



Midwifery Care Associates, P.C.

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CLIENT REGISTRATION (Please Print)				Date	
Name		Date of Birth		Phone (home) (work)	
Address		City State Zip		Cell	
Marital Status	Occupation	Primary Support Person	Referred By	eMail Address	
Father of Baby		Address City State Zip		Date of Birth	Occupation
Father's Phone		Another Emergency Contact	Relationship	Address City State Zip Phone	

Please complete this form in preparation for your initial visit. Your responses will be kept completely confidential. In the event your records are copied for another care provider, this page will not be copied. If you need more space than what's allotted, please use the area provided on back. Thank you.

Family History: Indicate if anyone in your family has ever had any of these; who; when.

- High Blood Pressure _____
- Cancer _____
- Diabetes _____
- Twins _____
- Severe Emotional Problems _____
- Alcohol/Drug Abuse _____
- Other _____

Father of Baby: Indicate if the baby's father has ever had any of these; when.

- Sexually Transmitted Disease _____
- Urethritis _____
- Herpes _____
- Severe Emotional Problems _____
- Alcohol/Drug Abuse _____
- Tobacco Use _____
- Other _____

Your Mother's History: Please answer the following regarding your mother.

- No. of Pregnancies _____
- No. of Live Births _____
- Miscarriages _____
- Any Complications _____

Father's Weight at Birth _____ Your Weight at Birth _____

PREVIOUS PREGNANCY OUTCOMES				<i>Please complete this table regarding your own pregnancies (from earliest to most recent.)</i>	
Date	# Weeks	Birth/Miscarriage/Termination	Comments/Problems		

QUESTIONNAIRE: Please answer the following questions which will help determine if there are potential problems which should be discussed further. Again, this information is completely confidential.

- Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?
- Yes No Do you or the FOB have any family members or birth defects or conditions diagnosed as genetic or inherited?
- Yes No Are you and the FOB related by blood? (eg. cousins)
- Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)
Jewish Black/African Mediterranean Eskimo Italian
- Yes No Have you or the FOB ever had hepatitis or jaundice?
- Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?
- Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?
- Yes No Had you had more than five sexual partners in the last five years?
- Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
- Yes No Do you think you are at increased risk for hepatitis?
- Yes No Do you think you are at increased risk for AIDS/HIV?
- Yes No Have you ever experienced dramatic fluctuations in your weight?
- Yes No Have you ever had anorexia, bulimia or eating problems?
- Yes No Is there anything about the development of your sexuality that you would like to discuss?
- Yes No Have you ever been in an abusive relationship, including now, or been abused (physically, emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?
- Yes No Have you ever had severe emotional problems?
- Yes No Have you ever been on any medication for psychological problems?
- Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?
- Yes No Do you have firearms in your household? Are they locked away at all times?
- Yes No Have you had chicken pox or the varicella vaccine, TDAP Vaccine?
- Yes No Have you travelled outside the country in the last 3 months? If so, where? _____

NAME _____

MEDICAL HISTORY Please indicate if you have ever had any of these; when:

- | | |
|--|--|
| <input type="checkbox"/> Severe headaches _____ | <input type="checkbox"/> Bowel problems _____ |
| <input type="checkbox"/> Eye/Vision problems _____ | <input type="checkbox"/> Colitis _____ |
| <input type="checkbox"/> Ear/hearing problems _____ | <input type="checkbox"/> Blood in stool _____ |
| <input type="checkbox"/> Dental problems _____ | <input type="checkbox"/> Gall bladder problems _____ |
| <input type="checkbox"/> Thyroid problems _____ | <input type="checkbox"/> Liver problems _____ |
| <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Blood clotting problems _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Hypoglycemia _____ |
| <input type="checkbox"/> Hemorrhage _____ | <input type="checkbox"/> Bladder infection _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Kidney infection _____ |
| <input type="checkbox"/> Varicose veins _____ | <input type="checkbox"/> Urinary surgery _____ |
| <input type="checkbox"/> Hemorrhoids _____ | <input type="checkbox"/> Urethral dilation _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Aching joints _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Pelvic/back injuries _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Stomach problems _____ | <input type="checkbox"/> Hospitalizations _____ |
| <input type="checkbox"/> Ulcers _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Other _____ | |

Do you have any allergies to medications? Yes No

GYNECOLOGIC HISTORY

Age at first period _____ When was your last pap smear? _____
Cycle length (days) _____ Have you ever had an abnormal pap? _____
Regular? Yes No If so, when? _____
Duration _____ If so, what? _____

Please indicate if you have ever had any of the following; when:

- | | |
|--|--|
| <input type="checkbox"/> Yeast _____ | <input type="checkbox"/> Cervicitis _____ |
| <input type="checkbox"/> Trichomonas _____ | <input type="checkbox"/> Cervical surgery _____ |
| <input type="checkbox"/> Gardnerella _____ | <input type="checkbox"/> Cervical polyp _____ |
| <input type="checkbox"/> Bacterial vaginosis _____ | <input type="checkbox"/> Ovarian cyst _____ |
| <input type="checkbox"/> Chlamydia _____ | <input type="checkbox"/> Fibroids _____ |
| <input type="checkbox"/> Gonorrhea _____ | <input type="checkbox"/> Endometriosis _____ |
| <input type="checkbox"/> Syphilis _____ | <input type="checkbox"/> Abnormal bleeding _____ |
| <input type="checkbox"/> PID _____ | <input type="checkbox"/> Uterine surgery _____ |
| <input type="checkbox"/> Genital sores _____ | <input type="checkbox"/> Breast lump(s) _____ |
| <input type="checkbox"/> Herpes _____ | <input type="checkbox"/> Breast surgery _____ |
| <input type="checkbox"/> Condyloma (warts) _____ | <input type="checkbox"/> Infertility _____ |
| <input type="checkbox"/> Other _____ | |

Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy and birth that you'd like to discuss?

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? Yes No
Last normal menstrual period _____
Suspected date of conception _____
Pregnancy test (date) _____ Planned pregnancy? Yes No
Feelings about pregnancy _____
Father's feelings _____
Most recent birth control used _____
Contraception used in the past: what, when, any problems? _____

Please indicate if you have had any of the following problems during this pregnancy:

- | | |
|---|---|
| <input type="checkbox"/> Nausea _____ | <input type="checkbox"/> Urinary complaints _____ |
| <input type="checkbox"/> Vomiting _____ | <input type="checkbox"/> Abdominal/pelvic pain _____ |
| <input type="checkbox"/> Fever _____ | <input type="checkbox"/> Vaginal bleeding/spotting _____ |
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Vaginal discharge _____ |
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Bleeding gums _____ |
| <input type="checkbox"/> Indigestion _____ | <input type="checkbox"/> Varicose veins _____ |
| <input type="checkbox"/> Leg cramps _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Rash _____ | <input type="checkbox"/> Loneliness _____ |
| <input type="checkbox"/> Backache _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Swelling _____ | <input type="checkbox"/> Family/relationship problems _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Work problems _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Other _____ |

Please indicate if you have used or been exposed to any of the following during this pregnancy:

- | | |
|---|---|
| <input type="checkbox"/> Tobacco _____ | <input type="checkbox"/> Herbs _____ |
| <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Fumes/sprays _____ |
| <input type="checkbox"/> Caffeine _____ | <input type="checkbox"/> X-rays _____ |
| <input type="checkbox"/> Marijuana _____ | <input type="checkbox"/> Ultrasound _____ |
| <input type="checkbox"/> Cocaine _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Street drugs _____ | <input type="checkbox"/> Viruses _____ |
| <input type="checkbox"/> Prescription drugs _____ | <input type="checkbox"/> Vaccinations _____ |
| <input type="checkbox"/> Non-prescr.drugs _____ | <input type="checkbox"/> Cats _____ |
| <input type="checkbox"/> Vitamins _____ | <input type="checkbox"/> Other _____ |

Planned Place of Birth

Home Hospital Undecided

Please use the space below to add any other information regarding any of the above.

