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_____

Father's Weight at Birth_____

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

No. of Pregnancies_____
No. of Live Births_____
Miscarriages_____
Any Complications_____
_____

Your Weight at Birth_____

PREVIOUS PREGANCY OUTCOMES *Please complete this table regarding your own pregnancies (from earliest to most recent.)*

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 of 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:

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

Do you have any allergies to medications? ☐ Yes ☐ No

GYNECOLOGIC HISTORY

Age at first period _____
Cycle length (days) _____
Regular? ☐ Yes ☐ No
Duration _____

When was your last pap smear? _____
Have you ever had an abnormal pap? _____
If so, when? _____
If so, what? _____

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

- ☐ Yeast
- ☐ Trichomonas
- ☐ Gardnerella
- ☐ Bacterial vaginosis
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ PID
- ☐ Genital sores
- ☐ Herpes
- ☐ Condyloma (warts)
- ☐ Cervicitis
- ☐ Cervical surgery
- ☐ Cervical polyp
- ☐ Ovarian cyst
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Abnormal bleeding
- ☐ Uterine surgery
- ☐ Breast lump(s)
- ☐ Breast surgery
- ☐ Infertility
- ☐ 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:

- ☐ Nausea
- ☐ Vomiting
- ☐ Fever
- ☐ Headache
- ☐ Dizziness
- ☐ Indigestion
- ☐ Leg cramps
- ☐ Rash
- ☐ Backache
- ☐ Swelling
- ☐ Constipation
- ☐ Diarrhea
- ☐ Urinary complaints
- ☐ Abdominal/pelvic pain
- ☐ Vaginal bleeding/spotting
- ☐ Vaginal discharge
- ☐ Bleeding gums
- ☐ Varicose veins
- ☐ Hemorrhoids
- ☐ Loneliness
- ☐ Depression
- ☐ Family/relationship problems
- ☐ Work problems
- ☐ Other

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

- ☐ Tobacco
- ☐ Alcohol
- ☐ Caffeine
- ☐ Marijuana
- ☐ Cocaine
- ☐ Street drugs
- ☐ Prescription drugs
- ☐ Non-prescr.drugs
- ☐ Vitamins
- ☐ Herbs
- ☐ Fumes/sprays
- ☐ X-rays
- ☐ Ultrasound
- ☐ Measles
- ☐ Viruses
- ☐ Vaccinations
- ☐ Cats
- ☐ Other

Planned Place of Birth

☐ Home ☐ Hospital ☐ Undecided

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