

History

We ask the following questions because it is information needed for filing a certificate of live birth for your new baby.

Race of Mother: (please circle one)

White Black/African American American Indian or Alaskan Native : Name of Tribe _____
Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian Samoan
Guamanian or Chamorro Other Pacific Islander (Specify) _____ Other Asian (Specify) _____
Other (Specify) _____
Are you Hispanic/Latina? Y/N If Yes, Mexican, Mexican American, Chicana Puerto Rican Cuban Other _____

Race of Father: (please circle one)

White Black/African American American Indian or Alaskan Native : Name of Tribe _____
Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian Samoan
Guamanian or Chamorro Other Pacific Islander (Specify) _____ Other Asian (Specify) _____
Other (Specify) _____
Are you Hispanic/Latina? Y/N If Yes, Mexican, Mexican American, Chicana Puerto Rican Cuban Other _____

Medical History

- Anorexia/Bulimia
- Chronic Hypertension (requiring Rx)
- Non-gestational Diabetes
- Heart Disease
- History of Sexual Abuse/Assault
- Oral/Genital Herpes
- Positive HIV Antibody
- Seizures (requiring Rx)
- Smoker
- Asthma (requiring Rx)
- Depression/Psychiatric Diseases (requiring Rx)
- Blood clotting disorders?/ Hemoglobinopathy
- History of Domestic Violence
- Chronic Renal Disease
- Family history of genetic disorders
- Thyroid Disease (requiring Rx)
- Cervical Surgery (Leep)
- Prior Chemotherapy or radiation treatment for a malignancy
- HIV positive status
- Current abnormal cervical cytology
- Sleep apnea
- Previous bariatric surgery
- Hepatitis
- Cervical Insufficiency
- Alcohol Abuse/Drug Abuse
- Allergies to Prescription Medications

History, Cont.

Family History

Please indicate if your mother or father has ever had any of the following:

- | | | |
|--|---------------------------------|---------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |

Health Questions

1. What forms of birth control have you used?

Pill or mini-pill IUD Diaphragm Cervical Cap Breastfeeding Condoms Natural Family Planning/Rhythm

2. Did you have any difficulty conceiving this baby? No Yes

(describe) _____

3. Was this a planned pregnancy? Yes No

4. When was your last pap smear? Mo/ Year _____

5. What was the result? Normal Irregular, if so, why? _____

6. At what age did you have your first period? _____

7. How often (every how many days) do you have a period? _____ days

8. How long do you bleed during your period? _____ days.

9. Are your periods regular? Yes No If no, please

describe _____

10. What was the first day of your last period? _____

11. Was this period normal? Yes No If no, please

describe _____

12. Are you certain about the date of your last period? Yes No

13. Do you know your date of conception? Yes No If yes, give date _____

14. Please list all ultrasounds you have had for this pregnancy.

Date _____ Week of pregnancy _____ Due date given based on ultrasound _____

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Date _____ Week of pregnancy _____ Due date given based on ultrasound _____

15. Has another care provider given you a due date? Yes No If yes, what is the date? _____

Other Care for this Pregnancy

Have you seen any other providers (for example, a doctor or another midwife) for this pregnancy? Yes No If yes, please describe:

Provider _____ Date of first visit _____ Number of visits w/ this provider _____

Provider _____ Date of first visit _____ Number of visits w/ this provider _____

History, Cont.

Pregnancy History

The following information is needed for filing a certificate of live birth for your new baby.

1. Is this your first pregnancy? ____Yes ____No If No:
2. How many times have you been pregnant before (including miscarriages, abortions, stillbirths)? ____
3. How many times have you:
Miscarried? ____ Month/Year of last miscarriage ____
Had an abortion? ____ Month/Year of last abortion ____
4. Have you had a C-Section? ____ And if so, how many? ____
5. What was your pre-pregnant weight for this pregnancy? ____

Pregnancy History

- Gestational Diabetes
- IUGR/SGA
- Neonatal Death
- Placenta Previa/Abruption
- Postpartum Hemorrhage
- Pyelonephritis
- Rh or other blood group or platelet sensitization
- Vacuum or Forceps
- Congenital Abnormalities/Genetic Disease
- Hyperemesis
- LGA
- Gestational Hypertension
- Postpartum Depression
- Preterm Birth (<37 weeks)
- Retained Placenta
- Shoulder Dystocia
- Pre-eclampsia resulting in preterm delivery
- GBS +



Birth History

Please fill out one of these charts for each previous pregnancy.

Pregnancy # _____ Date pregnancy ended _____ Week of gestation in which pregnancy ended _____

For these outcomes, skip the remainder of the table:

___ Miscarriage - did you have a D&C? ___ Yes ___ No

___ Ectopic Pregnancy

___ Elective Termination (abortion)

For these outcomes, fill out the remainder of the table:

___ Stillborn

___ Live Birth-is child still living? ___ Yes ___ No - cause of death? _____

Child's Name _____ **Date of Birth** _____ **Gender(circle one) M /F**

of Days Early _____ **OR # of Days Late** _____ **Birth Weight** _____

If born in Idaho, who was the care provider? _____

Labor: ___ Started on it's own ___ Was induced How many hours were you in labor? _____

If induced, what was the method of induction?

___ Pitocin (oxytocin) ___ Stripped membranes ___ Foley Catheter ___ Prostaglandin Gel

___ Breaking the water ___ Cytotec (miso-prostol) ___ Other _____

What medication did you receive during this labor? _____

Method of delivery: ___ Vaginal-spontaneous ___ vaginal-forceps ___ Vaginal-vacuum ___ Cesarean

If Vaginal:

How long did you push? _____

Did you have:

___ Episiotomy ___ First or second degree tear ___ Third or fourth degree tear ___ No tear

If Cesarean:

What type of incision did you have? ___ low transverse (bikini-cut) ___ vertical(classical) ___ unknown

Reason for cesarean:

___ failure to progress ___ baby in distress ___ baby too big ___ breech baby ___ posterior position

Please tell us any significant features about this birth, including any complications:
