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:_____

Obstetric Questionnaire: *Please fill out completely, if you have questions feel free to ask for assistance.*

Father of Baby:
Name_____Do you live with the baby's father? ___Yes ___No
Height: _____Weight: _____Highest Level of Education: _____
Are related to the baby's father?___Yes ___No Who else lives in your home?_____
Does the father of the baby smoke? ___Yes __No Does anyone else in your household smoke? __Yes__No

Mother of Baby:
Height: _____ Pre-pregnancy Weight: _____
Who will be your baby's **Pediatrician**? _____Pediatrician's Address:_____

Ethnicity/Genetic Testing: If you are:
____African American, have you had Sickle Trait Testing? ___Yes ___No
____Eastern European, have you been tested for Tay-Sachs? ___Yes ___No
____Asian or Mediterranean (Greek, Italian), have you been tested for Thalassemia Trait? ___Yes ___No

Occupation:
Job Title:_____ Is your workload: ____heavy ____moderate ____light
Can you rest at work? ___Yes ___No Are you exposed to chemicals/fumes? ___Yes ___No
Do you plan on working after delivery? ___Yes ___No How long will you stay home?_____

Psychosocial:
How do you feel about this pregnancy? _____ Was this pregnancy planned? ___Yes ___No
Do you have people to support you during your pregnancy? ___Yes ___No

Living Environment:
Are there any problems with your living arrangement? ___Yes ___No *If yes, please check all that apply:*
__no heat/fuel __no electricity __plumbing problems __too crowded __mold __other_____
Do you heat with a woodstove? ___Yes ___No Do you get water from a well? ___Yes ___No
Has your water been tested for Lead? ___Yes ___No Do you use a hot tub or sauna? ___Yes ___No
Is transportation a problem? ___Yes ___No If yes, why? __No vehicle __No license __other:
Do you have high stress? ___Yes ___No Is there violence or abuse in your life? ___Yes ___No
Do you have any pets? ___Yes ___No *If yes, please list what:*_____

Nutrition:
Do you skip meals >3x per week? ___Yes ___No Are you on a diet to control your weight? ___Yes ___No
Can you afford to eat balanced meals?___Yes ___No Do you need help obtaining food?___Yes___ No
Which of the following did you eat/drink yesterday? (*please check all that apply*)
__Water __Soda __Coffee __Juice __Tea __Beer __Wine __Liquor __Fruit Drinks __Sports Drinks
__Cheese __Vegetables __Salad __Fruit __Potatoes __Eggs __Yogurt __Peanut Butter __Nuts __Seeds
__Chicken __Beef __Fish __Beans __Rice __Bread __Noodles __Pizza __Macaroni & Cheese

During this pregnancy, have you been bothered by any of the following? (please check all that apply)
___Nausea ___Vomiting ___Heartburn ___Constipation

Since your last period, have you: (please check all that apply) __had abdominal pain? __had any x-rays?
__taken any pills/medicine? __had any vaginal bleeding? __had swelling in your hands or face?
__had unusual smelling vaginal discharge? __had vaginal itching? __had bladder/kidney problems?
__been exposed to any contagious diseases?