REGISTRATION FORM

Community Midwives, LLC
www.communitymidwives.info

Thank you for trusting me with your personal information. It will be honored with absolute confidence and respect.

Name: First Middle Last What name do you prefer to go by?			Today's Date
Married? Y / N	If unmarried, do you plan to add your partner/ father of your baby to the birth certificate? Y / N	Type of Work	Date of Birth
Address: Street City Zip County		Email	
Is there anything else you'd like me to know about your work, living situation, or personal identity?			Phone
Medicaid/BadgerCare 10-digit ID Number:		How did you learn about Community Midwives?	
Partner's Name (if partnered): First Middle Last What name do they prefer to go by?			Date of Birth
Is there anything else you'd like me to know about your partner's work, living situation, or personal identity?		Type of Work	
If the father/sperm donor is not your partner, is there anything you'd like me to know about that person?		Another person to contact, if needed: Name: Phone:	
Method of Payment: ☐ Public insurance (Medicaid/BadgerCare) ☐ Self-pay ☐ VA ☐ Tricare ☐ Private insurance – name of company:		Name of Insurance: Hospital that your insurance covers:	
Last 4 digits of your Social Security Number:	Your height:		Your weight:

PRESENT PREGNANCY **Do you have any known allergies?** ______________________________

1st day of last menstrual period:	How are you feeling about this pregnancy?
Was this a normal period for you? Y / N	
Date you believe you conceived:	How is your partner feeling about this pregnancy?
Pregnancy test date:	

Have you experienced any of the following during this pregnancy? (these can be normal in pregnancy)

☐ Nausea________	☐ Leg cramps________	☐ Sleep apnea________	☐ Stress________
☐ Vomiting________	☐ Rash________	☐ Abdominal / pelvic pain________	☐ Work difficulties________
☐ Fever________	☐ Backache________	☐ Vaginal bleeding / spotting________	☐ Loneliness________
☐ Infections________	☐ Swelling________	☐ Vaginal discharge________	☐ Family or relationship difficulties________
☐ Headaches________	☐ Constipation________	☐ Hemorrhoids________	________
☐ Dizziness________	☐ Diarrhea________	☐ Varicose veins________	________
☐ Indigestion________	☐ Bleeding gums________	☐ Depression________	☐ Other________

Have you been exposed to any of the following during this pregnancy? How frequently, when?

☐ Tobacco________	☐ Over-the-counter medications________	☐ Fumes / sprays________	☐ Vaccinations________
☐ Alcohol________	________	☐ X-rays________	☐ Cats________
☐ CBD/THC/Cannabis________	☐ Prescription meds________	☐ Ultrasound________	☐ Other________
☐ Cocaine________	☐ Vitamins________	☐ Measles / Viruses________	________
☐ Opioids________	☐ Herbs________	☐ Travel________	________

REPRODUCTIVE HISTORY

Do you have a period every 28 days or so? Y / N	When was your last Pap smear?
If not, how many days are there between cycles, usually?	Have you ever had an abnormal Pap? Y / N If yes, date(s) :
What are your periods like for you?	Type of treatment(s):

Have you experienced any of the following and if so, when?

☐ Yeast________	☐ Syphilis________	☐ Cervical surgery________	☐ Uterine surgery________
☐ Trichomonas________	☐ PID / Pelvic infection________	☐ Cervical polyp________	☐ Breast lump(s)________
☐ Group B Strep________	☐ Genital sores________	☐ Ovarian cyst________	☐ Breast surgery________
☐ Bacterial vaginosis________	☐ Herpes: Genital Oral	☐ Fibroids________	☐ Infertility________
☐ Chlamydia________	☐ Condyloma (warts)________	☐ Endometriosis________	☐ Other________
☐ Gonorrhea________	☐ HPV________	☐ Abnormal bleeding________	________

REGISTRATION FORM

PREVIOUS PREGNANCIES

	Date of childbirth or end of pregnancy	No. Weeks	Name	Weight	Medications/ procedures	Location	Briefly, what was this experience like for you? (I invite you to discuss this with me.)
1							
2							
3							
4							
5							
6							
7							

MEDICAL HISTORY

Have you experienced any of the following in the past? If yes, when?

☐ Severe headaches________	☐ High blood pressure________	☐ Bowel problems / colitis________	☐ Urinary tract infection________
☐ Eye / vision problems________	☐ Varicose veins________	☐ Blood in stool________	☐ Arthritis/Aching joints________
☐ Ear / hearing problems________	☐ Hemorrhoids________	☐ Gall bladder problems________	☐ Pelvic / back injuries________
☐ Dental problems________	☐ Tuberculosis________	☐ Liver problems________	☐ Seizures________
☐ Thyroid problems________	☐ Asthma________	☐ Hepatitis________	☐ Cancer________
☐ Rheumatic fever________	☐ Skin disorders________	☐ Diabetes________	☐ Hospitalizations________
☐ Blood clotting problems________	☐ Stomach problems________	☐ Hypoglycemia________	☐ Surgeries________
☐ Anemia________	☐ Ulcers________	☐ Bladder infection________	☐ Other________
☐ Hemorrhage________	☐ Chicken pox________	☐ Kidney infection________	________

Family history – Has anyone in your immediate family experienced any of the following? If so, who & when?	**Partner** – Has your partner experienced any of the following? If so, when?	**Your Mother**
☐ High Blood Pressure________	☐ Sexually transmitted infections________	How many pregnancies did your mother have?________
☐ Thyroid Imbalance________	☐ Herpes (Genital or Oral)________	How many full-term births did your mother have?________
☐ Diabetes________	☐ Severe emotional problems________	Please describe pregnancy complications, releases, or losses:________
☐ Twins________	☐ Alcohol/Drug dependency ________	________
☐ Severe emotional problems________	☐ Tobacco use________	Did your mother breastfeed? Y / N If yes, did she experience breastfeeding difficulties? ________
☐ Alcohol/Drug dependency________	☐ Sleep apnea________	What is your birth story?________
☐ Other________	☐ Other________	________

A few more questions that may be important to your own or your baby's health…. (feel free to write in the margins or on the lines provided below)

☐ Yes ☐ No Have you or the father of the baby (FOB) had a previous baby with a developmental problem?
☐ Yes ☐ No Do you or the FOB have any family member with birth defects or conditions diagnosed as genetic or inherited?
☐ Yes ☐ No Are you and the FOB related by blood? (for example, cousins)
☐ Yes ☐ No Are you or the FOB from any of these ethnic or racial groups ? ☐ Jewish ☐ Black/African ☐ Asian ☐ Mediterranean
☐ Yes ☐ No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
☐ Yes ☐ No Have your or the FOB ever had hepatitis or jaundice?
☐ Yes ☐ No Have you ever used any drug intravenously (IV)?
☐ Yes ☐ No Have you ever had a sexual partner who used IV drugs?
☐ Yes ☐ No Do you think you may be at risk for HIV, AIDS, or other sexually transmitted infections?
☐ Yes ☐ No Do you, or does your partner, have more than one sexual partner?
☐ Yes ☐ No Have you ever had anorexia, bulimia or other eating problems?
☐ Yes ☐ No Have you ever experienced dramatic fluctuations in your weight?
☐ Yes ☐ No Have you ever been in an abusive or violent relationship, including now (intimidated, hit, coerced, or made to take part in sexual activities against your will)?
☐ Yes ☐ No Have you been on medication for emotional or psychological difficulties?
☐ Yes ☐ No Has anyone ever told you or do you think you have used alcohol or drugs excessively?

If you answered "Yes" to any of the above, would you like to share further details?________

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Are there questions I should have asked but didn't?________

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Thank you!