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Health History

Name		SSN		Phone (home)		(work/cell)	
Ethnicity	Spiritual Orientation	Yrs. Educ	Occupation	Date of Birth	Marital Status	Years Together	
Address/Zip Code				Place of Birth			
Husband/Partner		Ethnicity	Yrs Educ.	Date of Birth	Place of Birth		
Address (if different than above)			Occupation	Phone (work)	Phone (cell)		
Spiritual Orientation		Any children from previous relationship			SSN		
Referred by							

Please answer the following questions to aid us in determining if there are potential problems which should be discussed further. If you have any questions about what information is important please discuss with the midwife. This information is completely confidential.

FAMILY HISTORY- Indicate if anyone in your immediate family has ever had any of these conditions. If yes, indicate who and when.

FATHER OF BABY- Indicate if the father of the baby has ever had any of these conditions and when.

YOUR MOTHER'S HISTORY- Please answer the following regarding your mother.

- Heart/Lung/TB _____
- Cancer _____
- Diabetes _____
- Twins _____
- Severe emotional problems _____
- Bleeding disorders _____
- Other significant health problems _____

- Sexually transmitted diseases _____
- Genital Herpes _____
- Oral Herpes _____
- Alcohol/Drug Abuse _____
- Severe emotional problems _____
- Tobacco use _____
- Other significant health problems _____

- No. Of pregnancies _____
- No. of births _____
- No. of miscarriages _____
- Complications of pregnancies _____
- Your birth weight _____
- Did she take DES while pregnant with you? _____

PREVIOUS PREGNANCY OUTCOMES <i>Please complete this table regarding your own pregnancy (from earliest to latest)</i>			
DATE	No. of Weeks	OUTCOME (birth/miscarriage/termination)	Comments/Problems

- Yes No Do you or the FOB have family members with birth defects, mental retardation, or genetic/inherited medical conditions?
- Yes No Do you have a history of infertility, miscarriages, stillbirths, or serious pregnancy complications?
- Yes No Are you or the FOB from one of these ethnic groups – (circle) – Jewish Black/African Asian Mediterranean
- Yes No Have you or the FOB ever had hepatitis or jaundice?
- Yes No Have you ever used drugs intravenously (IV) or had a blood transfusion?
- Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?
- Yes No Have you ever experienced extreme fluctuations in your weight?
- Yes No Have you ever had anorexia, bulimia, or other eating/weight disorders?
- Yes No Have you ever been in an abusive relationship, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?
- Yes No Has your current partner ever intimidated, beaten, or otherwise abused you?
- Yes No Have you ever been on any medication for psychological problems?
- Yes No Have you ever used alcohol or drugs excessively?
- Yes No Have you ever been referred for counseling or treatment for drug or alcohol issues?

NAME _____

MEDICAL HISTORY - Please indicate if you have ever had any of these:

- | | |
|--|---|
| <input type="checkbox"/> Severe Headaches _____ | <input type="checkbox"/> Bowel problems/colitis _____ |
| <input type="checkbox"/> Eye/vision problems _____ | <input type="checkbox"/> Blood in stool _____ |
| <input type="checkbox"/> Ear/hearing problems _____ | <input type="checkbox"/> Gall bladder problems _____ |
| <input type="checkbox"/> Dental problems _____ | <input type="checkbox"/> Liver problems _____ |
| <input type="checkbox"/> Thyroid problems _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Blood clotting problems _____ | <input type="checkbox"/> Hypoglycemia _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Bladder infection _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Urinary surgery _____ |
| <input type="checkbox"/> Varicose veins _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Pelvic/back injuries _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Skin disorder _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Stomach disorders _____ | <input type="checkbox"/> Hospitalizations _____ |
| <input type="checkbox"/> Ulcers _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Other _____ |

Do you have any allergies? Yes No

Please list _____

GYNECOLOGIC HISTORY

Age at first period _____ Cycle length (days) _____

Duration _____ Regular? Yes No

When was your last Pap smear? _____

Have you ever had an abnormal Pap? (dates) _____

Please describe _____

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

- | | |
|--|--|
| <input type="checkbox"/> Yeast _____ | <input type="checkbox"/> HPV _____ |
| <input type="checkbox"/> Trichomonas _____ | <input type="checkbox"/> Cervical surgery _____ |
| <input type="checkbox"/> Group B strep _____ | <input type="checkbox"/> Cervical polyp _____ |
| <input type="checkbox"/> BV _____ | <input type="checkbox"/> Ovarian cyst _____ |
| <input type="checkbox"/> Chlamydia _____ | <input type="checkbox"/> Fibroids _____ |
| <input type="checkbox"/> Gonorrhea _____ | <input type="checkbox"/> Endometriosis _____ |
| <input type="checkbox"/> Syphilis _____ | <input type="checkbox"/> Abnormal bleeding _____ |
| <input type="checkbox"/> PID _____ | <input type="checkbox"/> Uterine surgery _____ |
| <input type="checkbox"/> Herpes _____ | <input type="checkbox"/> Breast surgery _____ |
| <input type="checkbox"/> Condyloma _____ | <input type="checkbox"/> Other _____ |

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? Yes No

Suspected date of conception _____

Pregnancy test (date) _____

Planned pregnancy Yes No

Feelings about pregnancy _____

Father's/Partner's feelings _____

Most recent birth control used _____

Contraception used in past: what, when, any problems?

Please indicate if you have ever had any of the following problems during this pregnancy:

- | | |
|--|--|
| <input type="checkbox"/> Nausea _____ | <input type="checkbox"/> Urinary complaints _____ |
| <input type="checkbox"/> Vomiting _____ | <input type="checkbox"/> Abdominal/pelvic pain _____ |
| <input type="checkbox"/> Fever _____ | <input type="checkbox"/> Vaginal bleeding/spotting _____ |
| <input type="checkbox"/> Infections _____ | <input type="checkbox"/> Vaginal discharge _____ |
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Bleeding gums _____ |
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Varicose veins _____ |
| <input type="checkbox"/> Indigestion _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Leg cramps _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Rash _____ | <input type="checkbox"/> Back ache _____ |
| <input type="checkbox"/> Swelling _____ | <input type="checkbox"/> Constipation _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Other _____ |

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

- | | |
|--|---|
| <input type="checkbox"/> Tobacco _____ | <input type="checkbox"/> Herbs _____ |
| <input type="checkbox"/> Caffeine _____ | <input type="checkbox"/> X rays _____ |
| <input type="checkbox"/> Marijuana _____ | <input type="checkbox"/> Ultrasound _____ |
| <input type="checkbox"/> Street drugs _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Other viruses _____ | <input type="checkbox"/> Vaccinations _____ |
| <input type="checkbox"/> Cats _____ | <input type="checkbox"/> OTC drugs _____ |
| <input type="checkbox"/> Vitamins _____ | <input type="checkbox"/> Other _____ |

Please explain your dietary habits/diet _____

Are there any particular cultural, ethnic, or religious preferences for your care that you would like to discuss with me? _____

