Health History

ID# Date of initial Hx Updated (Date & Initial) Blood Type

Mother's Full Legal Name Including Maiden	Social Security #	DOB	Place of Birth
Father's Full Legal Name	Social Security #	DOB	Place of Birth
Address	Inside City Limits	Marital Status	Home #
City, State, Zip, & County	(F) Occupation	(M) Occupation	Cell #
Spiritual/Religious Affiliation as a Child	(F) Formal Education	(M) Education	Work#
Current Spiritual/Religious Affiliation	(F) Race	(M) Race	Email

Did you grow up in your birth family	How did you hear about me	Do you want a SS # for the baby

Emergency contact name, address, phone # _____

_____

FAMILY HISTORY: Has the biological father, or any immediate relatives had any of these health conditions?

Key to codes: MM-maternal mother, MF-maternal father, MS-maternal sibling, MGM- maternal grandmother, MGF-maternal grandfather, MA/MU-maternal aunt/uncle; use P for paternal before each designation for the biological father

PROBLEM	NO	FATHER	RELATIVES	DETAILS
Heart/BP				
Anemia/Blood Disorders				
Lung Disease				
Seizures				
Genetic Disorders				
Kidney Disease or Renal Failure				
Cancer				
Diabetes (Early or late onset)				
Mental illness/Emotional problems				
Mental Retardation (Birth related?)				
Thyroid Disorders				
Mulitple Births (Twins)				

Further details if needed _____

_____

Personal Lifestyle & Habits

DO YOU OR YOUR PARTNER:	MOTHER	FATHER	WHEN & HOW OFTEN/COMMENTS:
Smoke			
Drink Alcohol			
Use medications (over-the-counter/prescription)			
Have a history of recreational drug use (IV?)			
Use chemicals or harmful substances at work or home			
Use or work with/near microwave ovens			
Use computers/radiation			
Get regular exercise			
Drink caffeinated/sugared beverages			
Have pets			
Type of diet (omnivore/ovo-lacto/vegan/macrobiotic/other)			

Personal Medical History

PROBLEM	NO	IF YES, DESCRIBE	PROBLEM	NO	IF YES, DESCRIBE
Heart Problems			High Blood Pressure		
Severe Headaches			Thyroid Disorder		
Seizures			Kidney Infections		
Auto Immune Disorder			Bladder Infections		
Metabolic Disorder			Group Beta Strep		
Asthma/Lung Disorder			Diabetes		
Eye/Vision Problems			Hypoglycemia		
Ear/Hearing Problems			Rheumatic Fever		
Dental Problems			Rubella		
Clotting Disorders			Chicken Pox		
Anemia			Neurological Disorder		
Hemorrhage			Mental illness		
Gall Bladder Problems			Emotional Problems		
Hepatitis/Liver Disorder			Insomnia/Sleep Difficulty		
Stomach Disorder			Varicose Veins		
Eating Disorder			Hemorrhoids		
Ulcer			Skin Disorders		
Bowel Disorder/Colitis			Pelvic/Back Injury		
Chronic Constipation			Blood Transfusions		
Cancer			Genetic Disorder		

Please list month & year of any other surgeries, hospitalizations, details, and/or conditions not listed_____

_____

_____

_____

Please list all medications; prescription, over-the-counter, vitamins and herbs that you are currently taking ____

_____

Please list all allergies to medications, pets, food, and environmental substances _____

_____

_____

Contraceptive History

METHOD	TYPE	WHEN AND HOW LONG	COMMENTS/PROBLEMS
Natural Family Planning			
Barrier Methods (Condom)			
Oral Contraceptives			
IUD			
Morning After Pill			
Other			

Has the pregnant mother or the father been exposed to any of the following?

PROBLEM	NO	MOTHER	FATHER	IF YES, DESCRIBE INCLUDING MONTH & YEAR
DES/steroid therapy				
Genital herpes				
Genital warts				
Chlamydia				
Gonorrhea				
Syphilis				
HIV				
Hepatitis				
Trichomonas				
Excessive X-rays/ultrasound				
Other				

MENSTRUAL HISTORY: Age of onset _____ Average length of cycle _____ days (from 1st day of bleeding to 1st day of bleeding) and flow lasts _____ days? Are your cycles regular _____ Are your periods painful Y N Is your flow light _____ medium _____ heavy _____ Any problems (i.e. clots)_____

YOUR MOTHER'S OB HISTORY: Total pregnancies _____ How many live births _____ Stillbirths _____ Abortions _____ Miscarriages _____ Multiple births_____ Did she take hormones in any of her pregnancies (estrogen, DES) _____ What were her labors like (how long/medications used/complications) _____

How many weeks gestation did she carry her babies _____

How big were her babies _____ Postpartum Depression Y N

Did she birth vaginally or by c-section _____ Home or Hospital Births _____

Did she breastfeed (how many children and how long) _____

Please describe your relationship with your mother _____

_____

YOUR SISTER(S) PREGNANCIES:

Sister(s) first names _____ Given birth _____ Breastfed Y N

Please briefly describe their births _____

_____

Any postpartum depression _____

_____

What attitudes towards birth are conveyed in your family of origin? _____

_____

What support/encouragement have you received about homebirth? _____

_____

Have you experienced any opposition to your plans for a homebirth? _____

_____

Gynecologic History

PROBLEM	NO	IF YES, DETAILS & DATE	PROBLEM	NO	IF YES, DETAILS & DATE
Vaginal yeast infection			Fibroids		
Bacterial vaginosis			Endometriosis		
Non-specific vaginosis			Uterine surgery		
Pelvic inflammatory disease			Breast lumps		
Abnormal vaginal bleedin			Breast cancer		
Cervicitis			Breast surgery		
Cervical polyp			PMS		
Cervical surgery			Postpartum depression		
Ovarian cyst			Other		

Additional details and conditions not listed _____

_____

When was your last Pap smear _____ Have you ever had an abnormal Pap _____

Have you ever experience painful intercourse _____

Do you ever have irregular bleeding or spotting _____

Do you leak urine _____ When exercising _____ When you cough or sneeze _____

Have you had more than one sexual partner ____Have you ever been forced to engage in sexual activity Y N

If so, how do you think that may impact your labor and birth _____

Please describe any difficulties with becoming pregnant, infertility, and any procedures/treatment you have received _____

_____

How would you describe your sexual/marital relationship _____

Has your sexual relationship changed since you became pregnant _____

_____

Do you have difficulty having an orgasm or have lack of desire for sex _____

_____

PSYCHOLOGICAL PROFILE: Please answer the following questions to help us discover if there are potential problems that we should discuss together (sometimes memories of sexual abuse can arise during pregnancy and childbirth). It is our desire to help you to enjoy your pregnancy, to protect you, and to make a plan with you that helps you to feel safe. This information will only be available to those directly involved in your care with your permission. It will not be shared with others and it will be kept confidential.

How do you handle emotional issues in your life?_____

_____

Have you ever been, or are you now, in a relationship in which you have been physically or emotionally threatened, insulted, beaten, injured, inappropriately touched, or made to take part in sexual activities against your will _____

_____

Would you like to talk about the above question or any aspect of your sexual life Y N

Have you experienced any difficult emotions in this pregnancy that you would like to discuss _____

_____

How do you feel about how your parents related to you as a child?

_____

_____

Was there domestic violence in your family (physical or emotional)?

_____

What are your intuitions about the pregnancy, birth, or the baby?

_____

_____

Are there any relationship issues or difficulties that you would like to discuss _____

_____

How often do you feel down, depressed, or hopeless?

_____ Always _____ Often _____ Sometimes _____ Never

How often have you had little interest or little pleasure in doing things?

_____ Always _____ Often _____ Sometimes _____ Never

Have you ever had postpartum depression (how severe, when, and how long it lasted) _____

_____

_____

EXERCISE HABITS

What type of activity/exercise are you currently doing and how often _____

_____

NUTRITION/DIET/EATING HABITS

What are your major sources of protein _____

How often do you drink soda pop, coffee, tea, or eat chocolate (caffeine) _____

_____

What are you currently drinking (water, teas, juice, ect.) and how much daily _____

_____

PRIOR PREGNANCIES

Please list the dates, week's gestation, and method of any abortions you have had _____

_____

Have you experienced any premature labor or birth? If so, when _____

_____

_____

Do you feel that you have unresolved feelings, concerns, or questions about any of your pregnancy losses

_____

_____

_____

QUESTIONS FOR DAD

Blood type _____ What was your birth weight _____How many siblings do you have & what number are you _____

Are you in favor of having a home birth _____

Do you have concerns regarding any previous pregnancies, birth, and the postpartum period_____

_____

Do you have any fears or concerns related to having a home birth _____

_____

Have you ever fathered a child with a congenital problem (please describe) _____

_____

What role(s) have you played in previous pregnancies, labor, births, and the postpartum time _____

_____

Would you like the option of being assisted in "catching" your baby _____

If your wife decides to have a water birth, have you discussed whether she would like you to be in the water with _____

her _____

Was there ever domestic violence in your parent's household (physical or emotional) _____

_____

How do you feel about how your parents related to you as a child _____

_____

Do you have any health problems that could impact homebirth (i.e. anxiety attacks) _____

_____

Do you have excessive stress in your life related to work or other issues _____

_____

Have you ever struggle with anger and/or violence and is there anything we can do to prepare you for this _____

_____

How do you handle emotional issues in your life _____

_____

Are there any relationship issues or difficulties that would be pertained for us to know in caring for your family _____

_____

What information have you been given regarding circumcision _____

How can we help you better protect and care for your wife during this pregnancy and birth _____

_____

Prior Pregnancies: Total _____ Live _____ Stillbirths _____ Abortions ____ Miscarriages_____Those ending ≥ 20 weeks _____

Birth Weight					
Length					
Your Weight Gain					
Pregnancy Complications **- anemia** **- bladder infections** **- bleeding/spotting** **- constipation** **- GBS+** **- hemorrhoids** **- high blood pressure** **- hyper emesis** **- toxemia** **-other**					
How did labor begin					
Hours of Labor					
How long did you push					
When & How did Water Break					
Your Birthing Position					
Any Complications during birth -- fetal distress **- hemorrhage** **- infection** **- meconium** **- neonatal resuscitation** **- stuck shoulders** **- other**					
Episiotomy/Tear/Stitches					
Medications/Herbs Used					
Forceps/Vacuum					
Vaginal/C-Section					
Placental Complications					
D & C					
Baby Jaundice					
Postpartum Infection					
Postpartum Depression					
Place of Birth					
Duration of Breastfeeding					
Other					

Comments _____

_____

Please describe any complications or trauma from past births _____

_____

Was there anything about your past births that you particularly liked/disliked _____

_____

Present Pregnancy

Date of first day of last menstrual period _____ was it normal _____

Date of conception if known _____ How did you confirm this pregnancy and when _____

Have you felt the baby move/when _____

Have you had any prenatal care and with whom _____

Is this pregnancy planned/desired _____

What are your feelings about the pregnancy _____

Are there any ethnic, cultural, or religious preferences I should know that will help me better meet your needs __

_____

What reading and preparation have you done so far _____

_____

Do you plan on breastfeeding _____

If you are currently employed, or attending school, what are your plans for after your baby's birth _____

_____

BIRTH PLANS

Have you or are you planning on attending childbirth preparation class _____

Who else do you plan on having present at you birth _____

_____

Will they be available to come to the 36-37 week home visit (strongly recommended) _____

Will your other children be present for the birth, how are you preparing them, and who will be caring for them during the birth _____

Start thinking about, and make a list of who can care for you and your household in the first 2 weeks postpartum

_____

Problems which may have arisen during the current pregnancy

PROBLEM	NO	WHEN & COMMENTS	PROBLEM	NO	WHEN & COMMENTS
Nausea/vomiting			Drug use		
Heartburn			Spotting/Bleeding		
Poor appetite			Colds/Virus Infection		
Bruising easily			Vaginal Infection/Herpes		
Bleeding gums			Kidney/Bladder Infection		
Backache			Abdominal Pain		
Muscle Cramps			Headaches		
Itching/Rashes			Dizziness		
Constipation			Blurred Vision		
Diarrhea			Swelling		
Hemorrhoids			Pigment Changes		
Vericose Veins			Insomnia		
Fainting/Black outs			Radiation/Ultra Sound		
Leg Cramps			Excessive Fatigue		
Sleeping Difficulties			Unusual Weight Gain		
Fever			Contractions/Cramping		
Depression			Major loss/Change		
Work Problems			Increased Stress		

Further details or conditions not listed _____

_____

_____

_____

Why are you choosing a traditional midwife and homebirth _____

_____

_____

How do you feel about transporting to the hospital if complications arise _____

_____

_____

What do you see as the duties or responsibilities of your midwife _____

_____

_____

What do you see as your duties and responsibilities _____

_____

_____