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.

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.

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. Soda.

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. No.

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 per day?
Vegetables: 0. 1. 2. 3. 4.
Fruit: 0. 1. 2. 3. 4.
Grains: 0. 1. 2. 3. 4.
Dairy: 0. 1. 2. 3. 4.
Sweets: 0. 1. 2. 3. 4.
Liters of Fluids: 1. 2. 3. 4. 5. 6.

GYNECOLOGICAL HISTORY.
When was your last menstrual period? _____________
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 N/A

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 ____

PREGNANCY HISTORY.

Total Pregnancies (including current): ____ Full Term Births: ____ Preterm Births: ____
Twin/Multiple 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

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____________________

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

____ I Have No Known Drug Allergies

____

____

MEDICAL HISTORY.

Height ________ Weight _________

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

Date of last Flu shot: __________

When was your last visit to the dentist? _________

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

CURRENT HEALTH CONCERNS. REVIEW OF SYSTEMS.

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

General: ____
Negative= no recent change in health or weight, fever, headaches, fatigue, weakness. ____
HEENT: ____
Negative= no vision changes, hearing loss, allergies, nosebleeds, sore throat. ____
Breast: ____
Negative= no breast lump or pain, tenderness, nipple discharge. ____
Cardiac: ____
Negative= no chest pain, palpitations, varicose veins. ____
Respiratory: ____
Negative= Denies chronic cough, coughing up blood, shortness of breath. ____
Gastrointestinal:____
Negative= Denies heartburn, nausea/vomiting, constipation, abdominal or pelvic pain. ____
Genitourinary:____
Negative= Denies painful urination, vaginal bleeding or discharge, painful sex. ____
Musculoskeletal:____
Negative= Denies joint swelling, muscle pain, leg pain or cramping, swelling, back pain. ___
Integumentary:____
Negative= Denies skin rash or itching, dry skin, moles, change in skin color. ____
Neurological:____
Negative= Denies dizziness, light headed, seizures, numbness, paralysis, vision changes. ___
Psychiatric: ____
Negative= Denies anxiety, depression, memory loss, difficulty sleeping. ____
Endocrine: ____
Negative= Denies excess thirst or urination, heat or cold intolerance. ____
Hematologic/ Lymphatic:____
Negative= 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: _____________

Release of Records completed for: ______________________________________