Health History for Pregnant Mothers

Name: ____

Prenatal History

Is this your first pregnancy? __________ How many other births have you had? _____________

How many weeks pregnant are you now? _____________

Have you experienced any traumas during this pregnancy? (Accidents or falls) _______________

Please describe ____

Any medications taken during this pregnancy? ____

Do you smoke or drink alcohol? ___________

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?

____

Please list dates, frequency and reason for these procedures: ______________________________

____

How has your diet been during this pregnancy? ____

Have there been any stressful events in your life during this pregnancy? ______________________

____

What are your most significant fears associated with this birth? ______________________________

____

Who is your birth care provider? ____

Will you have someone with you at the birth for support? Please specify who:

____

Where do you plan on delivering? ____

Have you put together a birth plan? ____

Previous Birth History:

Place of birth: (circle one) Hospital / Birthing Center / Home / Other _________________________

Delivering Practitioner: (circle one)

OB/GYN Certified Nurse Midwife Certified Practicing Midwife Lay midwife

Position of Delivery: (circle one)

Lithotomy postion (on back with feet up) On your side kneeling squatting Other___________________

Was labor induced? (Contractions were stimulated prior to the natural onset of labor) _______

If yes, specify type: Pitocin / Prostaglandins / Gel Applied to Cervix / Unknown

Did your care provider rupture your membranes? ________

Were contractions stimulated intravenously with pitocin once labor started? ___________

NAME OF PATIENT: ____

Did you receive any pain medications or anesthesia? _________________

Please specify type used: ____

If you had an epidural, how many centimeters were you dilated when it was administered? __________

Did you experience back pain during labor? ________ Did you deliver vaginally? _______________

Baby presentation at the time of delivery? Normal Posterior Brow Facial Breech

If breech, specify type: Footling / Frank Complete / Kneeling

Was there any visible injury to your baby? ___________

If so, where on your baby was the injury sustained? _______________________________

Did your care provider assist delivery with his/her hands? _______________

Was there any turning of the neck, or traction (pulling) applied to the neck? ____________

Were operative devices used to facilitate the birth? ______ Which type? Forceps / Vacuum / Extraction

If yes, were there any visible signs of injury to your baby? ______________

If yes, where was the injury sustained? ____

Was there a birthing coach present? Husband / Doula / Friend / other_____________________

At what week of pregnancy was your baby born? _________________________________

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*DOCTOR'S NOTES:*____

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Recommendations: ____

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Patient accepted: YES NO Referred

I have reviewed the information contained on this form with the patient

Dr's signature ________________________________ Date_______________