

History Form

Today's Date _____

Mother's Information: Drug Allergies _____ Blood Type _____
 Mother's Full Name _____
 Maiden Name _____ Date of Birth _____ Age _____
 Phone Number _____ Email _____
 Address _____ City _____ Zip _____
 Religion _____ Education _____
 Social Security# _____ State of Birth _____
 Employer _____ Phone number _____
 Marital status _____ Years married _____ Living Together yes no
 Closest Relative _____ Phone _____
 Emergency Contact _____ Phone _____
 Nearest hospital _____ 2nd choice hospital _____
 Health Insurance Provider _____

Father's Information: Social Security# _____ State of Birth _____
 Father's Full Name _____ Blood Type _____
 Date of Birth _____ Age _____ Phone Number _____
 Address (if different) _____ City _____ Zip _____
 Religion _____ Education _____
 Employer _____ Phone number _____

Medical Providers (if applicable):
 Obstetrician's Name _____ Phone _____
 Pediatrician Name _____ Phone _____
 Other Care Provider _____ Phone _____

Do you or anyone in your family have any of the following? Y/N	Menstrual History:	Have you ever had any of the following?
Congenital anomalies	Age of onset _____ years	<input type="checkbox"/> serious car accident
Genetic diseases	Are you regular? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> surgery or blood transfusion
Twins or other multiples	Average days in cycle _____	<input type="checkbox"/> rubella/German measles
Blood disorders	Average length of flow _____	<input type="checkbox"/> rheumatic fever
Epilepsy	<input type="checkbox"/> heavy <input type="checkbox"/> moderate <input type="checkbox"/> scant	<input type="checkbox"/> pneumonia
Diabetes	Painful? _____	<input type="checkbox"/> hepatitis <input type="checkbox"/> tuberculosis
Hypoglycemia	Contraceptive Use:	<input type="checkbox"/> gonorrhea <input type="checkbox"/> Chlamydia
Thyroid disorder	<input type="checkbox"/> hormonal contraceptives	<input type="checkbox"/> syphilis <input type="checkbox"/> HIV/AIDS
Kidney or bladder problems	when _____	<input type="checkbox"/> fibroids <input type="checkbox"/> D&C
Respiratory disorders	for how long? _____	<input type="checkbox"/> pelvic inflammatory disease
Asthma	<input type="checkbox"/> IUD when _____	<input type="checkbox"/> genital warts or herpes
Heart problems	for how long? _____	<input type="checkbox"/> cervical cone biopsy
High blood pressure	<input type="checkbox"/> morning after pill _____ times	<input type="checkbox"/> LEEP procedure
Varicosities/phlebitis	when? _____	<input type="checkbox"/> endometriosis
Arthritis	<input type="checkbox"/> condoms <input type="checkbox"/> spermicide	<input type="checkbox"/> abnormal PAP smear
Colitis	<input type="checkbox"/> cervical cap <input type="checkbox"/> diaphragm	<input type="checkbox"/> cystic ovaries
Allergies	<input type="checkbox"/> breastfeeding <input type="checkbox"/> femcap	<input type="checkbox"/> nervous system problem
Mental problems/depression	<input type="checkbox"/> NFP/FAM/sympto-thermal	<input type="checkbox"/> bulimia or anorexia
Liver disorders	<input type="checkbox"/> unplanned pregnancy	<input type="checkbox"/> severe headaches
	<input type="checkbox"/> planned pregnancy	<input type="checkbox"/> back problems
		<input type="checkbox"/> stomach/GI issues

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Previous Pregnancies					
Number					
Name					
Gender					
Date					
Gestation					
Weight/length					
Twins					
Miscarriage					
Abortion					
Home					
Unassisted					
Birth Center					
Hospital					
Pitocin					
Epidural					
Induced					
Other drugs					
Water broken					
Hours of labor					
Hours pushing					
Episiotomy/tear					
Cesarean					
Complications					
Doc/midwife					
Breastfed					
Living					

Dating this pregnancy		
First day of last period _____		
Was it normal _____		
Date of conception _____		
How sure _____		
Ultrasound _____ EDD _____		
Mother's childbearing history		
# of pregnancies		Average weight of her babies _____
# of births		Average length of her labors _____
# in hospital		Complications _____
# at home		Where does she live? _____
# of Cesareans		Attitude about homebirth _____
# breech		
# breastfed		
# preterm		
Why are you choosing home birth? (pick 2)		
<input type="checkbox"/> partner/social pressure	<input type="checkbox"/> safety	
<input type="checkbox"/> family unity	<input type="checkbox"/> atmosphere	
<input type="checkbox"/> effect on baby	<input type="checkbox"/> cost	
<input type="checkbox"/> dislike hospitals	<input type="checkbox"/> control	
<input type="checkbox"/> want natural birth	<input type="checkbox"/> high risk	

Current Health	
<input type="checkbox"/> omnivore (whole foods)	<input type="checkbox"/> junk/fast food
<input type="checkbox"/> vegan	<input type="checkbox"/> macrobiotic
<input type="checkbox"/> lacto-ovo vegetarian	<input type="checkbox"/> other
<input type="checkbox"/> smoker _____ packs/day	
<input type="checkbox"/> alcohol in this pregnancy, when _____	
<input type="checkbox"/> recreational drugs type/when _____	
<input type="checkbox"/> over the counter meds, type _____ How often _____	
Exercise: _____ days/week _____ days/month	
Types of exercise _____	
Herbs & supplements used _____	
How often _____	
How do you handle emotional issues in your life? _____	
Have you ever been sexually assaulted? <input type="checkbox"/> Y <input type="checkbox"/> N	
At what age? _____ by whom? _____	
How would you describe your relationship with your parents? _____	
Have you ever experienced domestic violence? <input type="checkbox"/> Y <input type="checkbox"/> N when? _____	
Are you aware of the possible effects of these experiences on the birth process? _____	

Have you ever had any of these issues during any pregnancy?	This pg	Pre-vious
Weight Gain		
Nausea/vomiting		
Constipation		
Hemorrhoids		
Gall/kidney stones		
Arthritis		
Edema		
Kidney/bladder infection		
Protein in urine		
Glucose (sugar) in urine		
Gestational diabetes		
Hypoglycemia (low blood sugar)		
Headaches		
Hypertension		
Pre-eclampsia (toxemia)		
Eclampsia		
Sciatica (shooting pain down legs)		
Anemia (low iron)		
Spotting or bleeding		
Vaginal infections		
Rh sensitization/blood incompatibility		
PUPPS		
Other		
Notes:		

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