CLIENT REGISTRATION

Community Midwives, LLC
www.communitymidwives.info

Please complete the following contact information. Demographic details are required for your baby's birth certificate worksheet.

Name: First Middle Last				Today's date	Phone (home / work / cell)
Race	Married? Y / N	School Grade/Educ. Level Completed	Occupation/Type of Work	Date of Birth	State of Birth
Address: Street City Zip County					Email
Partner's Name: First Middle Last			Race	Date of Birth	State of Birth
Address (if different from above)		Phone (home / work / cell)		Occupation/Type of Work	
Father of Baby (if different from Partner)		Race	Another person to contact in emergency Name: Phone:		
Method of Payment: ☐ Insurance ☐ Cash ☐ Medicaid (Title 19 or BadgerCare) Eligible for WIC? Y / N			How did you find out about us?		
Social Security Number		Medicaid/Forward Card Number	Husband's Social Security Number (if married)		

PRESENT PREGNANCY

Do you have any allergies? _____

Please answer the following questions to help us thoroughly review the health of you and your baby. This information is completely confidential.

1st day of last menstrual period_____
Normal? ☐ Yes ☐ No

Planned pregnancy? ☐ Yes ☐ No

Suspected date of conception_____

Pregnancy test (date) _____

How do you feel about this pregnancy?_____

Partner's feelings?_____

Contraception used up to present: what/when/any problems?_____

Please indicate if you have had any of the following during this pregnancy (many of these are normal in pregnancy):

☐ Nausea_____	☐ Leg cramps_____	☐ Urinary complaints_____	☐ Stress_____
☐ Vomiting_____	☐ Rash_____	☐ Abdominal / pelvic pain_____	☐ Work difficulties_____
☐ Fever_____	☐ Backache_____	☐ Vaginal bleeding / spotting_____	☐ Loneliness_____
☐ Infections_____	☐ Swelling_____	☐ Vaginal discharge_____	☐ Family/relationship difficulties_____
☐ Headache_____	☐ Constipation_____	☐ Hemorrhoids_____	_____
☐ Dizziness_____	☐ Diarrhea_____	☐ Varicose veins_____	☐ Other_____
☐ Indigestion_____	☐ Bleeding gums_____	☐ Depression_____	_____

Please indicate if you have used or been exposed to any of the following during this pregnancy:

☐ Tobacco_____	☐ Non-pres.meds_____	☐ Fumes / sprays_____	☐ Vaccinations_____
☐ Alcohol_____	☐ Prescr. meds _____	☐ X-rays_____	☐ Cats_____
☐ Marijuana_____	☐ Vitamins_____	☐ Ultrasound_____	☐ Other_____
☐ Cocaine_____	☐ Herbs_____	☐ Measles / Viruses_____	_____
☐ Other drugs_____	_____	☐ Travel_____	_____

GYNECOLOGIC HISTORY

What are your menstrual periods like for you and how long do they last? _____

_____

_____

_____

When was your last Pap smear? _____

Have you ever had an abnormal Pap? (dates) _____

Are your cycles regular? ☐ Yes ☐ No Length of cycle?_____

Cause & treatment for your abnormal pap?_____

_____

_____

_____

Please indicate if you have had any of the following and 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_____	☐ Cervicitis_____	☐ Abnormal bleeding_____	_____

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PREVIOUS PREGNANCIES **Please complete this table regarding your own pregnancies**

	Date	Birth / Miscarriage / Termination	# Weeks	Name	Sex	Weight	Hours Labor	Any Meds	Any Complications	Location
1										
2										
3										
4										
5										

MEDICAL HISTORY **Please indicate if you have ever had any of these and when**

☐ Severe headaches_____	☐ High blood pressure_____	☐ Bowel problems / colitis_____	☐ Urinary tract infection_____
☐ Eye / vision problems_____	☐ Varicose veins_____	☐ Blood in stool_____	☐ Urethral dilation_____
☐ Ear / hearing problems_____	☐ Hemorrhoids_____	☐ Gall bladder problems_____	☐ Aching joints_____
☐ Dental problems_____	☐ Tuberculosis_____	☐ Liver problems_____	☐ Pelvic / back injuries_____
☐ Thyroid problems_____	☐ Asthma_____	☐ Hepatitis_____	☐ Seizures_____
☐ Rheumatic fever_____	☐ Skin disorders_____	☐ Diabetes_____	☐ Cancer_____
☐ Blood clotting problems_____	☐ Stomach problems_____	☐ Hypoglycemia_____	☐ Hospitalizations_____
☐ Anemia_____	☐ Ulcers_____	☐ Bladder infection_____	☐ Surgeries_____
☐ Hemorrhage_____	☐ Chicken pox_____	☐ Kidney infection_____	☐ Other_____

Family history – Indicate if anyone in your immediate family has ever had any of these, who, when.	**Father of Baby** – Indicate if the baby's father has ever had any of these; when.	**Your Mother's History** – Please answer the following regarding your mother:
☐ High Blood Pressure_____	☐ Sexually transmitted infections_____	☐ No. of pregnancies_____
☐ Thyroid Imbalance_____	☐ Herpes (Genital or Oral)_____	☐ No. of births_____
☐ Diabetes_____	☐ Severe emotional problems_____	What is your own birth story? Did your mother (or sister) have any pregnancy/birth/postpartum/breastfeeding difficulties?
☐ Twins_____	☐ Alcohol/Drug dependency _____	_____
☐ Severe emotional problems_____	☐ Tobacco use_____	_____
☐ Alcohol/Drug dependency_____	☐ Other_____	_____
☐ Other_____	_____	_____

I am grateful for your sharing the following pregnancy-relevant information with me. It will be held in the strictest confidence.

☐ Yes ☐ No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?

☐ 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? (e.g., cousins)

☐ Yes ☐ No Are you or the FOB from any of these ethnic or racial groups ? ☐ Jewish ☐ Black/African ☐ Asian ☐ Mediterranean

☐ Yes ☐ No Have your or the FOB ever had hepatitis or jaundice?

☐ Yes ☐ No Have you ever used any drug intravenously (IV) or had a blood transfusion?

☐ Yes ☐ No Have you ever had a sexual partner who used any IV drugs, had a blood transfusion, or had bisexual relations?

☐ Yes ☐ No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

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

☐ Yes ☐ No Have you ever experienced dramatic fluctuations in your weight?

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

☐ Yes ☐ No Has anyone ever told you or do you think you have ever used alcohol or drugs excessively?

☐ Yes ☐ No Have you ever been in an abusive relationship, including now (emotionally intimidated, hit, injured, or made to take part in sexual activities against your will)?

☐ Yes ☐ No Have you ever had severe emotional difficulties?

☐ Yes ☐ No Have you ever been on any medication for emotional or psychological difficulties?

☐ Yes ☐ No Is there anything about any of your relationships that you would like to discuss?

Please give brief directions to your home, including landmarks_____

_____

_____

_____