Midwifery Services of South Texas Claudine Crews CPM, LM 830-393-0337

# HEALTH HISTORY

## PERSONAL and DEMOGRAPHIC INFORMATION

DATE ________________

**MOTHER'S INFORMATION**

FULL NAME____________________________________________ MAIDEN NAME ________________ AGE ________

ADDRESS_______________________________________ CITY__________________________ TX. ZIP___________

COUNTY_____________________________ HOME PHONE______________________________ CELL __________________________

EMAIL ADDRESS ____________________________________________________ PETS______________________________________

SSN ______________________ OCCUPATION/TYPE OF WORK ____________________________________________________

DAYS AND HOURS WORKED PER WEEK ________________ COMPANY __________________WORK PHONE ____________________

DOB_________________ Where? (City and State) __________________________________________ Country ___________________

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Single Married to Father of Baby? _______RELIGION______________________________

**FATHER'S INFORMATION**

FATHER/PARTNER'S FULL NAME____________________________________________________ AGE_____ SSN ___________________

ADDRESS (If different than mother's) ________________________________________ CITY ________________ TX. ZIP___________

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Single Married to Mother-of-Baby? ______ RELIGION ______________________________

DOB _______________ Where? (City and State) _____________________________________________ Country ___________________

OCCUPATION_______________________ WORK PHONE ____________________ OTHER PHONE #"s________________________

What are your reasons for choosing your intended place of birth? ___________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

EMERGENCY CONTACT PERSON ____________________________________________________________________________

ADDRESS __________________________________ PHONE #S ______________________________ RELATIONSHIP _______________

DO YOU HAVE HEALTH INSURANCE? _______ NAME OF INSURANCE COMPANY ____________________________________________

**THE FOLLOWING QUESTIONS ARE MAINLY FOR STATISTICAL PURPOSES:**

COMBINED FAMILY INCOME: ☐< $24,000 ☐ $24,000 - $29,999 ☐ $30,000 - $34,999 ☐ 35,000 - 39,999 ☐ 40,000 - 49,999 ☐ 50,000+

How would you classify where you live: ☐Large City ☐Suburbs ☐Small Town ☐Rural ☐ Immigrant <10 years ☐ Immigrant =>10 years

Mother's years of education through high school ______ Years of secondary education _______ Race/Ethnicity _________________________

Father's years of education through high school ______ Years of secondary education _______ Race/Ethnicity _________________________

**NUTRITIONAL ASSESSMENT:** You will be given a nutritional assessment form, which includes a 3 day food intake diary. You will be asked to take this home and complete it, and either mail it to me or return it at your next visit. Current nutritional assessment will be done at that time. However, if you have ever had any eating disorders, or have a special diet or concerns please list here: ___________________________

______________________________________________________________________________________________

Is your diet primarily: ☐ meat and potatoes ☐ whole foods & meat ☐ junk food ☐ovo-lacto vegetarian ☐ vegan vegetarian ☐macrobiotic

Do you currently use: Tobacco ☐No ☐Yes ______ per _______ Alcohol ☐No ☐Yes ______ per _______ Recreational drugs ☐No ☐Yes

LIST **ALL** MEDICATIONS YOU TAKE AND DOSE OR AMOUNT. INCLUDE ANY HERBS, VITAMINS, OR OTHER SUPPLEMENTS:

1. ________________________________ 8.________________________________
2. ________________________________ 9.________________________________
3. ________________________________ 10.________________________________
4. ________________________________ 11.________________________________
5. ________________________________ 12. ________________________________
6. ________________________________ 13. ________________________________
7. ________________________________ 14. ________________________________

**MENSTRUAL HISTORY**

WHEN WAS THE **FIRST** DAY OF YOUR LAST MENSTRUAL PERIOD?____________________ WAS IT NORMAL? _____________ IF NO, EXPLAIN ____________________________________________________________________________

HOW OLD WERE YOU WHEN YOU BEGAN MENSTRUATING?_______ HOW LONG IS YOUR MENSTRUAL CYCLE (number of days you bleed)? ________ HOW MANY DAYS BETWEEN CYCLES (from the beginning of one to the beginning of the next)? _______ ARE THEY REGULAR?______ IF NO, EXPLAIN ____________________________________________

DO YOU KNOW WHEN YOU MAY HAVE CONCEIVED? ______________________________ Was this pregnancy: ☐ Planned ☐ Unplanned

WERE YOU USING BIRTH CONTROL WHEN YOU CONCEIVED?_______ What? ______________________________________

**OBSTETRICAL HISTORY**

TOTAL PREGNANCIES _____ FULL TERM BIRTHS (37-42 WKS. GESTATION)______ LIVE BIRTHS______ PREMATURE (<37 WKS) _____

MISCARRIAGE_______ ABORTION_______ ECTOPIC_____ STILLBIRTHS_____ LIVING CHILDREN______ C-SECTIONS______

VAGINAL BIRTH AFTER CESAREAN (VBAC)____ POST**DATES** (>42 WKS BY DATES ONLY) ______ POST**MATURE** (>42 WKS BY EXAM) ______

If Rh negative, did you receive Rhogam after any miscarriage or abortion, and after births of Rh+ babies? ___________________________

**PLEASE LIST INFORMATION ABOUT ALL OF YOUR PREVIOUS PREGNANCIES AND BIRTHS**

| Pregnancy # -> | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| CHILD'S NAME | | | | | | | |
| Date of birth | | | | | | | |
| SEX | | | | | | | |
| WEIGHT | | | | | | | |
| Weeks Gestation | | | | | | | |
| Live birth, stillbirth, misscarriage | | | | | | | |
| Where (hospital, home, etc.) | | | | | | | |
| Total Length of Labor | | | | | | | |
| How long did you push? | | | | | | | |
| Vaginal or C-Section? | | | | | | | |
| Forceps or Vacuum Ext. | | | | | | | |
| If C/S, reason and ype of incision | | | | | | | |
| Episiotomy/tears? | | | | | | | |
| 1st Sign of Labor | | | | | | | |
| Induced? | | | | | | | |
| Pitocin used? | | | | | | | |
| Pain Medications? | | | | | | | |
| Complications during pregnancy? (Elv BP, IUGR, shoulder dystocia, etc. | | | | | | | |
| Complications during labor? | | | | | | | |
| Excessive Bleeding? | | | | | | | |
| Complications Post-partum? | | | | | | | |
| Problems with the baby? | | | | | | | |
| Breast or Bottle Fed? | | | | | | | |
| Other information or comments: | | | | | | | |

Are there any circumstances, issues, or problems pertaining to previous pregnancies, labor and births, or the postpartum period which you would like to discuss? Please include negative experiences with previous care providers: __________________________________________

____________________________________________________________________________

Have you received any prenatal care so far this pregnancy? ____ If yes, with whom? __________________________________

How many times were you seen? _____ Did you have a sonogram? ______ If yes, what EDD were you given? __________________ What other information were you given? ________________________________________________ Can you get copies of your records?__________________

Please list any medications or illnesses have you been exposed to, along with the approximate date(s) of exposure since you conceived.

____________________________________________________________________________

DO ANY OF YOUR CHILDREN HAVE ANY BIRTH DEFECTS OR ANY INHERITED DISORDERS? IF YES, EXPLAIN ___________________

_______________________________________________________________________________________________

Are you or the baby's father from any of the following ethnic groups?
☐Hispanic ☐Jewish ☐Black/African ☐Asian ☐Mediterranean ☐Eskimo ☐Haitian

Are interested in testing for genetic or chromosomal disorders? ______________________________________________

## CONTRACEPTIVE HISTORY

| DATES USED | COMMENTS OR PROBLEMS | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Check if you have ever had any of these conditions:

| YOUR MEDICAL HISTORY | | |
|---|---|---|
| ☐ Kidney Disease | ☐ Liver Disease | ☐ Hearing Problems |
| ☐ Diabetes: type ____________________ | ☐ Tuberculosis | ☐ Dental Problems |
| ☐ High Blood Pressure | ☐ Pelvic/Back Injuries/Disorders | ☐ Eye/Vision Problems |
| ☐ Epilepsy | ☐ Stomach Problems | ☐ Varicose Veins |
| ☐ Heart Disease | ☐ Bowel Problems | ☐ Hemorrhoids |
| ☐ Hypothyroidism ☐ Hyperthyroidism | ☐ Skin Disorders | ☐ Phlebitis or blood clots |
| ☐ HIV/AIDS | ☐ Bladder/UT Infections | ☐ Surgeries ________________________ |
| ☐ Blood Clotting Problems | ☐ Seizures | ________________________________ |
| ☐ Hemorrhage | ☐ Allergies: type __________________ | ☐ Hospitalizations ___________________ |
| ☐ Anemia | ☐ Severe Headaches | ________________________________ |
| ☐ Hepatitis: type ____________ | ☐ Asthma | |
| Notes: ___________________________________________ | | |

Have you ever had any other illnesses or other health problems not listed above? ________ If yes, please describe: ______________________

_______________________________________________________________________________________________

**Please list all medications to which you are allergic or have had a bad reaction:** ______________________________________

_______________________________________________________________________________________________

DATE OF YOUR LAST PAP SMEAR?___________ Result_____________________________________________________

Have you ever had an abnormal PAP smear? ☐ No ☐ Yes If yes, what was the result, and describe any treatment ______________________

_______________________________________________________________________________________________

*Please answer the following questions carefully. We understand that some of them may be personal and/or embarrassing to you; however, it is very important for us to know these things in order to assess your current health status and any risk factors which may affect your health or the health of your baby. Feel free to discuss any of these things with us privately if you wish. (Your medical history is private. We will NOT discuss these things in front of any family member or friends.)*

Age sexual activity began _________ How many partners have you had? __________ How many partners in the last 5 years? __________
Do you have, or have you ever been diagnosed with any of the following (please fill in date last treated):
☐ Herpes ____________________ ☐ Gonorrhea __________________ ☐ Syphilis _______________ ☐ Chlamydia ________________
☐ HPV/Genital Warts ___________________ ☐ Frequent Yeast Infections (most recent) _______________ Bacterial Vaginosis ___________
☐ Other Vaginal infection (type and dates treated) ________________________________________________
Notes: ________________________________________________________________________________________
Have you ever used IV drugs – even one time? ☐ No ☐ Yes Dates used _______________________________________
Have you ever used intranasal cocaine? ☐ No ☐ Yes Have you ever had a blood transfusion? ☐ No ☐ Yes Date: __________________
Have you ever had a GI endoscopy? ☐ No ☐ Yes If yes, how many times? _______ Have you ever been on dialysis? ☐ No ☐ Yes
Have you ever had a suction abortion ☐ No ☐ Yes Have you ever had a needle-stick or sharps injury? ☐No ☐ Yes
Do you have any tattoos? ☐ No ☐ Yes Body piercing? (Not including ear piercing) ☐ No ☐ Yes Where? _________________________
Have you ever had a sexual partner with any of the above problems or issues? ☐No ☐ Yes ______________________________________

Do you have any emotional problems? ☐ No ☐ Yes Please describe ________________________ Have you ever been diagnosed with a depressive disorder, including prenatal or postpartum depression? ☐No ☐Yes When? ____________ Treatment? ________________________________________

Have you ever been the victim of: ☐ physical abuse ☐ sexual abuse ☐ rape ☐ emotional abuse ☐ Unsure
At what age(s)? ____________________ Are you currently in an abusive relationship? ____________________
Have you ever received any counseling or other help in resolving or dealing with issues associated with abuse?______________
What were the results of the counseling ________________________________________

You should be aware that issues from abuse, especially unresolved issues, often arise during pregnancy and especially during labor. Please feel free to discuss this with me privately, or I can refer you for professional counseling. These are problems that we need to work out prenatally, not during labor when you need to be focusing on giving birth to your baby!

## FAMILY HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY (Parents/Grandparents/Siblings):
Allergies____________________________ Cancer ____________________
Birth Defects (In yours OR the father's family)________________________________
Diabetes________________________ Thyroid Disorders____________________
Epilepsy__________ High Blood Pressure ____________________ Heart Disease ____________
Stroke ____________TB____________ Kidney Disease ________________________
Hepatitis__________ Liver Disease______________ Mental Retardation ________________
Twins/Multiple Births ____________________Breech Births ________________Other__________
________________________________________

Does anyone living in your household use: Tobacco ☐No ☐Yes Alcohol or drug use ☐No ☐Yes What/how much ____________

## YOUR MOTHER'S OBSTETRICAL HISTORY

No. of Pregnancies _____ No. of Births_____ Premature_____ Miscarriages _____ Stillbirth ____ Infant deaths _____ No. of C-Sections _____
Did she have any complications during her pregnancies or during the births? ________ If yes, please explain: ________________
________________________________________
________________________________________
Did she breastfeed? _______ How long? ____________ Where did her births take place?________________
What is her attitude towards childbirth in general? ________________________________
What is her attitude towards birth outside of a hospital? ________________________________
What about others in your family (Sisters, Grandmothers, Aunts?) Any complications? ______ Explain________________
____________________ What is their attitude towards childbirth? ________________

Did you take any childbirth preparation classes during a previous pregnancy? ________ When? ________________
Method: ☐ Lamaze ☐ Bradley ☐ Other ________________________________

Do you have any cultural, religious, or special preferences pertaining to labor and birth? ________________________
________________________________________
________________________________________
________________________________________
________________________________________

I, ______________________________ have completed this medical/health history and provided the information to my best ability and knowledge.

Signed ________________________________ Date ____________

Please do not write below this line

INITIAL ASSESSMENT OF RISK STATUS: ________________________________
AREAS THAT NEED FOLLOW-UP: ________________________________
________________________________________
PLAN OF CARE: ________________________________
________________________________________
________________________________________

Plan: ☐ Birth Center Birth ☐ Home Birth Assessed By ________________________