

# Birth by Design, LLC

Peggy Franklin, CPM  
Licensed Midwife

## Medical and Health History

Please fill out the following information. All information will remain confidential.

### Personal Information

Name _____	Father's Name _____
Address _____	Are you married to baby's father? _____
_____	Address (if different) _____
County _____	_____
Home Phone _____ Cell _____	Cell Phone _____
Email Address _____	Date of Birth _____ SSN# _____
Date of Birth _____ Ht _____ Wt. _____	Ethnicity _____ Are you of Hispanic origin? _____
SSN# _____ Ethnicity _____	If so, specify Cuban, Mexican, Puerto Rican, etc. _____
Are you of Hispanic origin? _____ If so, specify Cuban, Mexican, Puerto Rican, etc. _____	City, State or Country of birth _____
City, State or Country of birth _____	Highest level of Education _____
Religious Affiliation _____	Occupation _____
Highest Level of Education _____	Employer _____
Occupation _____	Business Phone _____
Employer _____	Childbirth Classes _____
Business Phone _____	Back-up Physician (ph#) _____
Emergency contact & phone _____	Pediatrician (ph#) _____
_____	Referred by _____

### Obstetrical History

Total Pregnancies _____	Living Children _____	Deceased Children _____
Vaginal Births _____	Cesarean Births _____	VBAC _____
Full Term (37+ weeks gestation) _____	Premature (less than 37 weeks) _____	Twins _____
Abortions _____ mo/yr	Ectopic _____ mo/yr	Miscarriage _____ mo/yr
Complications after abortion or miscarriage _____	If RH negative, did you receive RhoGAM? _____	

### Previous Pregnancy and Birth History Please list information about your previous pregnancies and births.

Child's name & gender (M/F)	Date of Birth	Weeks Gest.	Outcome (Term, miscarried, terminated, stillborn, adopted)	Birth Weight	Length of Labor	Place of Birth Home, BC, Hosp	Mode of Birth (vaginal C/S)	Complications (forceps, vacuum, episiotomy, failure-to-progress, fetal distress, hemorrhage)

**Gynecologic History**

Please ✓ if you have had any of the following.

Condition	✓	Date	Comments	Condition	✓	Date	Comments
Breast Lumps				Pelvic infections (PID)			
GYN or breast surgery				Endometriosis			
Syphilis				Fibroids			
Ovarian Cyst				Cervical Polyps			
Hemorrhage				Genial Herpes			
Infertility				Chlamydia			
Yeast				Genital warts			
BV				Gonorrhea			

**Menstrual History**

Your age at first period \_\_\_\_\_ When was your last Pap smear? \_\_\_\_\_  
 How often do you get your period? \_\_\_\_\_ Have you ever had an abnormal Pap? If so, when? \_\_\_\_\_  
 How many days does it last? \_\_\_\_\_ Is it regular? \_\_\_\_\_ How was it resolved? \_\_\_\_\_  
 Is it painful? \_\_\_\_\_ Do you do self breast exam? \_\_\_\_\_  
 Describe flow: Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_ Have you ever had a mammogram? \_\_\_\_\_ Date \_\_\_\_\_  
 Were you using birth control when you conceived? \_\_\_\_\_ Please list other birth control you have used in the past. \_\_\_\_\_

**Current Pregnancy**

When was your last menstrual period? \_\_\_\_\_ Did you do a pregnancy test? If so, when? \_\_\_\_\_  
 Was it normal? \_\_\_\_\_ Was this pregnancy planned? \_\_\_\_\_  
 When do you think you conceived? \_\_\_\_\_

Have you had any prenatal care for this pregnancy until now? Please list doctors, clinics, midwives, and hospitals where you have had care, what was done, and especially if you have had any lab work or special testing done.

Please describe your physical health during this pregnancy. \_\_\_\_\_

Have there been any challenges with this pregnancy? If so, what? \_\_\_\_\_

Do you feel that your sexual relationship has changed appreciably since you became pregnant? If so, would you like to discuss it?

Do you feel that you have adequate resources, i.e. food, shelter, money, for this pregnancy? \_\_\_\_\_

Please ✓ if you have used, experienced, or been exposed to any of the following during this pregnancy?

	✓	Weeks preg		✓	Weeks preg		✓	Weeks preg
Tobacco			Alcohol			Caffeine		
Marijuana			Cocaine			Street drugs		
Other meds			Non-pres drugs			Vitamins		
Herbs			Fumes/Sprays			X-rays		
Ultrasound			Measles virus			Travel		
Vaccinations			Cats			Other		

Please ✓ if you have had any of the following problems during this pregnancy.

Condition	✓	Weeks Preg.	Complications/Comments	Condition	✓	Weeks Preg.	Complications/Comments
Headaches				UTI pain or infection			
Dizziness				Herpes O / G			
Bleeding gums				Varicose veins			
Poor Appetite				Leg cramps			
Nausea				Swelling			
Vomiting				Colds / Viruses			
Indigestion				Fever / Illness			
Constipation				Itching / Rashes			
Diarrhea				Excessive Fatigue			
Hemorrhoids				Depression			
Abdominal pain				Worries			
Backache				Work problems			
Vaginal Discharge or Yeast				Financial problems			
Vaginal Bleeding				Other			

**Client Medical History**

Do you have any special concerns about your well-being? Please describe: \_\_\_\_\_

Please list any personal or family medical history that may influence your health and well-being. \_\_\_\_\_

- 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 baby's father have any relatives with birth defects or genetic/inherited conditions?
- Yes  No Are you and the father of your baby related by blood? (e.g., cousins)
- Yes  No Certain genetic problems may occur in the following ethnic/racial groups. Are you or the baby's father:
  - Jewish  Black/African  Asian  Aleutian  Mediterranean

How would you describe your usual diet? \_\_\_\_\_

Please list all medications and supplements you are currently taking on a regular basis. \_\_\_\_\_

What do you generally do for exercise? \_\_\_\_\_

Have you experienced any significant losses or other emotional experiences that might have an impact on your birthing experience? (For example, death of a child, parent, or sibling, divorce, separation, loss of birth family through adoption or separation).

Have you had any life trauma that might influence your birthing experience? (For example, physical, emotional, or sexual abuse, rape, or substance abuse, please give approximate age of occurrence.) Yes No If so, do you want to talk about it? Yes No

Please check if you have ever had any of the following conditions.

Condition	√	Date	Comments	Condition	√	Date	Comments
Allergies (including meds)				Hospitalizations			
General surgery				Severe accidents			
Severe illness				Childhood diseases			
Severe Headaches				DES / Steroid therapy			
Dental Problems				Arthritis			
Oral Herpes				Rheumatic fever			
Insomnia				Hypoglycemia			
Ulcers				IV Drug or blood products			
Digestive problems				Blood transfusion			
Bowel problems				HIV virus/ AIDS			
Hemorrhoids				Alcohol abuse			
UTI/Kidney infections				Abusive relationship			
Hepatitis/Jaundice				Severe emotional problems			
Back injuries				Anorexia/Bulimia			
Varicose veins				Medication for psychological problems			

**Family Medical History**

Check below any health condition the baby's blood relative may have or had:

Condition	√	Relationship	Condition	√	Relationship	Condition	√	Relationship
Vision problems/Blindness			STD			Genetic Disorders		
Hard of hearing/Deafness			Varicose veins			Cancer/Growths		
Thyroid disorders			Multiple Births			Alcohol/Drug use		
Respiratory/Lung disorders			Birth Defects			Tobacco Use		
Heart Disease / High Blood Pressure			Blood clotting disorders			Depression/Emotional problems		
Gallbladder/Liver disorders			Anemia			Mental retardation		
Diabetes			Sickle Cell			Other		
Herpes								