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)?

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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

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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?___________________________

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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?____

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Please check if you have had any of the following:

- ○ Yeast
- ○ Bacterial vaginosis
- ○ Syphilis
- ○ Genital herpes
- ○ Genital sores
- ○ PID
- ○ Cervicitis
- ○ Fibroids
- ○ Uterine surgery
- ○ Infertility
- ○ Trichomonas
- ○ Chlamydia
- ○ Gardnerella
- ○ Gonorrhea
- ○ Ovarian cyst
- ○ Abnormal bleeding
- ○ Breast surgery
- ○ Cervical polyp
- ○ Endometriosis
- ○ Breast lumps
- ○ Condyloma (warts)
- ○ HPV
- ○ Oral herpes
- ○ Cervical surgery
- ○ 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.________________________________

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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?____________________________

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