



MEDICAL AND PERSONAL HISTORY

PARENTS:

Mother _____ DOB _____ Occupation _____

Partner _____ DOB _____ Occupation _____

Address _____

Phone _____ (H) _____ (Mom's C) _____ (Partner's C)

Email Address _____

PHYSICIAN/MIDWIFE & HOSPITAL:

Name _____ Practice/Group _____ Phone _____

Hospital/Birth Center you plan to use _____ Phone _____

Pediatrician/Family Practice Physician _____ Phone _____

BABY BASICS:

Due Date _____ Sex of baby Boy Girl ??? Name of Baby _____ (if known)

Have you taken Childbirth Education Classes? Y N If yes, location & instructor _____

Have you taken a Breastfeeding Class? Y N If yes, location & instructor _____

Other classes taken in preparation _____

Who have you invited to your birth? _____

Do you have good help after the birth (who and how long)? _____

Do you plan to breastfeed? Yes Undecided No Do you sleep well? Yes Sometimes No

In general, how have you felt with this pregnancy? _____

PREGNANCY HISTORY:

of pregnancies(gravida) _____ # of Births(para) _____ # of Abortions _____ # of Miscarriages _____ @ _____ wk

Child's Name Birth Date Birth Weight Born Early/Late Spontaneous/Induced Length of Labor Length of Pushing

Did you have any complications during pregnancy, labor, delivery or postpartum _____

MEDICAL AND PERSONAL HISTORY, Continued

HEALTH HISTORY:

Are you taking any medications, supplements, herbs? If yes, what? _____

To what extent do you drink alcohol? _____

Do you smoke cigarettes? Yes No If yes, where and how much? _____

Does your partner? Yes No If yes, where and how much? _____

MEDICAL HISTORY (Mother (M) and Partner (P)):

_____ Asthma _____ Allergies _____ Anemia _____ Diabetes _____ HIV _____ PIH _____ Muscular/Skeletal Issues

_____ Rh Factor _____ Herpes _____ Cancer _____ Group B Strep _____ Eating Disorder _____ Drug Use _____ Infertility

_____ Hyper/Hypotension _____ Bladder/Kidney Infections _____ Surgeries _____ PCOS _____ Other (Comment)

Comments/Additional Medical History _____

PSYCHOLOGICAL HISTORY (Mom or Partner):

_____ Anxiety _____ Chronic Pain _____ Panic Attacks _____ Medical Trauma

_____ Bipolar _____ Depression _____ Obsessive/Compulsive _____ Other

Comments _____

What else would you like me to know about your history, hopes, dreams, fears, strengths or limitations?
What is your vision for bringing your baby into this world?