Initial Client History

date initial Hx _____ EDD _____ LMP _____ Blood type _____

Client: _____ Age: _____ Birthdate: _____ Occupation: _____

Partner: _____ Age: _____ Birthdate: _____ Occupation: _____

Address:

_____

Emergency Contact Person:

_____ Emergency

Contact Phone: ( ) _____ Who referred you? _____

Phone #(s) Home ( ) _____ Work ( ) _____ Cell ( ) _____

Have you had any prenatal care, and with whom? _____

Menstrual Hx

Age of onset: _____ Average cycle length: _____ Days, Flow _____ Days Are your cycles regular? _____ Unusual amount of flow? _____

When do you think you may have conceived? _____

First days of last normal menstrual period: _____

Birth control used? _____ Pregnancy test date and result: _____

Gynecological Hx:

Date of last pap smear: _____

Any abnormal paps? If so, when? _____

Please check if you've had any of the following:

Yeast
Bacterial vaginosis Syphilis
Genital herpes
Cervicitis
Ovarian cyst
Abnormal bleeding Breast surgery
Trichomonas
Chlamydia
PID
Oral herpes
Cervical surgery Fibroids
Uterine surgery Infertility
Gardnerella
Gonorrhea
Genital sores
Condyloma (warts)
HPV (human papilloma virus) Cervical polyp
Endometriosis
Breast lumps
Other reproductive problems/conditions

Yes No Have you ever used birth control? If so, what kind? Problems/complications? _____
_____
_____
_____

Prior Pregnancies

Total: _____ Live: _____ Stillbirths: _____ Abortions: _____ Miscarriages: _____

Record of Those Ending >= 20 Weeks Preg.

Child's name/Preg. #
Birth date/place/care-giver
Planned/using contraception
Weeks gest. at birth
Type of birth
Total weight gain
Prenatal problems
Early labor history
Active labor
Pushing phase
Placental birth/blood loss
Drugs/IV used
Experience of birth
Complications
Perineal trauma
Baby's position at birth
Weight/length of baby
APGAR 1/5 minutes
Problems w/baby
Postpartum exp./breastfed?
Child's health now

Record of Those Ending <= 20 Weeks Preg.

Date ended?/Wks gest./Preg. #
Location/care-giver
Drugs used
Procedures used
Complications
Experience
Counseling

Medical Hx:

Please check if you have had any of the following conditions. In the space below, record date, treatment, and any follow-up you received. Also feel free to list any other important conditions/concerns.

Kidney disease
Diabetes
Epilepsy
Blood clotting problems Asthma
Hepatitis
Liver problems
Tuberculosis
Urinary tract surgery

Pelvic/back injuries Stomach problems Bowel problems Skin problems
Bladder infection
Hospitalizations
Seizures
Surgeries

Hemorrhage
Allergies
Severe headaches
Ear/hearing problems Dental problems Eye/vision problems
Phlebitis/Varicosities
Hemorrhoids

PROBLEM NO PREG WOMAN FATHER RELATIVES COMMENTS Heart/circ/BP
Anemia/blood dis.
Diabetes
Thyroid disorders
Respiratory dis.
Convulsive/CNS dis.
Cancer/growths
Varicose veins
Genetic disorders

PROBLEMS WHICH MAY HAVE ARISEN DURING THE CURRENT PREGNANCY:

PROBLEM NO IF SO, WHEN/COMMENTS
Nausea/vomiting
Heartburn
Poor appetite
Bruising easily
Bleeding gums
Backache
Muscle cramps
Itching
Rashes
Constipation
Diarrhea
Hemorrhoids
Varicose veins
Fainting/black outs

_____ Did she have any miscarriages?
_____

PROBLEM NO IF SO, WHEN/COMMENTS Drug use
Spotting/Bleeding
Colds/virus infec.
Yoni infec./herpes
UT pain/infec.
Abdominal pain
Headaches
Dizziness
Blurred vision
Swelling
Pigment changes
Insomnia
Radiation/US
Excessive fatigue

How many times was your mother pregnant?
_____ How many children did she have?

Were there any complications during preg./birth?
_____ How long were her labors?

_____
Did your mother take DES while preg. with you?
_____ How much did you weigh at birth?
_____

Personal Lifestyle and Habits

DO YOU OR YOUR PARTNER: PREG WOMAN PARTNER WHEN & HOW OFTEN/COMMENTS: Smoke

Drink alcohol

Use medications (OTC/prescription)

Have a Hx of recreational drug us (IV?)

Have religious beliefs that affect your health care?

Use chemicals or harmful substances at work or home?

Use or work with/near microwave ovens?

Use computers/radiation?

Get regular exercise?

Drink caffeinated/sugared beverages?

Have pets?

Type of diet (omnivore/ovo-lacto/vegan/ macrobiotic/other)

Yes No Are you or the father of your baby from any of these ethnic/racial groups?

Ashkenazi Jewish
Black/African
Asian
Aleutian
Mediterranean

Yes No Do you have any severe emotional problems?

Yes No Do you think, or has anyone ever told you, that you have used drugs/alcohol excessively? Yes No

Have you ever experienced dramatic fluctuations in your weight?

Yes No Have you ever had anorexia, bulimia, or eating problems?

Yes No Have you ever been in an abusive relationship, including now, or been abused in the past (physi cally and emotionally intimidated, beaten, or injured)?

Yes No Have you ever had non-consensual sex?

Yes No Have you ever used any drug intravenously (IV)?

Yes No Have you ever had a blood transfusion?

Yes No Do you think you are at increased risk for HIV/AIDS?

Yes No Do you want information about safer sex practices?

Yes No Did you receive any of the Covid "vaccines" and/or booster “shots” before or during this pregnancy, or at any time?

Yes No Are you exposed regularly to people that have received the Covid "vaccine?"

What are your intuitions about the pregnancy, birth or baby?

_____

_

_____

_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Blood Type/Factor:

_____– **Due Date:** 

_____

Client: _____

DATE

WKS PREG

WEIGHT/Hemoglobin

BP/PULSE

Color/Clarity

Protein/Glucose

pH/Ketone**S**

Blood/Pain

EDEMA

HEADACHES

DIZZY/VISION?

ILLNESS/NAUSEA

CRAMPS/PAIN/BH

BOWELS?

YONI DISCHARGE

DIET

SLEEPING?

EXERCISE?

FUNDAL HT·

FETAL POSITIO^N

FETAL MOTIO^N

EST. FETAL WT·

FHT (+)

PLACENTA Sound (0)

COMMENT^S
&

RECOMMENDATION^S

Blood Type/Factor:

_____ – **Due Date:**

_____

Client: _____

DAT^E

WKS PRE^G

WEIGHT/Hemoglobi^n

BP/PULS^E

Color/Clarit^y

Protein/Glucos^e

pH/Ketone^S

Blood/Pai^n

EDEM^A

HEADACHE^S

DIZZY/VISION^?

ILLNESS/NAUSE^A

CRAMPS/PAIN/B^H

BOWELS^?

YONI DISCHARG^E

DIE^T

SLEEPING?

EXERCISE?

FUNDAL HT·

FETAL POSITION

FETAL MOTION

EST. FETAL WT·

FHT (+)

PLACENTA Sound (0)

COMMENTS
&

RECOMMENDATIONS