

# Medical and Personal History



Please fill out this form very carefully. When we meet again we will go over this history together and discuss any questions that you might have. Just leave blank any technical terms or questions with which you are not familiar or any questions you prefer to answer in person.

## MOTHER:

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Usual Weight (non-pregnant) \_\_\_\_\_

Your Weight at Your Birth (if known) \_\_\_\_\_

Occupation \_\_\_\_\_

## PARTNER:

Name \_\_\_\_\_

Baby's Father's Weight at His Birth \_\_\_\_\_ Father's Height \_\_\_\_\_

Occupation \_\_\_\_\_

## Midwife or Doctor:

Name \_\_\_\_\_

Practice Name (if different from above): \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Office Address \_\_\_\_\_

**HOSPITAL/BIRTH FACILITY/HOME:**

Where do you plan to have this birth? \_\_\_\_\_

**OTHER:**

Due Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex of baby (if known) M\_\_\_\_ F\_\_\_\_

Name of baby (if known) \_\_\_\_\_

Have you taken any childbirth preparation classes? Y\_\_\_\_ N\_\_\_\_

☞ If yes, location and instructor \_\_\_\_\_

How else have you prepared for this birth (books, videos, etc.)

\_\_\_\_\_  
\_\_\_\_\_

If you drink alcohol, how much do you drink, and how often?

\_\_\_\_\_

Do you smoke cigarettes? Y\_\_\_\_ N\_\_\_\_ Does your partner? Y\_\_\_\_ N\_\_\_\_

☞ If yes, how many? \_\_\_\_\_

☞ If you used to smoke, when did you quit? \_\_\_\_\_

How much do you usually sleep each night? \_\_\_\_\_

Do you have an opportunity for rest periods or a nap each day? Y\_\_\_\_ N\_\_\_\_

Do you sleep well? Y\_\_\_\_ N\_\_\_\_

Do you have any allergies? \_\_\_\_\_

Do you have any dietary restrictions? (i.e., vegetarian, kosher, diabetic, etc.)

\_\_\_\_\_

In general, how have you felt with this pregnancy?

\_\_\_\_\_

Please list the people you plan to invite to your birth:

\_\_\_\_\_

Do you plan to breastfeed this baby? Y\_\_\_\_ N\_\_\_\_

**THE FOLLOWING CAN GREATLY AFFECT YOUR LABOR:**

Do you have herpes? \_\_\_\_\_

Have you tested positive for Group B Strep? Y\_\_\_\_ N\_\_\_\_

Have you ever been sexually or physically abused? (You may respond verbally if you like) Y\_\_\_\_ N\_\_\_\_

What else would you like me to know about your history, hopes, dreams, fears, strengths or limitations?

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No. of pregnancies (Gravida) \_\_\_\_\_ No. of births (Para) \_\_\_\_\_

No. of Abortions \_\_\_\_\_ No. of Miscarriages \_\_\_\_\_

**IF YOU'VE GIVEN BIRTH BEFORE, PLEASE ANSWER THE FOLLOWING:**

How much did each of your babies weigh?

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Were your babies born early, on time, or late? \_\_\_\_\_

Did you breastfeed? Y\_\_\_\_ N\_\_\_\_ For how long? \_\_\_\_\_

How long were you in labor for each of your babies?

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How did your labor(s) begin?

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Did you have any complications during the labor(s) or after the birth(s)?

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Older Children(s) Name(s) Age(s)

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