

Medical History:

Please check 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.

- | | | |
|--|--|---|
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary tract surgery | <input type="checkbox"/> Hemorrhage |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pelvic.Back injuries | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Thyroid 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 | |

Is there any hereditary disease or condition in your family such as diabetes, cancer, heart disease, hypertension? List, and indicate which relative.

Yes No Have you or the father of your baby ever had a baby with a birth defect or mental retardation?

Yes No Do you or the father of your baby have any family members with birth defects or conditions diagnosed as genetic or inherited? _____

Yes No Are you and the father of your baby related by blood? (e.g. cousins)

Yes No Certain genetic problems may occur in the following ethnic/racial groups. Are you or the father of your baby:
Jewish Black/African Asian AleutianMediterranean

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? _____

What did your mother tell you about birth? _____

Do you have sisters who have given birth? _____ How long were their labors? _____

Did they have any pregnancy complications? _____

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Yes No Do you suffer from recurrent anxiety or depression?

Yes No Have you ever had anorexia, bulimia, or eating problems?

Yes No Have you ever been in an abusive relationship, including now, or been abused in the past (physically and emotionally intimidated, beaten, or injured)?

Yes No Have you ever had non-consensual sex?

Yes No Were you sexually abused/molested as a child?
 Yes No Do you think, or has anyone ever told you, that you have used drugs/alcohol excessively?
 Yes No Have you ever used any drug intravenously (IV)?
 Yes No Have you ever had a blood transfusion? Year _____
 Yes No Do you think you are at increased risk for HIV/AIDS?

Gynecological/Contraceptive History

When was your last Pap smear? _____ By whom? _____
 Have you ever had an abnormal Pap? _____ When? _____ How was it resolved? _____
 Do you do self breast exams? _____
 Please check if you have ever had any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Yeast | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Genital sores |
| <input type="checkbox"/> Bacterial vaginosis (BV) | <input type="checkbox"/> PID | <input type="checkbox"/> Condyloma (warts) |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Oral herpes | <input type="checkbox"/> HPV (human papilloma virus) |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Cervical surgery | <input type="checkbox"/> Cervical polyp |
| <input type="checkbox"/> Cervicitis | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Uterine surgery | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Infertility | <input type="checkbox"/> Other reproductive problems/condition |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Gardnerella | |
| <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Gonorrhea | |

Yes No Have you ever used birth control? If so, what kind? Problems/complications?

Current Pregnancy:

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

Yes No Have you smoked cigarettes in the three months prior to conception? How many a day? _____
 Yes No Do you currently smoke? How many a day? _____

Please check if you've had any of the following problems during this pregnancy:

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

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

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

How would you describe your usual diet? _____

*****Please keep a week long diet log of everything you eat/drink, and bring to your consultation*****

What do you generally do for exercise? _____

How do you feel about this pregnancy? _____

How does your partner feel about this pregnancy? _____

Do you feel that your sexual relationship has changed appreciably since you became pregnant? _____

Do you plan to breast feed this baby? If so, for how long do you think you'll nurse? _____

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

Do you feel you have adequate resources, i.e., food, shelter, money, for this pregnancy? _____

Do you have a car seat for this baby yet? _____

Please list the people you plan to invite to your birth. _____

Have you faced any opposition to your plans for home birth? _____

In general, how do you cope with stress? How do you cope with pain? _____

Please give some thought to the following questions and write your ideas. If you and your partner are together, each of you should answer. Please read all questions before answering.

Why do you want to have this baby at home? _____

Partner: _____

What do you see as the duties or responsibilities of your midwife? _____

Partner: _____

What do you think are the benefits of having your baby at home? _____

Partner: _____

There are some things that can go wrong without previous warning during labor and birth and after. If you are a low risk woman, the chances of unpredictable complications are very, very low. However, if such complications should occur, you or your baby might be at greater risk because of being at home. There are risks involved in childbirth just as there are with driving a car. Some of these risks will probably never be eradicated no matter what our state of technology. There is a certain subset of risks involved with having your baby at the hospital as well as in your home. If you opt for the risks involved in birthing at home you need to find out what they are and how they can be dealt with. Please comment on what you know about risks and complications and how you feel about them:

Partner: _____

How do you feel about going to the hospital to deliver if your midwife feels that complications are arising?

Partner: _____

How do you think you might deal with the problem of a baby or mother who suffered permanent injury or died at home?

Partner: _____

In your home, do you have the following:

Heat	Yes	No	Air conditioning	Yes	No
Running water	Yes	No	Electricity	Yes	No
Refrigeration	Yes	No	Phone	Yes	No

Do you have anyone available to help you for a while after your baby is born? _____

Who? _____ How long? _____

Please add any comments or thoughts that you think might be important for your midwife to know about you:

Lab Work (please leave blank)

INITIAL LABS	DATE	RESULT			
Blood Type		A	B	AB	O
Rh Type					
Antibody Screen					
HCT/HGB				%	g/dL
Pap Smear					
Rubella					
VDRL					
Urine Culture/Screen					
HBsAg					
HIV Counseling/Testing			Pos	Neg	Declined
Chlamydia					
GC					
GBS					
Diabetes Screen		Random:		2 hour:	
GTT (if screen abnormal)		FBS:	1 hr	2 hr	3 hr
HCT/Hgb				%	g/dL