A Midwife for Better Birth

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CLIENT REGISTRATION

Today's Date_____
Name_____ Maiden Name_____
Age_____ Birthdate_____ Occupation_____

Home Phone_____ Work Phone_____ SS#_____
E-Mail Address_____
Address_____
Marital Status_____ Religion_____ Planned Pregnancy?_____
Father of the Baby_____ Occupation_____
Age_____ Birthdate_____ Work Phone_____ SS#_____
Address(if different)_____
Referred by_____
Emergency Contact_____ Phone_____
Insurance_____

Medical History

Is there any hereditary disease or condition in your family such as diabetes, cancer, heart disease, hypertension? Please list and indicate which relative:_____
_____
_____
Have you ever had surgery or been hospitalized for any reason? Please explain: _____
_____

Do you have or have you ever had. . . ?

__Severe headaches	__Anemia	__Kidney disease	__Hypertension
__Diabetes	__Epilepsy	__Heart disease	__Thyroid problems
__Asthma	__Hepatitis	__Liver disease	__Dental problems
__Tuberculosis	__Allergies	__Seizures	__Vision problems
__Hemorrhage	__Phlebitis	__Varicosities	__Hearing problems
__Ulcers	__Hypoglycemia	__Vaginal infections	__Endometriosis
__Blood clotting problems	__Breast lumps	__STDS	__Hemorrhoids
__Uterine infection	__Bowel problems	__Bladder infection	__Skin problems
__Gall bladder problems	__Genital herpes	__HIV/AIDS	__PMS
__Depression	__Postpartum Depression		__Baby Blues

Have you or the father of your baby ever had hepatitis, jaundice, blood transfusion or used IV drugs?_____
Do you think you are at risk (for any reason) for HIV/AIDS?_____
Are you aware of being sexually or physically abused as a child or as an adult? _____
Have you ever had or do you now have an eating disorder?_____
Do you smoke tobacco or marijuana?_____
Have you used alcohol during this pregnancy?_____
Are you currently taking any medications prescribed by a physician?_____
If so, what and what for?_____
Have you taken any over the counter medications during this pregnancy?_____
If so, what and when?_____
History of recreational drug use? If so, what and when?_____
Have you had a fever during this pregnancy?_____ When?_____ What was it?_____
Any nausea or vomiting during this pregnancy?_____
Have you had any bleeding or spotting during this pregnancy?_____
Have you had any symptoms of a urinary tract or bladder infection?_____

Menstrual History

When do you think you may have conceived?_____
How long is your menstrual cycle?_____
LMP-last menstrual period_____
Was it normal in length and heaviness of flow?_____
Did you have a pregnancy test?_____ Date_____
Were you using birth control when you conceived?_____
What kind?_____
How old were you when you began menstruating?_____
Any complications after miscarriage or abortion?_____
__Pain __Infection __Incomplete __Emotional trauma
If Rh negative, did you receive RhoGAM?_____

Obstetrical History

Total Pregnancies:_____
Full term:_____
Premature:_____
Abortion:_____
Ectopic:_____
Miscarriage:_____
Twins:_____
Cesarean section:_____
VBAC:_____

Birth History

Birthdate	# of weeks	Weight gain	Labor/Hrs.	BirthWt.	Girl/Boy	Birthplace	Meds/Complications

Gynecological/Contraceptive History

When was your last Pap smear? _____ Was it normal? _____
Have you ever had an abnormal Pap? If so, when? _____
Do you do self breast exam? _____
Have you ever used birth control? If so, what kind? Problems/complications? _____
_____
_____

Please check if you've ever had any of the following:

__Yeast infection
__Bacterial vaginosis
__Syphilis
__Genital herpes
__Cervicitis
__Ovarian Cyst
__Cervical polyp
__Breast surgery
__Trichomonas
__Gonorrhea
__Chlamydia
__PID
__Oral herpes
__Cervical surgery
__Fibroids
__Uterine surgery
__Abnormal bleeding
__Infertility
__Gardnerella
__GBS
__Genital Sores
__Condyloma (warts)
__HPV (human papilloma virus)
__Endometriosis
__Breast lumps
__Uterine surgery
__Other reproductive problems/conditions
__Body Piercings

Current Pregnancy

Have you received any prenatal care prior to this visit? _____ Lab work? _____
Please check if you've had any of the following conditions <u>during this pregnancy</u>:

__Nausea
__Dizziness
__Backache
__Urinary problems
__Vaginal discharge
__Vaginal bleeding/ spotting
__Vomiting
__Indigestion
__Swelling
__Abdominal/pelvic pain
__Relationship problems
__Varicose veins
__Fever
__Leg cramps
__Constipation
__Loneliness
__Hemorrhoids
__Work problems
__Headache
__Rash
__Diarrhea
__Bleeding gums
__Depression
__Family problems

Have you used or been exposed to any of the following <u>during this pregnancy</u>?

__Tobacco __Viruses __Herbs __Caffeine __Measles
__Vitamins __Alcohol __Cats __Non-prescription drugs
__Marijuana __Vaccinations __Prescription drugs __Cocaine
__Ultrasound __Fumes/sprays __Street drugs __X-rays
__Environmental Hazards

Diet Log

Please enter everything you have eaten for meals and snacks for the past three days. Also include what you have had to drink.

	Breakfast	Lunch	Dinner	Snacks	Fluids
Day 1					
Day 2					
Day 3					

Do you exercise on a regular basis? YES NO

What kind of exercise do you participate in regularly? _____
_____
_____

What are your favorite things to do in your free time? _____
_____
_____
_____