Sacred Midwifery
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Medical/ Health History

Please fill out this medical and personal history very carefully. We will go over the history together and discuss any questions you might have. Just leave blank and questions you are not familiar with.

Personal Information Date_____

Your Name_____Phone_____

Birth date_____Age_____ Other Phone_____

Address_____

Email_____

Partner's Name_____Birth date_____

Partners Phone_____

Who referred you to me?_____

Menstrual History

LMP-last menstrual period_____ EDD_____

Was it normal in length and heaviness?_____

Is your cycle regular?_____

Did you have a pregnancy test?_____

When do you think you may have conceived?_____

How long is your menstrual cycle?_____

How old were you when you began menstruating?_____

Any difficulty in conceiving?_____

Were you on birth control when you conceived?_____

What kind?_____

Obstetrical History (Information about current pregnancy will come later)

Blood Type_____Fathers Type_____

Total Pregnancies_____(before current one)

Full term_____

Premature_____

Abortion_____ Date:

Miscarriage_____ Date:

Cesarean_____

VBAC_____

Living Children_____

If Rh negative, did you receive RhoGAM?_____

Any complications after abortion or miscarriage? (pain, infection, incomplete,

emotional)_____

Any complications during pregnancy (anemia, high/low weight gain, nausea, varicosities, high blood pressure, spotting, infections, early onset of labor)?

_____

_____

Please list information about your previous births

Birth Date	# of weeks	Length Labor	Birth Weight	M/F	Home or Hospital	Medications/complications

Your Mother's Obstetrical History:

How many children did she have?_____

Any complications in pregnancy or labors?_____

Length of pregnancies_____

Size of babies_____

Medical History

Please check if you have had any of the following conditions. In the space below, record date, treatment, and any follow-up. List any other important conditions or concerns.

- Kidney disease
- Diabetes
- Hypertension
- Epilepsy
- Heart disease
- Thyroid problems
- Blood clotting problems
- Asthma
- Anemia
- Hepatitis
- Liver problems
- Tuberculosis
- Pelvic/back injuries
- Pelvic infection
- Stomach problems
- Bowel problems
- Skin problems
- Bladder infection
- Hospitalizations
- Surgeries
- Seizures
- Hemorrhage
- Allergies
- Severe headaches
- Ear/hearing problems
- Dental problems
- Eye/vision problems
- Phlebitis/varicosity
- Hemorrhoids
- Urinary tract infection

_____

_____

_____

Are you allergic to any medications:_____

Are you on any medications now?_____

What type?_____

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 or the father related by blood?

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 been abused in the past (physically/emotionally intimidated, beaten, injured)?

Yes No Have you ever had non-consensual sex?

Yes No Have you ever used any drug intravenously (IV)?

Yes No Have you ever had a blood transfusion?

Yes No Do you think you are at increased risk of HIV/AIDS?

How would you describe your usual diet? Anything special?_____

_____

What do you generally do for exercise?_____

Gynecological History

Have you ever had an abnormal pap?_____

Do you do self breast exams?_____

Have you ever used birth control? If so, what kind and for how long? Any problems/complications?_____

_____

Please check if you have had any of the following:

- o Yeast
- o Bacterial vaginosis
- o Syphilis
- o Genital herpes
- o Genital sores
- o PID
- o Cervicitis
- o Fibroids
- o Uterine surgery
- o Infertility
- o Trichomonas
- o Chlamydia
- o Gardnerella
- o Gonorrhea
- o Ovarian cyst
- o Abnormal bleeding
- o Breast surgery
- o Cervical polyp
- o Endometriosis
- o Breast lumps
- o Condyloma (warts)
- o HPV
- o Oral herpes
- o Cervical surgery
- o Other reproductive problems/conditions

Current Pregnancy

What prenatal care have you had up to the present? Please list where you have had care, what was done, any lab work or special testing._____

_____

_____

Pre-pregnancy Weight_____

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

- Nausea
- Headache
- Constipation
- Indigestion
- Abdominal/pelvic pain
- Bleeding gums
- Leg cramps
- rash
- Swelling
- Vaginal bleeding/spotting
- Varicose veins
- Fever
- Backache
- Diarrhea
- Loneliness
- Relationship problems
- Depression
- Work problems
- Urinary problems
- Vaginal discharge
- Hemorrhoids
- Family problems
- Vomiting
- Dizziness

Have you been exposed to any of the following:

- Tobacco
- Caffeine
- Alcohol
- Street drugs
- Viruses
- Measles
- Cats
- Vaccinations
- Ultrasound
- X-rays
- Other environmental hazards

Are you taking prenatal vitamins, herbs, or supplements?_____

_____

Do you have health insurance?_____ Do you want to put in a claim for the birth?_____