

Lovers Lane Birth Center

Medical History (Pregnant Client)

Name _____

Today's Date _____

Your Medical History:

Indicate if you have had any of these conditions and when:

- ___ Drug Allergies _____
- ___ Other Allergies _____
- ___ Seizures/neurological _____
- ___ Eye Problems _____
- ___ Ear Problems _____
- ___ Dental Problems _____
- ___ Thyroid Problems _____
- ___ Asthma _____
- ___ Heart Problems _____
- ___ Blood Pressure Problems _____
- ___ Back or Joint problems _____
- ___ Stomach Problems _____
- ___ Bowel Problems _____
- ___ Gall Bladder Problems _____
- ___ Liver Problems _____
- ___ Bleeding Problems _____
- ___ Bladder Infections _____
- ___ Kidney Infections _____
- ___ Diabetes _____
- ___ Emotional/Mental Illness _____
- ___ Hospitalizations _____
- ___ Surgeries _____
- ___ Other Medical Conditions _____

Family Medical History:

Do you have siblings _____
Any sibling health issues? _____
Any health issues with your parents? _____

Any health issues w/ your grandparents? _____

Do any of your immediate family members have or have had:

- Diabetes _____
- Blood Pressure Problems _____
- Drug/Alcohol Problems _____
- Emotional issues/depression _____
- Other significant family history _____
- Father of the Baby's medical history:
Significant Medical Conditions _____
- Tobacco/Drug/Alcohol _____
- Emotional issues/depression _____

If this is YOUR first pregnancy:

Regarding your mother's pregnancies:

- Number of pregnancies _____
- Number of Births _____
- Any Complications _____

Your birth# _____ Your weight _____

Midwife Notes:

Midwife Notes:

Genetic History:

Do you have a history of any birth anomalies in your family? _____
(Yourself, father of the baby, extended family)

There are genetic screenings that calculate your risk for the following: Neural Tube Defect, Trisomy 21 (Down Syndrome) , Trisomy 18 (Edwards Syndrome). It is important to understand these tests are not DIAGNOSTIC but rather calculate the RISK of your baby having one of these anomalies.

Name: _____

Are you aware of genetic screening available? _____

(Early Screen, MSAFP, Quad Screen, Penta Screen)

Do you want to be screened this pregnancy? _____

Gynecological History

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

___ Yeast Infections _____ Breast Lumps _____

___ Bacterial vaginosis _____ Breast Surgery _____

___ HPV _____ Uterine Fibroids _____

___ Chlamydia _____ Endometriosis _____

___ Gonorrhea _____ Ovarian Cysts _____

___ Syphilis _____ Other Gynecological Conditions _____

___ Herpes _____ Trichomonas _____

___ Pelvic Inflammatory Disease _____

Date of Last PAP / / _____ Have you ever had an abnormal PAP? Yes/No

If Yes, please give date, classification(if known), treatment & outcome.

How long are your menstrual cycles from the beginning of one period to the beginning of the next?

___ Are they regular? _____

Previous Pregnancies

Have you ever experienced a miscarriage or pregnancy termination ? Yes/No

If yes please give date(s) , # of weeks pregnancy(if known) & any complications that may have occurred:

Please complete the following about your past birth(s):

First baby's name _____ Birthdate _____ #weeks _____ BirthWeight _____

Place of Birth _____ Length of labor _____ Complications _____

How do you feel it went?

Did you breastfeed Yes / No How Long _____ Issues? _____

Second baby's name _____ Birthdate _____ #weeks _____ BirthWeight _____

Place of Birth _____ Length of labor _____ Complications _____

How do you feel it went?

Did you breastfeed Yes / No How Long _____ Issues? _____

Third baby's name _____ Birthdate _____ #weeks _____ BirthWeight _____

Place of Birth _____ Length of labor _____ Complications _____

How do you feel it went?

Did you breastfeed Yes / No How Long _____ Issues? _____

Fourth baby's name _____ Birthdate _____ #weeks _____ BirthWeight _____

Place of Birth _____ Length of labor _____ Complications _____

How do you feel it went?

Name: _____

Did you breastfeed Yes / No How Long _____ Issues? _____

*List additional babies at the end of this form

Present Pregnancy

First day of your last period ___/___/___

Was it normal? Yes/No If no date of last normal period ___/___/___

Suspected date of conception (if known) ___/___/___ Have you had a sonogram? Yes/No

Midwife's Notes Due Date _____ EGA _____ Sono? _____

How are you feeling today? _____

Is this a planned pregnancy? Yes / No/ Sort Of _____

How do you feel about being pregnant? _____

Father of the baby's feelings about the pregnancy? _____

Which of the following pregnancy discomforts are you or have you experienced?

- | | | |
|---|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fatigue How many hrs of sleep |
| <input type="checkbox"/> Backache | | <input type="checkbox"/> /night _____ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Gas | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Urinary complaints | <input type="checkbox"/> Unusual Vaginal Discharge |

Midwife's Notes:

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

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Street drugs |
| <input type="checkbox"/> Prescription Drugs: _____ | <input type="checkbox"/> Other medicines: _____ | |
| <input type="checkbox"/> Herbs _____ | <input type="checkbox"/> Vitamins _____ | |
| <input type="checkbox"/> Prescription Drugs: _____ | | |

