ARIZONA WOMB SERVICE LLC

Serving Women in the Childbearing Year

www.AZwombService.com

Health History

Name _____ **Date of Birth** _____

Today's Date _____

Present Pregnancy

First Day of your last menstrual period: _____ How sure? _____

Normal? Y N

Date of Conception: _____ unknown Pregnancy Test (date): _____

EDD: _____ 36th week _____ 42nd week _____

Planned pregnancy? Y N

Pre Pregnancy Weight: Height:

Feelings about pregnancy:

Father and/or partner's feelings about pregnancy:

Family history/ indicate if anyone in your immediate family has ever had the following. If yes, who and when?

High Blood Pressure		Heart Attacks	
Diabetes		Twins	
Birth Defects		Cancer	
Mental Illness		Alcohol/Drug Abuse	
Tuberculosis		Other:	

Pregnancy Problems/indicate if you have any of these during this pregnancy:

Nausea		Vomiting		Midwife Notes:
Infections		Headache		
Indigestion		Backache		
Diarrhea		Abdominal/pelvic pain		
Bleeding Gums		Depression		
Work problems		Leg cramps		
Swelling		Non-food cravings (dirt)		
Bleeding/ Spotting		Varicose Veins		
Loneliness		Family/relationship		
Fever		Dizziness		
Rash		Constipation		
Urinary complaints		Vaginal discharge		
Hemorrhoids		Other:		

Pregnancy Exposure/indicate if you have used, experienced, or been exposed in this pregnancy:

Tobacco		Alcohol		Midwife's Notes:
Caffeine		Other meds		
Non-pres. drugs		Street drugs		
Vitamins		Herbs		
Fumes/Sprays/Pesticide		X-Rays		
Ultrasound		Measles/Viruses		
Mercury		Lead		
Vaccinations		Travel		
Cats		Raw Meat		

Father's history/indicate if the baby's father has ever had the following. If yes, when?

Sexually transmitted infections		Genital/Oral Herpes		Midwife's Notes:
Mental Illness		Alcohol/Drug Abuse		
Tobacco Use		Other:		

Father's birth weight:

YOUR mother's history/ Please answer the following regarding your mother:

No. of pregnancies: _____

No. of births: _____

No. of Cesarean deliveries: _____

No. of premature births: _____

No. of miscarriages: _____

Complications with pregnancies: _____

Did she take DES (Diethylstilbestrol use 1948-1971) when pregnant with you? Y N

Did she breastfeed? Y N

Your birth weight: _____

Do you know your birth story? Y N

Genetic history:

Y N Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation? Please describe:

Y N Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited? Please describe:

Y N Are you and the FOB related by blood? (e.g. cousins)

Y N Are you or the FOB from any of the below racial or ethnic groups? (circle)
Jewish / Black, African / Asian / Mediterranean

Y N Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

Gynecologic History

Age when periods began _____ Any Medications? _____

No. of days of bleeding: _____ Describe: Heavy Medium Light

Cycles length (days): _____

When was your last pap smear? _____

Have you ever had an abnormal pap? Y N If so when? _____

Result of the abnormal pap: _____

Do you do self breast exams? Y N How often? _____

Most recent birth control used: _____

Contraception used in past; what, when, any problems?_____

Do you douche? Y N

Gynecological Problems/indicate if you have ever had any of the following. If yes, when

Yeast infections		Trichomonas		Midwife's Notes:
Group B Strep		Bacterial vaginosis		
Chlamydia		Gonorrhea		
Syphilis		PID/pelvic infection		
Genital sores		Herpes/ Oral Genital		
HPV or Genital Warts		Cervicitis		
Cervical surgery		Cervical polyp		
Ovarian cyst		Fibroids		
Endometriosis		Abnormal Bleeding		
Uterine Surgery		Breast lump(s)		
Breast surgery		Fertility problems		

Medical History

Do you have any allergies (drug/environmental)? Y N Please list and describe severity & type of reaction:

Are you currently taking any medications or supplements? Y N (prescription, herbal, vitamins & OTC)? Please list and describe (name, dosage, frequency, reason for taking):

Are you currently under the care of a physician or other health care provider(s) (including alternative care such as chiropractic, homeopathy, acupuncture, massage, etc)? Y N
If yes, please list and describe (name & type of provider, reason for care)

Do you exercise regularly? If yes, please describe the type of exercise, how often, for how long, etc.

Do you think you are at increased risk for HIV/AIDS? Y N

Medical history/ indicate if you have ever had any of the below. If yes, when

Severe headaches		Dental problems		Midwife's Notes:
Blood clotting probs		Hemorrhage		
Hemorrhoids		Skin disorders		
Bowel problems		Gall bladder problems		
Diabetes		Kidney infection		
Seizures		Surgeries		
Eye/Vision problems		Thyroid problems		
Heart problems		High Blood pressure		
Tuberculosis		Stomach problems		
Blood in stool		Liver problems		
Hypoglycemia		Arthritis		
Cancer		Blood transfusions		
Ear/Hearing problems		Rheumatic fever		
Anemia		Varicose veins		
Asthma		Ulcers		
Chicken Pox		Hepatitis		
Bladder infection		Pelvic or back injuries		
Hospitalizations		Fifths Disease		
Weight Fluctuations		Tattoos		

Pregnancy History/List all pregnancies, miscarriages, abortions:

	1	2	3	4	5	Midwife Notes
Childs Name						
Date of Birth						
# Weeks						
Prentatal Problems						
Prenatal Classes?						
Length of Labor						
Baby's Wt						
Birth Place						
Drugs/ Interventions						
Perineal Trauma						
Baby Problems						
Breastfed? How Long?						
Child's Health Now						
Feelings on Experience						