Women's View Midwifery, LLP
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Name: _____Maiden:_____ Date of Birth: _____ Age: _____
Address:_____ Phone: (_____)-_____-_____
City: _____ State:_____ Zip Code: _____
Social Security # _____-_____-_____ Marital Status: Single Married Widowed Divorced Separated Civil Union
Race: _____Ethnicity: _____ Primary Care Physician: _____
Employer:_____ Phone Number/Ext:_____
Occupation:_____ _____ # hours worked/week:_____
Spouse/Significant Others Name:_____Phone:_____
Emergency Contact _____Phone: _____
Please List any medications you take regularly (name & dosage): _____
_____
Please list any allergies you have:_____

Social History
Do you consume caffeine? Y/N If yes, type?_____ amount/day?_____
Do you smoke tobacco? Y/N If *yes*, how much? _____ cigarettes/packs (circle one) per day
If *no*, are you a former smoker? ___Yes ___No If *yes*, when did you quit? _____
Do you drink alcohol? Y/N If yes, how many drinks per day: _____ per week: _____
Have you ever had a problem with alcoholism in the past? Y/N
Do you/have you used marijuana? Y/N If yes, When is the last time you used?_____
Do you/have you used any mind altering drugs? Y/N If yes, when is the last time you used? _____
Do you take any medication/street drugs that are not yours? Y/N If yes, what medication? _____
What is your highest level of education? _____
Do you exercise? ____Y/N (if yes, type, frequency & duration): _____
When was your last dental exam? _____

Menstrual History
First day of your last period (LMP) ___/___/___ Age at first period ____ # of days periods last ____
Days between periods:____Regular?____Cramps or Pain?___Are your periods:___Light___Medium___Heavy
If menopausal, age at which periods ended: _____ Have you ever taken hormones? Y/N
Date of last mammogram: ___/___/___ Have you ever taken fertility drugs? Y/N *If yes,* which?_____
Are you sexually active? Y/N *If yes*, what are you using for birth control?
_____Birth Control Pills: Brand? _____ _____IUD: Mirena/Paragard (circle one)
_____Tubes Tied _____Patch _____Condoms _____Depo Provera _____Diaphragm _____Foam
_____Rhythm _____Partner with Vasectomy _____None Other: _____

Have you ever been diagnosed with any of the following medical problems? Please check all that apply:

_____Breast Lumps	_____Breast Biopsy	_____**Chickenpox**	_____Asthma
_____Blood Clots	_____Anemia	_____Hemorrhage	_____Gallbladder Attacks
_____Stroke	_____Seizures	____Multiple Sclerosis	_____TB
_____Varicose Veins	_____Diabetes	_____Broken Bones	_____Unusual Hair Growth
_____Cystic Fibrosis	_____Cancer	_____Stomach Ulcers	_____Kidney Infection
_____Abnormal Pap	_____Anxiety	_____Depression	_____Eating Disorder
_____Incontinence	_____Recurrent UTIs	_____High Blood Pressure	_____Thyroid Dysfunction
_____Chlamydia	_____Gonorrhea	_____Syphilis	_____Herpes
_____HIV/AIDS	_____Hepatitis	_____Group B Strep	_____Vaginal Itching/Burning
_____Heart Problems	_____Hernia	_____Frequent Headaches	Other:_____

Surgical History

Have you ever had any of the following surgeries? Please check all that apply:

_____Tonsillectomy _____Laparoscopy _____Hysterectomy _____Surgery for Endometriosis ___Bladder Repair
_____Appendectomy _____C-Section _____Hemorrhoidectomy _____Gallbladder _____Tubal Ligation
_____Breast Surgery _____D&C _____Other: _____

Have you ever had a blood transfusion? _____ If yes, date(s): ___/___/___

Please list any hospitalizations OTHER than surgical or childbirth _____

Obstetrics History

# of pregnancies: _____ # of miscarriages: _____ # of abortions: _____ # of ectopic pregnancies: _____
# of children born alive: _____ # of premature births: _____ # of stillbirths: _____

If you had any miscarriages, how far along were you?

Date: ___/___ Duration of pregnancy: _____
Date: ___/___ Duration of pregnancy: _____

If you have had an abortion(s):

Date(s): ___/___ How far along were you?_____

If you delivered any babies prematurely, how far along were you?

Date: ___/___/___ Duration of pregnancy: _____

Have any of your children had birth defects of any kind? Describe fully: _____
_____

Have you ever had any pregnancy or labor complications? Describe fully: _____
_____

Summary of previous pregnancies:

Date MO/YR	Place of Delivery	Vaginal (V) Cesarean (C)	Weeks Gestation	Length of Labor	Sex M/F	Birth Weight	Comments

Which *childhood* immunizations have you received? Please check all that apply & year if known:

_____Tetanus _____Hepatitis _____MMR _____Polio _____Smallpox _____DPT _____**Varicella(Chickenpox)**

Which *adult* immunizations have you received? Please check all that apply:

_____Influenza _____ H1N1 _____Pneumonia _____Hepatitis ___TB Skin Test (PPD) ___HPV

Family History

Have your parents, grandparents, siblings, aunts or uncles ever had: please note (D) if deceased

_____Heart Trouble Relatives:_____
_____High Blood Pressure Relatives:_____
_____Diabetes Relatives:_____
_____Cancer (specify) Relatives:_____
_____Thyroid Issues Relatives:_____
_____Kidney Problems Relatives:_____
_____Hemophilia Relatives:_____
_____Birth Defects Relatives:_____
_____Mental Illness Relatives:_____
_____Alcohol/Drug Abuse Relatives:_____
_____Multiple Pregnancies Relatives:_____
_____HIV/AIDS Relatives:_____
_____Other: please list Diagnosis & Relatives:_____