



CLIENT REGISTRATION

Full current legal name _____
 Maiden name (if any) _____
 Full address _____
 Phone numbers _____
 Father of baby's full name _____
 Your Social Security number _____ Partner's Social _____
 Your occupation _____ work phone _____
 Partner's occupation _____ work phone _____
 Your: date of birth _____ Age _____ State of birth _____
 Partner's: date of birth _____ Age _____ State of birth _____
 Are you legally married? Y N
 Total # of pregnancies _____ Miscarriages _____ Abortions _____ Premature _____ Living _____
 Date last pregnancy ended _____ Pre-pregnancy weight _____ Weight now _____
 Name of any doctor/midwife seen during this pregnancy _____

Obstetric History

	Child 1	Child 2	Child 3	Child 4
Name				
Date of birth/sex				
Home/hospital/center				
Weeks gestation				
1 st sign of labor				
Length of labor				
Length of pushing				
IV / induction?				
IV pain meds?				
Pitocin?				
Epidural?				
Tear/episiotomy?				
Vacuum/forceps?				
Vaginal birth?				
Position of baby?				
Meconium?				
Weight of baby				
Complications?				
Hemorrhage/transfusion?				
Breastfed / how long?				
Contraception after?				
Depression postpartum?				

If additional space is needed, please use back of form.

Health History

Check any of the following conditions that you or any of your close relatives have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Severe emotional problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Twins |

Notes: _____

Check any of the following that YOU ONLY have had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Urinary tract surgery |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Pelvic/back injuries | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Phlebitis/Varicosities |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Severe accidents | <input type="checkbox"/> Cravings | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Other major illness |
| <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Joint/muscle problems |

Notes: _____

Are you: Overweight Underweight Average

What medications have you taken since your last period? _____

Gynecological History

Please circle any of the following conditions you or your partner have had or currently have:

- | | | |
|--|---|---|
| <input type="checkbox"/> Yeast infection | <input type="checkbox"/> Bacterial Vaginosis (BV) | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Cervicitis | <input type="checkbox"/> Ovarian Cyst |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Trichomonas (Trick) |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> PID | <input type="checkbox"/> Oral herpes (cold sores) |
| <input type="checkbox"/> Cervical surgery | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Uterine surgery |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Genital sores | <input type="checkbox"/> Condyloma (warts) | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Cervical polyp | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> HIV | <input type="checkbox"/> DES exposure | |

What kinds of birth control have you used in the past? _____

Any problems or complications from them? _____

When was your last pap smear? _____

Current Pregnancy

Please check any of the following problems you have experienced during this pregnancy:

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

Notes: _____

When do you think you may have conceived? _____
 Have you had a positive pregnancy test? Yes No When? _____
 Was this a planned pregnancy? Yes No
 What are your feelings about this pregnancy? _____
 Were you using birth control? Yes No What kind? _____
 Are you taking prenatal vitamins? Yes No When did you start? _____

Menstrual History

How old were you when your periods started? _____
 How many days do your periods usually last? _____
 My periods are usually (circle one): light medium heavy very heavy
 Are your periods painful? _____
 When was your last menstrual period? _____
 Are you sure? Yes No Was it a normal period? _____
 Previous menstrual period: _____

Additional Information

How many times was your mother pregnant? ____ How many children did she have? ____
 Did she have any miscarriages? ____ How long were her labors? ____
 Were there any complications in any of her pregnancies? _____
 How much did you weigh at birth? _____ The baby's father? _____
 Do you have any sisters who have given birth? _____
 How long were their labors? _____
 Did they have any complications in pregnancy or birth? _____

Do you suffer from anxiety or depression? Yes No
 Have you ever had an eating disorder? Yes No
 Have you been in an abusive relationship in the past? Yes No
 Are you in an abusive relationship now? Yes No

Have you ever had non-consensual sex? Yes No
Were you sexually abused or molested as a child? Yes No Not Sure
Do you have, or have you ever had, a drug problem? Yes No
Have you ever used intravenous (injected) drugs? Yes No
Have you ever had a blood transfusion? Yes No If so, when and where? _____
Do you think you are at increased risk for HIV/AIDS? Yes No
How many alcoholic drinks have you had in the past week? ____ Past month? ____ Since you found out you were pregnant? ____ Past year? _____
Do you smoke? Yes No How many cigarettes per day? _____
If you smoked in the past but don't now, when did you quit? _____

Do you believe your baby could be at risk for any hereditary medical conditions, and if so, which one(s)? _____

Check all of the following that you have used or been exposed to during this pregnancy:

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

How would you describe your usual diet? _____

Why do you want to use a midwife? _____

Do you have any ethnic, cultural, or religious preferences for your care? _____

Is there anything else you would like to tell me or that you think I should know? _____

Allergies: