of the baby's family** have any of the following? List relation.

____ Negative Family and Father of Child Family History
____ Down's Syndrome _____
____ Turner's Syndrome _____
____ Tay Sachs _____
____ Canavan _____
____ Congenital Heart Defects _____
____ Muscular Dystrophy _____
____ Cystic Fibrosis _____
____ Sickle Cell Trait _____
____ Hemophilia _____
____ Neural Tube Defects _____
____ Mental Deficits _____
____ Born prior to 37 weeks gestation _____
____ Other genetic or chromosomal disorder? _____

CURRENT HEATLH. CONCERNS.

Consider how you are feeling TODAY. If you are not experiencing any of the symptoms below, please initial the negative box.

General: _____
Neg = no recent change in health or weight, fever, headaches, fatigue, weakness. ____
HEENT: _____
Neg = no vision changes, hearing loss, allergies, nosebleeds, sore throat. ____
Breast: _____
Neg = no breast lump or pain, tenderness, nipple discharge. ____
Cardiac: _____
Neg = no chest pain, palpitations, varicose veins. ____

Respiratory: _____
Neg = Denies chronic cough, coughing up blood, shortness of breath. ____
Gastrointestinal:_____
Neg= Denies heartburn, nausea/vomiting, constipation, abdominal or pelvic pain. ____
Genitourinary:_____
Neg = Denies painful urination, vaginal bleeding or discharge, painful sex. ____
Musculoskeletal:_____
Neg= Denies joint swelling, muscle pain, leg pain or cramping, swelling, back pain. ____
Integumentary:_____
Neg= Denies skin rash or itching, dry skin, moles, change in skin color. ____
Neurological:_____
Neg= Denies dizziness, light headed, seizures, numbness, paralysis, vision changes. ____
Psychiatric: _____
Neg= Denies anxiety, depression, memory loss, difficulty sleeping. ____
Endocrine: _____
Neg = Denies excess thirst or urination, heat or cold intolerance. ____
Hematologic/ Lymphatic:_____
Neg= Denies bleeding or bruising tendency, anemia, enlarged glands. ____

PRIMARY CARE. ALTERNATIVE THERAPIES.
Who is your primary care physician? _____ phone #_____
When was your last physical exam? _____
Who is your children's pediatrician? N/A or _____
Acupuncturist _____
Chiropractor _____
Massage Therapist _____
Physical Therapist _____
Psychotherapist _____

SIGNATURE.
My signature confirms that the information provided is correct as far as I know.

Signature: _____ Date: _____

Thank you for taking the time to share with us your history.

Client History Reviewed by: _____ Date: _____