Womancare Midwifery Center 20 East. Cherry. Flagstaff, AZ 86001 928-779-6064

PRENATAL AND HOME BIRTH SCREENING QUESTIONAIRE

Name:_______________________________________ SSN: __________________ Date: _______________
Address: ____ Phone: _________________
Maiden name if married ____________________E-mail:____
Age: ___________ Date of Birth: ______________________ Place of Birth: _____________________________
Occupation: _____________________________ Employer: ______________________________ Full/Part Time
Marital Status: ___________________________ Race/Ethnic Background: ______________________________
Education: ___________________________ Do you have dependents at home? __________ How many?______
Husband or Partner: ____ SSN: _______________________
Age: _______Date of Birth: _________________ Place of Birth: __________________Phone:______________
Occupation: _____________________________ Employer: ______________________________ Full/Part Time
Education: ______________________________ Race/Ethnic Background: ______________________________

PRESENT PREGNANCY INFORMATION

First day of your last menstrual period: _____________________ Previous menstrual period: ________________
Are you sure of this date? ________________________________

During this pregnancy have you experienced any of the following?

___ Anemia (medically diagnosed)
___ Bladder/Kidney Infection
___ Immunizations
___ Ultrasound Examination
___ X-rays
___ TB skin test
___ Food cravings
___ Non-food cravings (clay, starch, etc)
___ Vaginal infections
___ Vaginal bleeding
___ Herpes outbreak
___ Pain with intercourse
___ Repeated vomiting
___ High fever
___ Rash
___ Headaches
___ Blurred vision
___ Dizziness
___ Fainting
___ Swelling
___ Leg cramps
___ Tiredness
___ Depression

Please comment on any checked above: ____
____
____

PREVIOUS PREGNANCIES: (Including miscarriages, abortions, stillbirths, etc.)

Date	Name	Sex	Weight	Full-term	Type of Delivery	Length of Labor	Weight Gain	Complications

In previous pregnancies, have you had any of the following occurrences? If yes, explain.

_____Anemia_______________________________
_____ Severe nausea or vomiting requiring an IV
____
_____ Spotting or bleeding ___________________
_____ Bladder infections ____________________
_____ Kidney infections _____________________
_____ High blood pressure ___________________
_____ Toxemia or pre-eclampsia _______________
_____ Placenta previa _______________________
_____ Diabetes ____________________________
_____ Rh incompatibility _____________________
_____ Other blood incompatibility
____
_____ Group B Streptococcus _________________
_____ A cerclage placed on the cervix
____
_____ A breach baby at delivery________________
_____ A baby with a congenital anomaly
____
_____ Intrauterine Growth Restriction
____
_____ Posterior baby during labor or at birth
____
_____ Premature labor _______________________
_____ Placental abrubtion _____________________
_____ Induced labor _________________________
_____ Membranes ruptured longer than 12 hours
____
_____ Medication for pain ____________________
_____ Shoulder Dystocia _____________________
_____ Episiotomy ___________________________

_____ Tearing and stitches (how severe?) ____
_____ Difficulty delivering placenta ____
_____ Forceps/Vacuum delivery _______________
_____ Hemorrhage ___________________________

_____ Cesarean delivery ______________________
_____ Severe depression after birth ____
_____ Difficulty breastfeeding ____

GYNECOLOGICAL HISTORY

Menstruation:
Age began: _______ Regular: __________ Irregular: ___________ Number of days between periods: _________
Number of days flow: ______________ Light, Medium, Heavy: ____
Bleeding between periods: __________________________ Severe pain or cramps: ________________________

Have you ever had any of the following problems? If so, explain situation and treatment.

___ Vaginal infection ______________________
___ Pelvic infection _______________________
___ Ovarian cysts ________________________
___ Fibroids or tumors _____________________
___ Abnormal pap smear ___________________
___ D & C (dilation & curettage) _________________
___ Genital herpes ______________________________
___ Gonorrhea or Chlamydia ____________________
___ Syphilis ____________________________________
___ Venereal warts _____________________________

What methods of birth control have you used? ____
Were these methods satisfactory? If not, why? ____
What was the most recent method used and when was it last used? __________________________________
Was this a planned pregnancy? ____
Did you have any difficulties getting pregnant? If so, explain. ____
____
Is your sex life entirely satisfactory? ____
Is your mate supportive of this pregnancy? ____
Did you breastfeed previous children? __________ How long did you breastfeed? _________________________
Do you intend to breastfeed this baby? If not, why? ____

PERSONAL MEDICAL HISTORY (Explain as necessary)

Have you been in good health most of your life? ____
How have you been feeling with this pregnancy? ____
Were you ever chronically ill as a child? ____
Are you a survivor of any kind of abuse (emotional, physical, sexual, or other)? ___________________________
Would you accept a blood transfusion? ____
Have you ever had a serious injury? ____
Have you gained or lost 10 pounds or more in the past year? ___________________________________

Give the approximate age at the onset of any of the following illnesses you have or have had in the past:

Age
____ Measles (3 day)
____ German measles
____ Mumps
____ Chickenpox
____ Mononucleosis
____ Scarlet fever
____ Rheumatic fever
____ Tuberculosis
____ Meningitis
____ Repeated urinary infections
____ Anorexia or Bulimia

Age
____ Diabetes
____ Emphysema
____ Bronchitis
____ Asthma
____ Thyroid disease
____ Hepatitis/Jaundice
____ Pancreatitis
____ Cancer
____ Kidney disease
____ Pneumonia
____ Substance Abuse

Age
____ Peptic ulcer
____ Varicose veins
____ Gallbladder problems
____ Seizures
____ Hives
____ High blood pressure
____ Arthritis
____ Hernia
____ Heart Disease
____ Emotional Disorder

____ Other ____
Please comment on any checked above if complications arose: ____________________________________
____
____

Have you had any operations or illnesses requiring hospitalization?

Type of Illness or Operation Requiring Hospitalization	Month/Year	Hospital/City/State
____	__________	____________________
____	__________	____________________
____	__________	____________________

Are you allergic or sensitive to any of the following? If yes, explain what happened when you took it.

____ Penicillin or other antibiotics ____________________

____ Morphine, codeine, or Demerol ____________________

____ Novacaine or anesthetics ____________________

____ Sulfa drugs ____________________

____ Aspirin, empirin, or other pain medicine ____________________

____ Latex ____________________

____ Iodine or merthiolate ____________________

____ Other specific drug or medication ____________________

____ Specific foods, vitamins, etc. ____________________

Are you currently using any medications or natural remedies? If yes, explain.

____ Antacids ____________________

____ Aspirin ____________________

____ Cold medications ____________________

____ Tranquilizers ____________________

____ Accutane in past 5 years ____________________

____ Herbs, teas or capsules ____________________

____ Homeopathic tinctures ____________________

____ Laxatives ____________________

____ Any prescription medications ____________________

____ Other ____________________

Have you or your blood relatives ever had:

	Problem	Relative(s)
____	Cancer	____________________
____	Tuberculosis	____________________
____	Emotional disorders	____________________
____	Heart disease	____________________
____	High blood pressure	____________________
____	Kidney disease	____________________
____	Seizures	____________________
____	Diabetes	____________________
____	Anemia	____________________
____	Suicidal tendencies	____________________
____	Asthma or allergies	____________________
____	Multiple pregnancies (twins)	____________________
____	Premature babies	____________________

PRENATAL DIAGNOSIS SCREENING QUESTIONS

Have you or the baby's father or anyone in either or your families ever had:

	Yes	No	Explain
Down's syndrome or mongolism?	___	___	____________________
Spinabifida, anecephaly, or meningomyelocele (open spine)	___	___	____________________
Hemophilia (excessive bleeding)	___	___	____________________
Muscular dystrophy	___	___	____________________
A child born dead or alive with a birth defect not listed in above questions	___	___	____________________
A child who was mentally retarded (If yes, list cause if known)	___	___	____________________
Any inherited genetic or chromosomal disease or disorder not listed above	___	___	____________________
Three or more miscarriages	___	___	____________________
A positive screen for sickle-cell trait	___	___	____________________

Any relatives descended from Jewish people who lived in eastern Europe (Ashkenazic) ___ ___ ______________________________
If yes, have you or the baby's father been screened for Tay Sachs disease? ___ ___ ______________________________

YOUR MOTHER'S OBSTETRICAL HISTORY

How many babies did your mother have? _______ Any Cesarean sections?_______ Why? ________________
Were there any twins, breech babies, or serious complications that you know of? ____________________
____
What was her attitude toward childbirth? ____
What was her attitude toward breastfeeding? ____
Did your mother or your husband's mother take DES while pregnant? __________________________
How do your parents feel about your pregnancy? _______________________________________
Is there a history of very large or very small babies in your family? ___________________________

PERSONAL/SOCIAL SITUATION

Why do you want to give birth at home? ____
____
____
Directions to your home: ____
____
____
Describe your living space: ____
____
If you don't have a telephone, do you have immediate access to one? __________________________
Name of family physician: ___________________________ Pediatrician: _____________________________
What physician would you prefer to be involved with your care when necessary during this pregnancy? ________
____
Would you for any reason <u>refuse</u> any medical procedures (i.e., blood products and/or transfusions)? ___________
If yes, please describe which procedures you would refuse. ________________________________
Do you smoke cigarettes? ________ Amount per day 3 months prior to pregnancy:________ Does your partner smoke? _______ Are you trying to quit for this pregnancy? ________ Amount per day now:_________________
Do you drink alcohol? _____________ Drinks per week 3 months prior to pregnancy_______________________
Drinks per week now______________ Do you smoke Marijuana?________ Amount per day:________________
During this pregnancy have you used recreational drugs? If so, explain when, type, and amount. (Answers will be held in strict confidence): ____
Are you taking vitamins now? Explain:____
Do you have any dietary restrictions? ____
Briefly describe your food intake on an average day (number of meals, content, snacks, amount of water and other liquids):____
____
Briefly describe what you do for exercise:____
____
Briefly describe what you do for relaxation: ____
____

EMERGENCY CONTACT

(other than your partner)

Name: ____ Phone: ____________________________
Address: ____

Name and signature of person who filled out this form if other than client: _______________________
Signature of client: ____
Signature of midwife: ____ Date: __________________________