Natural Choice
MIDWIFERY

Pamala Wilson LM, CPM
Phone: 803.617.6710

INTAKE & HEALTH HISTORY

Mother's Full Legal Name: _____

Maiden Name (if any): _____

Street Address: _____

City, State, Zip: _____

Email address: _____

Phone: _____ Cell: _____ Work: _____

Occupation: _____

Social Security #: _____

DOB: _____ Age: _____ Race: _____

State of Birth: _____

Father's Full Legal Name: _____

Occupation: _____

Social Security #: _____

Phone: _____ Cell _____Work: _____

DOB: _____ Age: _____ Race: _____

State of Birth: _____

Emergency contact, name & #: _____

Physician contact, name & #: _____

Are you legally married? Y N

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OBSTETRIC HISTORY

Total pregnancies including current: ____ Miscarriages: _____ Abortions_____ Premature_____ Living _____
Date last pregnancy ended: _____ Weight: _____ Pre-pregnancy: _____ Current: _____
Name of Doctor/Midwife seen during this pregnancy: _____

	Child 1	Child 2	Child 3	Child 4
Name				
DOB/Sex				
Home/Hospital/Center				
Weeks Gestation				
1st Sign of Labor				
Length of Labor				
Length of Pushing				
IV/Induction?				
IV Pain Meds?				
Pitocin?				
Epidural?				
Tear/Episiotomy?				
Vacuum/Forceps?				
Vaginal Birth				
Position of Baby?				
Meconium?				
Weight of baby				
Complications?				
Hemorrhage/transfusion?				
Breastfed/how long?				
Contraception after?				
Depression postpartum				

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HEALTH HISTORY

Please CIRCLE any of the following conditions that you and/or the father's family have had:

High blood pressure	Heart condition	Tuberculosis
Diabetes	Epilepsy	Thyroid problems
Severe emotional problems	Cancer	Twins
None		

Other (Explain): _____

_____

Please CIRCLE any of the following that YOU ONLY have had:

Kidney disease	Surgeries	Urinary tract surgery
Hemorrhage	Pelvic/back injuries	Allergies
Stomach problems	Severe headaches	Bowel problems
Dental problems	Skin Problems	Phlebitis/Varicosities
Blood clotting problems	Bladder infection	Hemorrhoids
Asthma	Anemia	Hepatitis
Hospitalization	Liver problems	Seizures
Sever accidents	Cravings	Constipation
Insomnia	Blood transfusions	Other major illness
Gallbladder problems	Hypoglycemia	Joint/muscle problems

Notes: _____

_____

Are you: Overweight Underweight Average

What medications have you taken since your last period? _____

Do you have any known allergies to medications? _____

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GYNECOLOGICAL HISTORY

Please CIRCLE any of the following conditions you or your partner have had or currently have:

Yeast infection	Bacterial vaginosis (BV)	Syphilis
Genital herpes	Cervicitis	Ovarian cyst
Abnormal bleeding	Breast surgery	Trichamonas (Trich)
Chlamydia	Fibroids	PID
Oral herpes (cold sores)	Cervical surgery	Uterine surgery
Infertility	Abnormal PAP	Gonorrhea
Genital sores	Condyloma (warts)	HPV
Cervical polyp	Endometriosis	Breast lumps
HIV	DES exposure	

What kinds of birth control have you used in the past? _____

Any problems or complications from them? _____

When was your last pap smear? _____Was it normal? _____

MENSTRUAL HISTORY

How old were you when your periods started? _____

How many days do your periods last? _____

My periods are usually (CIRCLE one): light medium heavy very heavy

What was the FIRST day of your last period? _____

Are you sure? (CIRCLE one) Yes No Was it a normal period? _____

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CURRENT PREGNANCY

Please CIRCLE any of the following problems you have experienced during this pregnancy:

Nausea	Headache	Leg cramps
Swelling	Urinary problems	Vaginal discharge
Indigestion	Vomiting	Dizziness
Fever	Rash	Bleeding gums
Constipation	Hemorrhoids	Abdominal/pelvic pain
Vaginal bleeding/spotting	Varicose veins	Backache
Diarrhea	Family problems	Loneliness
Relationship problems	Depression	Work problems

Notes: _____

_____

When do you think you may have conceived? _____

Have you had a positive pregnancy test? (CIRCLE one) Yes No When? _____

Was this a planned pregnancy? (CIRCLE one) Yes No

What are your feelings about this pregnancy? _____

_____

Were you using birth control? (CIRCLE one) Yes No What kind? _____

Are you taking prenatal vitamins? (CIRCLE one) Yes No When did you start? _____

What kind are they? _____

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ADDITIONAL INFORMATION

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

Did she have any miscarriages? _____ How long were her labors? _____
Were there any complications in any of her pregnancies? _____
How much did you weigh at birth? _____ The baby's father? _____

Do you have any sisters who have given birth? _____
How long were there labors? _____
Did they have any complications in pregnancy or birth? _____
Do you suffer from any anxiety or depression? (CIRCLE one) Yes No

Have you had an eating disorder? (CIRCLE one) Yes No

Describe: _____

Have you been in an abusive relationship in the past? (CIRCLE one) Yes No

Are you in an abusive relationship now? (CIRCLE one) Yes No

Have you ever had non-consensual sex? (CIRCLE one) Yes No

Were you sexually abused or molested as a child? (CIRCLE one) Yes No Not sure

Do you have or have you ever had, a drug problem? (CIRCLE one) Yes No

Have you ever had a blood transfusion? (CIRCLE one) Yes No

If so, when and where? _____

Have you ever used intravenous (injected) drugs? (CIRCLE one) Yes No

Do you think you are at increased risk for HIV/AIDS? (CIRCLE one) Yes No

How many alcoholic drinks have you had in the past week? _____ Month? _____

Since you found out you were pregnant? _____

Do you smoke? (CIRCLE one) Yes No How many cigarettes per day? _____

If you smoked in the past but don't now, when did you quit? _____

Do you believe your baby could be at risk for any hereditary medical conditions, and if so, which one(s)?

_____

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CIRCLE all the following that you have used or been exposed to during this pregnancy:

Tobacco	Caffeine	Alcohol
Marijuana	Cocaine	Street drugs
Viruses	Measles	Cats
Vaccinations	Ultrasounds	X-rays
Herbs	Vitamins	Non-prescription drugs
Prescription drugs	Fumes/sprays/pesticides	Other hazards

How would you describe your usual diet? _____

_____

Why do you want to use a midwife? _____

_____

_____

Do you have any ethnic, cultural, or religious preferences for your care? _____

_____

_____

Is there anything else you would like to tell me or that you think I should know? _____

_____

_____