New Earth Midwifery

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Client Registration and Medical History

Name: ____ Date of first prenatal visit: __________________
Address: ____
Phone: _________________________________ Email____
Age: _________ Date of Birth: ____________Marital Status: _________ Education: ___________________
Occupation: ____________________________Employment: _______________________________ Full/Part

Husband or Partner: ____
Phone_________________________________Email____
Age: _________ Date of Birth: ____________ Marital Status: _________ Education: ___________________
Occupation: ____________________________Employment: _______________________________ Full/Part

Insurance Company: ______________________________ ID#_____________________________________

Current Pregnancy Information

First day of your last menstrual period: __________ How often do you get your period? ________________
Conception Date (if known): ___________________
Due date: ___________________________________ What is this based on? ___________________________
Feelings about this pregnancy: ____
Physical and emotional concerns: ____
____
____

Previous Pregnancies: (include miscarriage and termination)

Date # weeks birth weight normal or complications Name of child

1. ____

____

2. ____

____

3. ____

____

4. ____

____

5. ____

____

6. ____

____

In this pregnancy or previous pregnancies, have you had any of the following occurrences?

____ Anemia
____ Spotting or bleeding
____ Prolonged vomiting
____ Bladder infections
____ Kidney infections
____ High blood pressure
____ Pre-eclampsia or eclampsia
____ Diabetes
____ Premature Labor
____ Episiotomy or ________ tearing
____ Difficulty delivering placenta
____ Hemorrhage
____ Severe depression pregnancy or postpartum
____ Difficulty breastfeeding
____ GBS
____ Sick Newborn

If yes, please explain: ____

____

Your Mother's Birth History

Pregnancies____________ Type of births/complications__________________________

Gynecologic History

Last pap smear_________________ Normal/Abnormal______________________________

If abnormal, please describe: ____

Have you ever had any of the following problems? If so, When? How often? Please describe below.

___ Vaginal yeast
___ Pelvic infection
___ Gonorrhea or chlamydia
___ Fibroids, tumors, or ovarian cysts
___ Syphilis

Do you or your partner have genital herpes? ______________________________________

Your Health History Allergies: ____

Have you had any health problems, including:

____ Measles
____ Varicose veins
____ Gallbladder problems
____ Seizures
____ Hepatitis/Liver
____ Cancer
____ Urinary tract infections
____ Diabetes
____ Anemia
____ Chickenpox
____ Thyroid disease
____ High blood pressure
____ Kidney disease
____ Heart Problems
____ Alcohol/Drug abuse
____ Surgery
____ Asthma
____ Depression
____ Tuberculosis
____ Hernia
____ Blood disorder/transfusion

Please comment on any checked problem, if complications arose: ________________________________
____

Are you in an abusive relationship? ________________ Are you safe? ___________________________
Have you ever been molested or raped? ____
Can we discuss this event at this visit ____ yes or ____ NO (I don't want to discuss this right now)

Family Medical History (Check off if any of these apply to your mother, father, sister or brother)
____ Cancer
____ Tuberculosis
____ Emotional disorders
____ Heart disease
____ High blood pressure
____ Diabetes
____ Multiple pregnancies (twins)
____ Alcohol or drug abuse
Does anyone you have close contact with have Hepatitis B or C, or HIV? ___________________

Has anyone in your family or the baby's father's family been born with:
____ A birth defect
____ Down syndrome
____ Spinabifida, anencephaly, or meningomyelocele (open spine).
____ Hemophilia (excessive bleeding)
____ Cleft Palate
____ Cystic Fibrosis
____ A child who was mentally retarded (If yes, list cause if known)
____ Any inherited genetic or chromosomal disease or disorder not listed above
____ A positive screen for sickle-cell trait

Do you smoke cigarettes? _____________ Amount per day: ____________________________
Marijuana? ________________________ Amount per day: ____________________________
Are you trying to quit for this pregnancy? ____
Does your partner smoke? ___________
Do you drink alcohol? _______________ Amount and frequency: _____________________
During this pregnancy, have you used any other drugs? If so, explain when, type, and amount.
(Answers will be held in strict confidence): ____

Nutrition/ Diet / Eating Habits

Describe your diet____
____
Do you take any medications, vitamins, herbs or supplements? ______________________________
____
Briefly describe what you do for exercise: ____
____
Briefly describe what you do for relaxation: ____
____
Please describe your life in a few words (happy, healthy, unhealthy, stressed out, etc….) __________
____

Signature of Midwife: ______________________________ Date________________