Seven Cities Midwifery Care, LLC

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Registration & Health History

Please fill this out very carefully. When you come to your next visit, we will go over the health history together and discuss any questions you may have. Just leave blank any question you do not understand completely.

Full Name: ________________________(__________________)____________________ Today's Date: ___________
First Middle Maiden Last

Email: ______________________________________

Address:____

Home telephone: ___________________________ Cell phone(s): ____

Your Birth date: __________ Age: ___ Height: _____ Pre-pregnancy weight: ____ Religion: ________________________

Partner's name: ___________________________Partner's age: ___ Are you also under the care of an MD or CNM? ______

Name: _______________________________ Practice: _____________________________ Phone:___________________

Health Insurance ________________________________Medicaid/Other ____

Do you have any drug allergies or sensitivities? Yes / No

To:____

What happens?

____

Medical History

Please circle if you have had any of the following conditions. In the space below, record date, treatment, and any follow up you received. Also feel free to list any other important conditions/concerns.

Severe headaches
Ear/hearing problems
Eye/vision problems
Nasal or Sinus problems
Dental problems
Thyroid problems
Hypertension
Heart disease
Asthma

Tuberculosis
Stomach problems
Bowel problems
Bladder infection
Urinary tract surgery
Kidney disease
Diabetes
Epilepsy/Seizures
Neurological disorder

Mental / emotional problems
Hepatitis
Pelvic/back injuries
Fractures
Skin problems
Blood clotting problems
Anemia
HIV / AIDS

Cancer
Phlebitis/Varicosities
Hemorrhoids
Surgeries
Blood transfusions
Hospitalizations
Other

____

____

Menstrual History

Are your cycles regular or irregular (circle one)?
How long is your menstrual cycle? (from the first day of one period to the first day of the next period) __________ days.
How long does your bleeding last? ____ days. How old were you when you began menstruating? Age _____
Are your periods typically painful?____ What do you do about it? __________

LMP Date (first day of your last menstrual period) _______________ Estimated due date ___________
Yes No was it normal in length and heaviness of flow? Prior menstrual period date: _______________
Yes No Did you have a positive pregnancy test? If yes: date________________ Urine ___ Blood ____
Yes No was this a planned pregnancy? Were you breastfeeding when you conceived? _____________
Yes No Were you using birth control when you conceived? If so, what type?
____

Do you know when you ovulated or conceived? ___________ Were you using a cycle awareness method to determine fertility? _____ What? _______________________________ Did you take any medicines or treatments specifically to help with fertility? _____ What? ____________________________________
How do you feel about this pregnancy?____
Partner's feelings____

Please circle if you've ever had any of the following and write in date next to condition:

HPV (human papilloma virus)
Cervicitis
Cervical polyp
Cervical surgery
Cervical Laser or Cryo
Colposcopy
PID/Pelvic infection
Gonorrhea
Chlamydia

Oral Herpes
Genital Herpes/sores
Syphilis
Condyloma (warts)
HIV/AIDS
Bacterial vaginosis
Gardnerella
Trichomonas
Yeast / Candida
Endometriosis

Abnormal bleeding
Infertility
Breast lumps
Breast surgery
Group B Strep
Fibroids
Ovarian cyst/mass
Uterine surgery
Uterine prolapse
Cystocele

Rectocele
Incontinence
D & C or D & E
DES exposure in-utero

Other reproductive problems/conditions
Describe:
____
____

Yes No Have you ever you used birth control? If so, what kind(s)?

____

Problems/complications?____

Obstetrical History

Please list information about your previous births on the following chart:

Child's Name					
# Of Weeks Pregnant					
Birth/Abortion/Miscarriage					
Date					
Father's name					
Childbirth Classes					
Length of Labor					
Birth Weight					
Sex - M/F					
Place of Birth					
Pain Meds -Type					
Vaginal/Cesarean/VBAC					
Head Down / Breech					
Posterior					
Gestational Diabetes					
Group B Strep					
Induction? Using___					
Vac Extract/Forceps					
Blood loss					
Episiotomy/Tears					
Complications					
Feelings about Pregnancy / Birth					
Breastfeed? How long?					
Breastfeeding Problems					

Total Pregnancies: ____ Living Children: _____ Full Term: _______ Premature: ______
Miscarriages: ______ Abortion: ______ Ectopic: ______ Twins (or more): _______
Cesarean section: _____ Reason (s)____________________VBAC: ______ Adoption: ______

Any complications/ procedures listed below, after abortion or miscarriage?

Pain Infection Incomplete D&C or D&E Emotional Trauma Other

Blood type _____________ If Rh negative, did you receive RhoGAM?
Following miscarriage or abortion – Yes No
At 28wks gestation - Yes No
Within 72 hours of birth of RH+ baby – Yes No

Yes No Do you have any severe emotional problems?
Yes No Have you ever taken medications for depression or other mental issues? When____
Yes No Do you think, or has anyone ever told you, that you have used drugs/alcohol excessively?
Yes No Have you ever had anorexia, bulimia, or eating problems?
Yes No Have you ever been in an abusive relationship, including now ___ , or in the past ___ (emotionally and/or physically intimidated, beaten, or injured)
Yes No Have you ever had non-consensual sex?
Yes No Have you ever used any drug intravenously (IV)?
Yes No Do you currently receive alternative health treatments (chiropractic/acupuncture, etc)?
Yes No Have you ever been hospitalized and/or had an operation or procedure, if yes, please explain.

____

____

Are you currently taking any medications, vitamins, herbs, or other supplements? Please explain.

____

____

How would you describe your usual diet?

____

____

What do you generally do for exercise?

____

____

Describe a typical day (activities) in your life:

____

____

Current Pregnancy

What prenatal care have you had up to the present? Please list doctors, clinics, and hospitals where you have had care, what was done, and especially if you had any lab work, ultrasounds or special testing done.

____

____

Please circle if you've had any of the following during this pregnancy*:*

Fever	Hemorrhoids	Extreme Fatigue
Infection	Dizziness	Indigestion
Nausea	Rash	Backache
Vomiting	Constipation	Diarrhea
Headache	Abdominal/pelvic pain	Loneliness
Leg cramps	Bleeding gums	Relationship challenges
Swelling	Vaginal bleeding/spotting	Depression
Urinary problems	Varicose veins	Work challenges
Vaginal discharge	Fall /Accidental injury	Moving/Relocating

Other:____

Have you used or been exposed to any of the following during this pregnancy? Please circle.

Tobacco - # per day _____	Street drugs	Herbs
Currently smoking? ____	Viruses	Vitamins
2nd hand exposure____	Measles	Travel
Caffeine	Cats	Non-prescription drugs
Alcohol	Vaccinations	Prescription drugs
Marijuana	Ultrasound	Fumes/sprays
Cocaine	X-Rays	Other environmental hazard

Social Health and Current Situation

Is this your Partner's first baby?______ How long together with partner?____ Married to partner? _______
What do you do for work?____
Your partner?____
What is your first language? __________ Do you understand English Yes No Do you need an interpreter? Yes NO
Do you have family, friends or religion members who provide emotional support?_____________
How do significant people in your life feel about your decision to receive midwifery care and give birth outside of the hospital?____
Do you have any special requests for your pregnancy, birth or postpartum?
____
____
Do you have any concerns not listed above?____
____

I have been completely honest in detailing my health information above.

Signed____ Date_______________

Thank you for responding to these questions, so that we can get to know you better to provide you with the most satisfying care.

Please use this space to write your feelings about choosing to give birth at home.

Mother:

Partner:

Please use the space below to make notes or for any questions you may have.