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Health History

Name		SSN		Phone (home)	(work/cell)	
Ethnicity	Spiritual Orientation	Yrs. Educ	Occupation	Date of Birth	Marital Status	Years Together
Address/Zip Code				Place of Birth		
Husband/Partner		Ethnicity	Yrs Educ.	Date of Birth	Place of Birth	
Address (if different than above)			Occupation	Phone (work)	Phone (cell)	
Spiritual Orientation	Any children from previous relationship				SSN	
Referred by						

Please answer the following questions to aid us in determining if there are potential problems which should be discussed further. If you have any questions about what information is important please discuss with the midwife. This information is completely confidential.

FAMILY HISTORY- Indicate if anyone in your immediate family has ever had any of these conditions. If yes, indicate who and when.

☐ Heart/Lung/TB_____
☐ Cancer _____
☐ Diabetes_____
☐ Twins _____
☐ Severe emotional problems_____
☐ Bleeding disorders_____
☐ Other significant health problems_____

FATHER OF BABY- Indicate if the father of the baby has ever had any of these conditions and when.

☐ Sexually transmitted diseases_____
☐ Genital Herpes _____
☐ Oral Herpes_____
☐ Alcohol/Drug Abuse_____
☐ Severe emotional problems_____
☐ Tobacco use_____
☐ Other significant health problems_____

YOUR MOTHER'S HISTORY- Please answer the following regarding your mother.

☐ No. Of pregnancies_____
☐ No. of births _____
☐ No. of miscarriages_____
☐ Complications of pregnancies_____
☐ Your birth weight_____
☐ Did she take DES while pregnant with you?_____

PREVIOUS PREGNANCY OUTCOMES *Please complete this table regarding your own pregnancy (from earliest to latest)*

DATE	No. of Weeks	OUTCOME (birth/miscarriage/termination)	Comments/Problems

Yes No Do you or the FOB have family members with birth defects, mental retardation, or genetic/inherited medical conditions?
Yes No Do you have a history of infertility, miscarriages, stillbirths, or serious pregnancy complications?
Yes No Are you or the FOB from one of these ethnic groups – (circle) – Jewish Black/African Asian Mediterranean
Yes No Have you or the FOB ever had hepatitis or jaundice?
Yes No Have you ever used drugs intravenously (IV) or had a blood transfusion?
Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?
Yes No Have you ever experienced extreme fluctuations in your weight?
Yes No Have you ever had anorexia, bulimia, or other eating/weight disorders?
Yes No Have you ever been in an abusive relationship, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?
Yes No Has your current partner ever intimidated, beaten, or otherwise abused you?
Yes No Have you ever been on any medication for psychological problems?
Yes No Have you ever used alcohol or drugs excessively?
Yes No Have you ever been referred for counseling or treatment for drug or alcohol issues?

NAME_____

MEDICAL HISTORY- Please indicate if you have ever had any of these:

- ☐ Severe Headaches_____
- ☐ Eye/vision problems_____
- ☐ Ear/hearing problems_____
- ☐ Dental problems_____
- ☐ Thyroid problems_____
- ☐ Rheumatic fever_____
- ☐ Blood clotting problems____
- ☐ Anemia_____
- ☐ High blood pressure_____
- ☐ Varicose veins_____
- ☐ Tuberculosis_____
- ☐ Asthma_____
- ☐ Skin disorder _____
- ☐ Stomach disorders_____
- ☐ Ulcers_____
- ☐ Chicken pox_____
- ☐ Bowel problems/colitis_____
- ☐ Blood in stool_____
- ☐ Gall bladder problems_____
- ☐ Liver problems_____
- ☐ Hepatitis_____
- ☐ Diabetes _____
- ☐ Hypoglycemia_____
- ☐ Bladder infection_____
- ☐ Urinary surgery_____
- ☐ Hemorrhoids_____
- ☐ Pelvic/back injuries_____
- ☐ Seizures _____
- ☐ Cancer _____
- ☐ Hospitalizations_____
- ☐ Surgeries_____
- ☐ Other _____

Do you have any allergies? ☐ Yes ☐ No
Please list _____
_____

GYNECOLOGIC HISTORY
Age at first period_____ Cycle length (days) _____
Duration_____ Regular? ☐ Yes ☐ No
When was your last Pap smear? _____
Have you ever had an abnormal Pap? (dates)_____
Please describe _____

Please indicate if you have ever had any of the following and when:

- ☐ Yeast_____
- ☐ Trichomonas_____
- ☐ Group B strep_____
- ☐ BV_____
- ☐ Chlamydia_____
- ☐ Gonorrhea_____
- ☐ Syphilis_____
- ☐ PID_____
- ☐ Herpes_____
- ☐ Condyloma_____
- ☐ HPV_____
- ☐ Cervical surgery_____
- ☐ Cervical polyp_____
- ☐ Ovarian cyst_____
- ☐ Fibroids_____
- ☐ Endometriosis_____
- ☐ Abnormal bleeding_____
- ☐ Uterine surgery_____
- ☐ Breast surgery_____
- ☐ Other _____

PRESENT PREGNANCY
Last menstrual period (1st day) _____ Normal? ☐ Yes ☐ No
Suspected date of conception_____
Pregnancy test (date)_____
Planned pregnancy ☐ Yes ☐ No
Feelings about pregnancy _____
Father's/Partner's feelings_____
Most recent birth control used_____
Contraception used in past: what, when, any problems?
_____
_____

Please indicate if you have ever had any of the following problems during this pregnancy:

- ☐ Nausea_____
- ☐ Vomiting_____
- ☐ Fever_____
- ☐ Infections_____
- ☐ Headache_____
- ☐ Dizziness_____
- ☐ Indigestion_____
- ☐ Leg cramps_____
- ☐ Rash_____
- ☐ Swelling _____
- ☐ Diarrhea_____
- ☐ Urinary complaints_____
- ☐ Abdominal/pelvic pain_____
- ☐ Vaginal bleeding/spotting_____
- ☐ Vaginal discharge_____
- ☐ Bleeding gums_____
- ☐ Varicose veins_____
- ☐ Hemorrhoids _____
- ☐ Depression_____
- ☐ Back ache_____
- ☐ Constipation_____
- ☐ Other _____

Please indicate if you have exposed to any of the following during this pregnancy:

- ☐ Tobacco_____
- ☐ Caffeine_____
- ☐ Marijuana _____
- ☐ Street drugs_____
- ☐ Other viruses_____
- ☐ Cats_____
- ☐ Vitamins_____
- ☐ Herbs_____
- ☐ X rays_____
- ☐ Ultrasound_____
- ☐ Measles_____
- ☐ Vaccinations_____
- ☐ OTC drugs_____
- ☐ Other _____

Please explain your dietary habits/diet_____
_____

Are there any particular cultural, ethnic, or religious preferences for your care that you would like to discuss with me?_____
_____
_____