Around the Circle Midwifery, LLC

Please fill out this form as completely as possible. We will review it together at your next visit. Feel free to skip over any questions that are unclear. Please use ink and print clearly. Thanks.

CLIENT INFORMATION

Date: ____________

Your full name____Maiden ________________________
Birth Date/Place ____E-mail address ________________________
Address ____Inside city limits? Y/N
Phone: home____________________work__________________________ cell__________________________
Your occupation______________________Marital status______________SS#__________________________
Religious preference ____________________Highest level of education completed ______________________
Partner/Father's full name____________________________________Education __________________________
Partner's Birth Date______________SS#____________________Occupation____________________________
Address if different____Phone____________________
Children's names/ages ____
Emergency name/number____Relationship______________
Pediatrician/phone_________________________________Family Doctor/phone_______________________
How did you find us?____First out-of-hospital birth? Y / N
Planned pregnancy? Y/N Your feelings about being pregnant:

Why do you want an out-of-hospital birth/midwife-attended birth?

What do you see as the duties or responsibilities of your midwife?

Are there any particular ethnic, cultural or religious preferences for your care during pregnancy and birth that you'd like to discuss?

What sort of reactions have you received from family and friends about your plans to have an out-of-hospital birth?

What are your and/or your partner's main concerns about this birth?

How do you feel about going to the hospital if your midwife feels that complications are arising?

Who will be with you during your labor and birth?____
Who will help you after the birth?______________________________Do you plan to have children at your birth? Y/N
If yes, who will be there to attend to their needs? ____
Do you plan to breastfeed your new baby? Y / N How long?____

We often encourage partners, kids, family and labor support people to come for some of your prenatal visits as well. Would you prefer that we met alone instead? Yes / No / Sometimes

Around the Circle Midwifery, LLC ____________ **Name:** ________________________

Gynecological herstory: Please indicate if you have now or have ever had any infections, surgeries or problems.

Yeast infections
Bacterial vaginal infection
STD (chlamydia, gonorrhea, syphilis, trichomonas, other)
Pelvic Inflammatory Disease
Genital Herpes
Herpes on the mouth (cold sores)
Genital warts/HPV

Abnormal Pap smear
Surgery on your cervix
Unusual uterine shape
Growths, cysts, fibroids or tumors on your uterus or ovaries
Surgery on your uterus or ovaries
Breast lumps

Surgery on your breasts
Unexplained itching/sores/ bumps on your vulva, legs, buttocks or lower back
Infertility
Urinary complaints/Urinary tract infections/bladder infections
Other problems or concerns
____

If you have marked yes on any of the above, please give dates and treatment:______________________________________
____
____

How old were you when you had your first period? ____________ years old.
How long from the start of one period to the start of the next period? ______ days. How many days of flow? _____ days.
Amount of flow: light/medium/heavy. Cramps? Y/N Ovulation pain? Y/N Do you chart your cycles? Y/N
When and where did you last have a Pap smear? ____Normal? Y/N
If it was abnormal, did you have follow up? Y/N
If you have genital herpes, how long have you had it?_________Does your partner have oral or genital herpes? Y/N
Please list all contraceptives you have used. Include dates, length of use and any difficulties you may have had:
____
____

CURRENT PREGNANCY

Place a ✕ in the box if you have experienced any of the following with this pregnancy:

Nausea/vomiting
Bleeding/cramping
Diarrhea/Constipation
Headaches
Vaginal discharge/sores/irritation

Fever/rash/flu/infection
Urinary tract/bladder pain
Family/relationship problems
Other discomforts or problems______________________________________
____

Place a ✕ in the box if you have been exposed to any of the following during this pregnancy. Please write in type of exposure, how much and when exposed:

Tobacco/2nd hand smoke________________________
Alcohol____
Caffeine_______________________________________
Prescription/ Over-the-counter drugs _____________
Marijuana/Street drugs__________________________
Vaccinations___________________________________
Vitamins/herbs_________________________________
Fumes/sprays/paints/chemicals___________________

Computer monitors/TV, hours per day_______
X-rays/radiation/ultrasound____________________
Cats/raw meat/gardening/hot tubs________________
Fish/raw milk/soft cheeses ____________________
Measles/Rubella/Fifth's Disease_________________
Sexually transmitted diseases___________________
Trauma/injury____________________________________
Other__________________________________

Around the Circle Midwifery, LLC ________________ **Name:** ____________________________

Pregnancy Herstory: How many times have you been pregnant including this pregnancy? ___________________________
Have you had any miscarriages? Y/N How many?________Have you had any abortions? Y/N How many?_____________
If you have had miscarriage(s) and/or abortion(s) please give the following information: Specify month & year, at how many weeks pregnancy was terminated, any complications, method used (if abortion), and any other information that you feel is important to share.____
____

If you've had any previous births, please fill out this section to the best of your knowledge. We will go over it together at your first visit.

	1st child	**2nd child**	**3rd child**
Baby's name	______________	______________	______________
Birthdate	______________	______________	______________
Term/early/late	______________	______________	______________
where/attendant	______________	______________	______________
Vaginal/C-sec	______________	______________	______________
Birth weight	______________	______________	______________
Your weight gain	______________	______________	______________
Hypertension	______________	______________	______________
Gest. diabetes	______________	______________	______________
Toxemia/eclampsia	______________	______________	______________
Other prenatal probs.	______________	______________	______________
1st sign of labor	______________	______________	______________
Induced? How?	______________	______________	______________
Pain relief drugs	______________	______________	______________
IV? Pitocin?	______________	______________	______________
Length of labor	______________	______________	______________
Artificial rupture of bag of waters? When?	______________	______________	______________
Length of pushing	______________	______________	______________
Head/breech/posterior	______________	______________	______________
Fetal distress	______________	______________	______________
Epis./tear/stitches	______________	______________	______________
Forceps/Vacuum	______________	______________	______________
Difficult delivery?	______________	______________	______________
Baby's condition	______________	______________	______________
Hemorrhage	______________	______________	______________
Placenta problems	______________	______________	______________
RHoGam injection	______________	______________	______________
Postpartum infection	______________	______________	______________
Breastfed? How long?	______________	______________	______________
Newborn Jaundice	______________	______________	______________
Postpartum depression	______________	______________	______________
Now living?	______________	______________	______________

Was anything done to you/your baby that you particularly liked or disliked?_________________________________
____
____
____

Around the Circle Midwifery, LLC Name:________________________________

These questions help us to determine if there are issues or topics that we need to discuss with you further. Please answer the following questions by putting a circle around 'Yes' or 'No'.

Yes/No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
Yes/No Are you or the FOB from any of the following ethnic/racial groups? Please circle all that apply:
Jewish Black/African Asian Mediterranean Aleutian Alaskan Other:____________________
Yes/No Have you ever been a health care or daycare worker? Exposure to bodily fluids? Y/N
Yes/No Have you ever used any drugs intravenously (IV) or had a blood transfusion?
Yes/No Have you or the FOB had a sex partner who used IV drugs or had a blood transfusion?
Yes/No Have you had 5 or more sexual partners in the past 5 years? How often did you use a barrier method of birth control (male or female condoms)? Circle one: always / usually / sometimes / never
Yes/No Do you think you are at high risk for hepatitis or HIV/AIDS? Have you had a recent HIV test? Y/N Date:
Yes/No Have you ever been on medication for psychological problems?
Yes/No Have you ever been in an abusive relationship, or been abused (physically, sexually or emotionally)?
Yes/No Do you feel safe in your home?
Yes/No Is there anything about your sexuality that you would like to discuss? Please use this space.

Medical History. Please ✕ **all those that apply**. Please note who was affected and when, and give details.

	You	**Your family**
Chicken pox	________	________
Severe headaches	________	________
Seizure disorder	________	________
Thyroid conditions	________	________
Rheumatic fever	________	________
Heart disease/MVP	________	________
High blood pressure	________	________
Hereditary disease	________	________
Respiratory problems	________	________
Tuberculosis	________	________
Digestive problems	________	________
Endocrine disorders	________	________
Autoimmune disorder	________	________
Kidney problems	________	________
Gall bladder problems	________	________
Liver problems	________	________
Pelvic/back injury	________	________
Anemia	________	________
Transfusion	________	________
Bleeding disorders	________	________
Venous thrombosis	________	________
Surgeries/hospital	________	________
Cancer/type	________	________
Diabetes/type	________	________
Birth defects	________	________
Multiple births	________	________
Mental/Emot. probs.	________	________
Addictions/alcohol	________	________
Allergies to meds	________	________

FOB/Donor

Hereditary disease ____________________
Birth defects ____________________
Bleeding disorders ____________________
Tuberculosis ____________________
Mental/Emotional Problems ____________________
Seizure disorder ____________________
Addictions/alcohol ____________________
Tobacco use ____________________
Urethritis ____________________
Blood type ____________________

FOB's family

Hereditary disease ____________________
Birth defects ____________________
Bleeding disorders ____________________
Tuberculosis ____________________
Mental/Emotional Problems ____________________
Seizure disorder ____________________
Addictions/alcohol ____________________
Tobacco use ____________________

Your Mother's OB Herstory

Number of pregnancies ____________________
Miscarriages/complications ____________________
Early / term / late babies? (Please circle)
Did she breastfeed? ____________________
Did she have a midwife? ____________________
Did she take DES with you? ____________________

Around the Circle Midwifery____________________**Name:** ________________________

DIET AND NUTRITIONAL INFORMATION

Has your appetite changed with this pregnancy?_______How?____
____
What is your feeling about weight gain during pregnancy?______________________________________
Your partner's?____________________Your parents'_____________________Who cooks?________________
Please describe your diet (omnivore, vegetarian, vegan, no dairy, etc.)_____________________________
Do you take a prenatal vitamin? Y/N Brand:____________, ____tablets/day. Other supplements?______________
Do you receive food stamps?_________WIC Coupons?______________Other assistance?__________________
How often do you usually eat? (include snacks)____/day. Allergy restrictions?_______________________________

Please record everything you eat and drink for 3 days. Include amounts, sizes, whole wheat or white, etc.

Day #1, Date: _____________

Breakfast:____
____
AM Snack:____
Lunch:____
____
PM Snack:____
Dinner: ____
____
Bedtime Snack: ____
Anything else you ate or drank? ____

Day #2, Date:_______________

Breakfast:____
____
AM Snack:____
Lunch:____
____
PM Snack:____
Dinner:____
____
Bedtime Snack: ____
Anything else you ate or drank?____

Day #3, Date:_______________

Breakfast:____
____
AM Snack:____
Lunch:____
____
PM Snack:____
Dinner: ____
____
Bedtime Snack: ____
Anything else you ate or drank?____
Do these 3 days represent your typical eating habits?__________If not, what was different?__________________
____

Around the Circle Midwifery, LLC

Name: ________________________**Phone number:** ______________________**EDD:**____________

Address: ____

Please use this space to draw a careful map to your home. Please include landmarks, mileage and helpful directions.