

NAME _____

MEDICAL HISTORY - Please indicate if you have ever had any of these, and when:

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

Do you have any allergies? Yes No

Please List: _____

GYNECOLOGIC HISTORY:

Age at first period _____ How often do you get your period? _____

How many days does it last? _____

Is it regular? Yes No Is it painful? Yes No

When was your last Pap smear? _____

Was it normal? Yes No

Have you ever had an abnormal Pap? Yes No

Please explain _____

Have you 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"/> Group B Strep _____ | <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/Pelvic Infection _____ | <input type="checkbox"/> Uterine surgery _____ |
| <input type="checkbox"/> Genital Sores _____ | <input type="checkbox"/> Breast Lump(s) _____ |
| <input type="checkbox"/> Herpes <input type="checkbox"/> Genital | <input type="checkbox"/> Breast surgery _____ |
| <input type="checkbox"/> Oral | <input type="checkbox"/> Infertility _____ |
| <input type="checkbox"/> Condyloma (warts) _____ | <input type="checkbox"/> Other _____ |

PRESENT PREGNANCY:

1st day of Last Menstrual Period _____ Normal? Yes No

Date of pregnancy test (if known) _____

Do you know when the baby was conceived? _____

Have you felt the baby move yet? Yes No When? _____

Were you using birth control when you conceived? _____

What kinds of birth control have you used in the past? 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 _____ |
| <input type="checkbox"/> Infections _____ | <input type="checkbox"/> Vaginal discharge _____ |
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Bleeding gums _____ |
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Varicose veins _____ |
| <input type="checkbox"/> Indigestion _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Leg cramps _____ | <input type="checkbox"/> Diarrhea _____ |
| <input type="checkbox"/> Rash _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Backache _____ | <input type="checkbox"/> Family problems _____ |
| <input type="checkbox"/> Swelling _____ | <input type="checkbox"/> Work problems _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Other _____ |

Please indicate if you have used, experienced, 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/viruses _____ |
| <input type="checkbox"/> Street drugs _____ | <input type="checkbox"/> Travel _____ |
| <input type="checkbox"/> Other meds. _____ | <input type="checkbox"/> Vaccinations _____ |
| <input type="checkbox"/> Non-pres. Drugs _____ | <input type="checkbox"/> Cats _____ |
| <input type="checkbox"/> Vitamins _____ | <input type="checkbox"/> Other _____ |

What kinds of food do you usually eat? Check two:

meat & potatoes whole foods & meat junk food

ovo-lacto vegetarian vegan macrobiotic

other (describe) _____

What do you generally do for exercise? _____

Please tell me briefly why you have chosen a home birth? _____

