

Birth With Midwife, LLC
N3631 Slatts Rd Cascade WI 53011
920.528.7072

Today's Date: _____ Due Date: _____

Name: _____

Spouse/Coach Name: _____

Address: _____

Phone: _____ **email:** _____

Your age: _____ Height: _____ Pre-pregnant Weight: _____

Your Occupation: _____ Mate's Occupation: _____

Back-Up Doctor: _____ **Phone:** _____

Hospital: _____ **Phone:** _____

Closest hospital to home: _____ Phone: _____

Ambulance: _____ Phone: _____

YOUR HISTORY (circle)

Asthma; TB; respiratory; kidney or heart disease; rheumatic fever; high or low blood pressure; cancer; German Measles; diabetes; thyroid problems; epilepsy; pelvic infection; birth defects; twins. Details: _____

Name any known drug allergies: _____

List any injuries, surgeries or hospitalizations (give dates): _____

Blood transfusions (give dates): _____ Details: _____

Chlamydia: Yes No Details of treatment: _____

Bacterial Vaginosis: Yes No Details of treatment _____

Herpes: Yes No Details of treatment: _____

Birth Control Pills: Yes No Type: _____ Duration: _____

Age when taken: _____ Complications or side effects: _____

Intra-Uterine Device: Yes No Complications: _____

Other birth control used: _____

Complications or side effects: _____

Difficult in conceiving: Yes No Details and treatment (if any): _____

List any drugs you are presently taking: _____

Vitamins or Herbs: _____

Cigarettes: _____ Coffee (caffeine): _____

Diet: Vegetarian: _____ Type: _____ For how long: _____

Non-Vegetarian: _____ Type of meat eaten: _____

Do you think your nutrition is adequate: Yes No

Do you want more specific guidance: Yes No

HISTORY SINCE LAST MENTRUAL PERIOD: (circle)

First day of last M.P.: _____ Sure: _____ Describe last M.P. _____

Menstrual History: Length of Cycle: _____ Days of Flow: _____

Bleeding or spotting; rashes; varicose veins; headaches; insomnia; constant fatigue; backache; leg cramps; morning sickness; poor appetite; overweight; excessive nervousness; bowel irregularity; x-rays; anemia; heartburn; inverted nipples; retain water; yeast; or other vaginal infection; viral or bacterial infection; medication

Details: _____

PREVIOUS PREGNANCIES:

Names and ages of any living children: _____

Give by number and year any of the following that apply:

_____ Live Births _____ Miscarriages
_____ Still Births _____ Abortions

PREVIOUS LABORS:

	1 st	2 nd	3 rd	4 th	5 th
Length of labor	_____	_____	_____	_____	_____
First sign of labor	_____	_____	_____	_____	_____
Drugs (if used)	_____	_____	_____	_____	_____
Where delivered	_____	_____	_____	_____	_____
Weeks gestation	_____	_____	_____	_____	_____
Presentation	_____	_____	_____	_____	_____
Baby's Weight	_____	_____	_____	_____	_____
Method of preparation	_____	_____	_____	_____	_____
Breastfed (how long)	_____	_____	_____	_____	_____
Hemorrhages	_____	_____	_____	_____	_____

Explain any problems you had during pregnancy, labor or delivery: _____

GENERAL:

To what extent will the child's father be assisting you in the birth? _____

What children and provisions for their tending will be there? _____

What is the major influence in your wanting a home birth? _____

Who made the decision to have this baby at home? _____
