



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. . . ?

<input type="checkbox"/> Severe headaches	<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Seizures	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Varicosities	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Vaginal infections	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Blood clotting problems	<input type="checkbox"/> Breast lumps	<input type="checkbox"/> STDS	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Uterine infection	<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Bladder infection	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Gall bladder problems	<input type="checkbox"/> Genital herpes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> PMS

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Yeast infection | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Genital Sores |
| <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> PID | <input type="checkbox"/> Condyloma (warts) |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Oral herpes | <input type="checkbox"/> HPV (human papilloma virus) |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Cervical surgery | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Cervicitis | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Ovarian Cyst | <input type="checkbox"/> Uterine surgery | <input type="checkbox"/> Uterine surgery |
| <input type="checkbox"/> Cervical polyp | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Other reproductive problems/conditions |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Infertility | <input type="checkbox"/> Body Piercings |
| <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Gardnerella | |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> GBS | |

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 during this pregnancy:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Fever | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Swelling | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Abdominal/pelvic pain | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Vaginal bleeding/
spotting | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Work problems | <input type="checkbox"/> Family problems |

Have you used or been exposed to any of the following during this pregnancy?

- | | | | | |
|--|---------------------------------------|---|---|----------------------------------|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Viruses | <input type="checkbox"/> Herbs | <input type="checkbox"/> Caffeine | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Vitamins | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cats | <input type="checkbox"/> Non-prescription drugs | |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Prescription drugs | <input type="checkbox"/> Cocaine | |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Fumes/sprays | <input type="checkbox"/> Street drugs | <input type="checkbox"/> X-rays | |
| <input type="checkbox"/> 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? _____
