Please complete prior to your first appointment.

Date ____________

DEMOGRAPHICS.

NAME
First _____________ Middle ____________ Maiden _________________ Last _________________
Birth date ________ Age ____
Address _________________________________ City _____________ State ___ Zip _________
Mobile # _____________________ Home # _____________________
Email ________________________________

Race/ethnicity ________________________________
Primary language _____________________________
Marital status: Married. Partnered. Single. Widowed

Spouse/partner name _______________ Spouse/partner # ____________________________

Identified gender and pronoun _______

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_____________
Authorization to provide medical information to ______________________________________

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. The information you provide will help us get to know you and personalize your care.

Height _____
Pre-pregnancy weight _____

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 co-parent 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?

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?
____ New relationship
____ 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.

1 in 3 women have been sexually assaulted in their lifetimes. These traumas can impact how we feel about pregnancy and influence our labor and birthing process in unexpected ways. If you have experienced sexual assault, are you interested in a recommendation for a therapist? Yes No

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? _________________
How many cigarettes per day? ____ Do you want to quit? Yes No

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

Does anyone in your household use drugs? ____ No____ Yes

What type 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?
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 ______

Protein recommendation during pregnancy is 60-100 grams. Please do a 3 day diet recall to calculate protein intake.

Do you feel like you eat a well balanced diet? Yes No

Recommendation for adequate fluid intake is 4-6 liters per day.
How many liters of fluid do you drink a day? _____

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

We will review your BMI and diet recommendations and weight gain goals at your appointment.
Low BMI: 28-40 pound weight gain
Normal BMI: 25-35 pounds weight gain
High BMI: 15-25 pounds weight gain

GYNECOLOGICAL HISTORY.
When was the first day of 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? ____________

How old were you got your first period? _____

How regular are your cycles? <28 days. 28-30 days. >30 days. Irregular.
Duration of flow? 2-3 days. 3-5 days. 5-7 days.
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
Please complete a release of records for your last pap for our records.

If age > 40, have you had a baseline mammogram or thermogram? Yes No
Have you received the Gardasil vaccine? Yes No

PREGNANCY HISTORY.
Tell us more about this pregnancy, specifically conception:
___ Intercourse ___ IUI ___IVF ___ Surrogacy
___ Embryo Transfer ___ Donor Egg ___ My Egg
___ Partner Sperm ___ Donor Sperm

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 BIRTH	GENDER	HOURS OF LABOR	WEIGHT	PLACE OF BIRTH	PAIN	CHILD'S NAME

Were you happy with your birth experience(s)?

Did you have any complications with any pregnancy, birth, or postpartum? If yes, please elaborate:

Did any of your babies have any problems after birth, and do any of them have health issues now? If yes, please elaborate:

How do you plan to feed your baby? Breast. Bottle. Both.
If breastfeeding, for how long? 3-6 months. 6-9 months. 9-12 months. >12 months.

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?
N/A: same sex relationship _____
Oral Contraceptives____
Condoms ____
Withdrawal____
Natural Family Planning ____
ParaGard____
Mirena/Skyla/Kylee____
Diaphragm/Cervical Cap____
DepoProvera ____
NuvaRing ____
Nexplanon/Implanon ____
Vasectomy ____

GYNECOLOGIC DISORDERS.
Note the date(s) that you had any of the following.
____ I Have No History of Gynecological Problems

Abnormal Mammogram/ Breast US ____

Abnormal Paps ____
Cryo / LEEP / Conization of the Cervix _____________________________________
Endometriosis ____
Fibroids ____
Genital Warts ____
Genital Herpes ____
Does your current partner HSV 2? Yes No
Gonorrhea or Chlamydia ____
Infertility ____
Ovarian Cysts ____
Pelvic Inflammatory Disease ____
Trichomoniasis or Syphilis ____
Uterine Abnormal ____
Vaginal Infections: Yeast, Bacterial Vaginosis _____________________________
Other____

MEDICAL HISTORY.
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:

Have you traveled internationally in the past 6 months? Yes No If so, where?

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 ______________________________
Mental Illness ____
Periodontal Disease ____
Rh negative blood type____
Seizures____
Thyroid Dysfunction____
Varicose Veins ____
Other ____
No history of medical problems ______

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
Would you like more information on Advanced Directives and/or Power of Attorney? 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:____

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? _____________________________________

HEREDITARY BREAST AND OVARIAN CANCER SCREEN.

Please complete the riscover cancer compass questionnaire (attached).

CURRENT HEATLH. CONCERNS.

Consider how you are feeling TODAY. If you are not experiencing any of the symptoms below, please initial.
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 ____
Other Practitioner ____

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.
Please remember to complete a release of records if needed.
Please review our consents prior to your first appointment.

Client History Reviewed by: _______________________ Date: _____________