Center for Natural Birth
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Client History Questionnaire

Welcome to Center for Natural Birth. We are happy to provide prenatal care for you and are happy to be your partner for health care during your pregnancy. Our goal is to understand your health history so that we can individualize your care and provide a foundation for remaining healthy both in the pregnancy and for the future. Please help us to begin your care by completing the following questionnaire. It will give us an opportunity to identify areas that we need to discuss further and begin meeting some of the questions or concerns that you might have. Attached is also a "Notes" page that we hope you will use to write down any questions that you might have for us. That way your questions don't get forgotten! We look forward to working with you and your family during this special time.

Today's Date: ________________

Patient's Name: ____ (______________________)
First Middle Last Maiden

Home Address: ________________________________ Phones: _______________________________

Date of Birth: ______ Age: _______ Height: _____ Pre-pregnant weight: ______ Religion: ______________

Occupation: _____________________________ Highest grade of school completed: ________________

Race/Ethnicity (Mark all that apply for YOU)

☐ Hispanic	☐ White	☐ Black	☐ Chinese	☐ Japanese
☐ Korean	☐ Cambodian	☐ Laotian/Laos	☐ Vietnamese	☐ Other Southeast Asian
☐ Filipino	☐ Native American	☐ Middle Eastern	☐ Asian-East Indian	☐ Hawaiian
☐ Guamanian	☐ Samoan	☐ Unknown	☐ Other (please specify) ____________________	

Baby's Father:

Name: __________________________________ Age: ______ Height: __________ Weight: _________

Occupation: _____________________________ Business Phone: ______________________________

Race: ☐ Hispanic ☐ White ☐ Black ☐ Asian ☐ Native American Other: ______________

Is he the father of your other children: ☐ Yes ☐ No ☐ N/A
Does he have children from a previous relationship? ☐ Yes ☐ No ☐ N/A
Does he have any serious illness? ____

How did you hear about our practice? ____

PERSONAL MEDICAL HISTORY:

Do YOU now have (or have you ever had) any of the following?
If the answer to any of the questions is yes, circle the problem and explain what and when

		NO	YES	Explain
1.	Ulcers, Colitis, Hepatitis	☐	☐	____________________
2.	Eating disorders: Anorexia, Bulemia	☐	☐	____________________
3.	Bladder Infection, Urinary Tract Infection (UTI) Kidney Infection (Pyelonephritis), Kidney Disease	☐	☐	____________________
4.	Sexually Transmitted Diseases/Infections For example: Trichomonas, Genital Warts (Condyloma/HPV), Chlamydia, Gonorrhea, Herpes, Syphilis, HIV (AIDS). If history of herpes, give date of last outbreak	☐	☐	____________________
5.	Gynecology (female) problems: Ovarian cysts, Infections of tubes or ovaries, PID (Pelvic Inflammatory Disease), Fibroids (tumors of the womb), Abnormal Pap Smear, Cryosurgery (freezing of the cervix), LEEP (Loop Electrosurgical Excision Procedure), Cone Biopsy of the Cervix	☐	☐	____________________
6.	Lung disease: Tuberculosis, Asthma	☐	☐	____________________
7.	Seizures, Epilepsy, Paralysis	☐	☐	____________________
8.	Blood Diseases: Anemia, Sickle Cell Disease, Thalassemia, Bleeding Disorders, History of Blood Clots in legs or lungs	☐	☐	____________________
9.	Allergy to any medicine	☐	☐	____________________
10.	Operations: C-section, Abortion, D&C, Cerclage, Tubal/Ectopic, Myomectomy (removal of fibroids), Appendectomy, Laparoscopy, or any other operation	☐	☐	____________________
11.	Have you been told you are a carrier for Group B Beta Streptococcus (GBS)?	☐	☐	____________________
12.	Have you had prenatal care during this pregnancy elsewhere? If so, where ______________________________	☐	☐	____________________
13.	Any other medical conditions not listed above?	☐	☐	____________________
14.	Anything else we should know about this pregnancy? Such as: history of infertility and took medication to get pregnant, I am a vegetarian or am on other special diet, I take insulin, I am a surrogate, I am not sure that I want to keep the baby, etc.	☐	☐	____________________

MEDICAL HISTORY:

Do **YOU** or **YOUR** FAMILY mother, father, sister, brother, son, daughter – (do not include the father of the baby or his family) now have (or ever had) any of the following?
If the answer is YES, circle the problem(s) and explain who and what:

	No	You	My Family	Who?	Explain
1. Heart disease, Rheumatic Fever, Mitral Valve Prolapse, Heart Murmur	☐	☐	☐	___________	_________________
2. High Blood Pressure, Stroke	☐	☐	☐	___________	_________________
3. Toxemia, Pre-eclampsia, Eclampsia Pregnancy Induced Hypertension (PIH)	☐	☐	☐	___________	_________________
4. Depression, Mental Disease, Suicide	☐	☐	☐	___________	_________________
5. Thyroid Disease, Endocrine Problem	☐	☐	☐	___________	_________________
6. Diabetes, Gestational Diabetes	☐	☐	☐	___________	_________________
7. Breast or Ovarian Cancer	☐	☐	☐	___________	_________________
8. Crib Death, also know as: Sudden Infant Death Syndrome	☐	☐	☐	___________	_________________

MENSTRUAL HISTORY:

Date of FIRST day of your last menstrual period: _________________________Was it a normal period? ☐ Yes ☐ No

If NOT normal, please explain: ____

How often do you have a period? (# of days from 1st day or one period to 1st day of the next) ______ # days of bleeding? _____
Date of positive pregnancy test, if done _______________ How old were you when had your first period?__________

During the last 12 months, did you use

Birth Control Pills ☐ Yes ☐ No

Norplant ☐ Yes ☐ No

IUD ☐ Yes ☐ No

Depo-Provera (3-month birth control shot) ☐ Yes ☐ No

Lunelle (monthly birth control shot) ☐ Yes ☐ No

If yes to any of the above, when did you stop using the method? ____

Since your last period have you had:
☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Unusual vaginal discharge ☐ Ultrasound, if yes, when _____________

PREVIOUS PREGNANCY HISTORY:

In order, list all of your pregnancies, including abortions, miscarriage, stillbirth or ectopic (tubal) pregnancy

List **ALL** In Order	Date	Where was baby born Name of facility, City and State if outside of California	Length of Pregnancy Number of months or weeks	How many hours in labor	Medication or Anesthesia Used	Outcome of pregnancy Vaginal, C/S, Forceps, Vacuum, Miscarriage, Stillbirth, Abortion, Ectopic/Tubal	Baby's Weight	Baby's Sex	Problems with Pregnancy? Labor? Birth? You had a problem? Baby had a problem? What was the problem, if any?
Example	1/00	Hospital or Birth Center Name, Home	9 months	12	None, IV med or Epidural	Vaginal	7-13	Male	None
1st									
2nd									
3rd									
4th									
5th									
6th									
7th									
8th									
9th									

PREGNANCY HISTORY:

Have you ever had any of the following:

1. Labor before 9 months (<36 weeks)? ☐ N/A ☐ Yes ☐ No
2. Ruptured bag of waters or fluid leaking from the vagina before 9 months? ☐ N/A ☐ Yes ☐ No
3. Have you ever been given medications or bed rest to stop contractions? ☐ N/A ☐ Yes ☐ No
4. Has you mother or sister(s) ever delivered a baby before 9 months? ☐ N/A ☐ Yes ☐ No
5. Have you ever had a postpartum hemorrhage? When? ______________ ☐ N/A ☐ Yes ☐ No
6. Have you ever had a retained placenta? When? ______________ ☐ N/A ☐ Yes ☐ No

PSYCHO-SOCIAL HISTORY:

1. Are you in or have you ever been in a relationship where you are afraid of being hurt physically or emotionally? ☐ Yes ☐ No
2. During the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? ☐ Yes ☐ No
3. If any of your children (or his children) have died, please explain cause of death and age? ☐ N/A ☐ Yes ☐ No

   ____

4. Are you currently experiencing difficulty in caring for your children? ☐ N/A ☐ Yes ☐ No
5. Are you currently having emotional or family problems? ☐ Yes ☐ No
6. After the birth of your children, did you experience postpartum depression? ☐ N/A ☐ Yes ☐ No
7. Are you currently experiencing problems with obtaining food or housing? ☐ Yes ☐ No
8. Have you had difficulty adjusting to this pregnancy? ☐ Yes ☐ No

WORK HISTORY: Do you:

1. Work with chemicals or dangerous substances? ☐ Yes ☐ No
2. Do <u>excessive</u> walking/standing (more than 6 hours at a time without a break) or heavy lifting (over 50 pounds)? ☐ Yes ☐ No
3. Work long hours (more than 12 hours/day or more than 50 hours/week)? ☐ Yes ☐ No
4. Commute more than 1 hour (one way) to work or school? ☐ Yes ☐ No

EDUCATIONAL NEEDS: I need more information on the following topics (mark all that apply):

☐ How to have a Healthier Pregnancy	☐ How the Baby is Growing	☐ Hospital Tour	☐ Birth Control Methods
☐ What Happens during Labor	☐ Signs and Symptoms of Labor	☐ Breast Feeding	☐ Tubal Ligation
☐ Vaginal Birth After Cesarean (VBAC)	☐ Premature Labor/Birth	☐ Bottle Feeding	☐ Vasectomy
☐ Brother/Sister Adjustment	☐ Exercise in Pregnancy	☐ Baby Care	☐ Paternity Testing

☐ Other: (please list) ____

GENERAL INFORMATION

1. Do you have a religious objection to receiving a blood transfusion in a medical emergency? ☐ Yes ☐ No
2. Do you plan to breast feed your baby? ☐ Yes ☐ No
3. Which of the following statements best describes your smoking habit?
   - ☐ I smoke now — How many cigarettes a day? ____________
   - ☐ I smoke now, but cut down since I became pregnant — Date of last cigarette? ________________
   - ☐ I quit smoking since I became pregnant
   - ☐ I smoke from time to time
   - ☐ I don't smoke
   - ☐ I have never smoked
5. Which of the following statements best describes your drinking habit?
   - ☐ I drink alcoholic beverages (wine, beer, hard liquor). What? _______________ How much? ________________
   - ☐ I drink alcoholic beverages, but cut down since I became pregnant. Date of last drink _____________________
   - ☐ I quit drinking since I became pregnant.
   - ☐ I drink from time to time.
   - ☐ I don't drink.
   - ☐ I have never consumed alcoholic beverages.
6. Which of the following statements best describes your recreational drug habit (cocaine, PCP, marijuana, speed, LSD, heroin)?
   - ☐ I use recreational drugs Which ones? ____
   - ☐ I use recreational drugs, but cut down since I became pregnant. Date of last use: ______________________
   - ☐ I quit the use of recreational drugs since I became pregnant.
   - ☐ I use drugs from time to time
   - ☐ I don't use recreational drugs
   - ☐ I have never used recreational drugs
7. Are you concerned that alcohol or drugs you have used during this pregnancy may have harmed your baby? ☐ Yes ☐ No
8. Are you concerned about the use of drugs/alcohol of someone close to you? ☐ Yes ☐ No
9. If your partner smokes, drinks alcoholic beverages, or uses recreational drugs, please describe his habit(s): _________

____

SEXUAL HISTORY/RISKS FOR HIV:

1. Are your sexual partners ☐ men ☐ women ☐ both
2. Have you, or your partner, ever had a Sexually Transmitted Disease (STD)? ☐ Yes ☐ No

   For example: Trichomonas, Genital Warts (Condyloma/HPV), Chlamydia, Gonorrhea, Herpes, Syphilis, etc.
3. Have you, or your partner, ever had a blood transfusion? ☐ Yes ☐ No
4. Have you, or your partner, had more than two sexual partners in your life? ☐ Yes ☐ No
5. Have you, or your partner, ever had rectal/anal sex? (circle who) Do you currently? ☐ Yes ☐ No
6. Have you, or any of your sexual partners, ever injected drugs or had sexual relations with gay or bisexual men, or prostitutes? If yes, have you been tested for HIV? ☐ Yes ☐ No
7. Do you or your partner have the HIV (AIDS) virus? ☐ Yes ☐ No
8. Do you or your partner have tattoos? If yes, have you been tested for Hepatitis C? ☐ Yes ☐ No

GENETIC QUESTIONNAIRE:

1. Please list ALL medications taken since your last period (prescription and non-prescription): including vitamins and natural or herbal preparations ____
2. Will you be 35 years or older when your baby is born? ☐ Yes ☐ No
3. Have you or the baby's father, currently or in a previous relationship, had a stillborn child? ☐ Yes ☐ No
   Three or more first trimester spontaneous (miscarriage) pregnancy losses? ☐ Yes ☐ No
4. Are you and the father of the baby related by blood (cousins, etc)? ☐ Yes ☐ No
5. If you, or the baby's father are of the following racial background(s) have you ever been tested for: ☐ N/A

Ancestry or Racial Background	You	Baby's Father	Has testing been done?	You	Baby's Father
Eastern European Jewish, French Canadian, Cajun			Tay-Sachs Disease		
Italian, Greek, Mediterranean			Beta Thalassemia		
Southeast Asian, Philippine			Alpha Thalassemia, Beta Thalassemia		
Black/African American			Sickle Cell Trait/Disease, Thalassemia		

6. Are you interested in blood testing for the following inherited conditions?
   Cystic Fibrosis: ☐ Yes ☐ No Tay Sachs disease: ☐ Yes ☐ No Sickle Cell Disease: ☐ Yes ☐ No
7. Are you interested in Genetic Counseling or Prenatal Diagnosis? (CVS or Amniocentesis) ☐ Yes ☐ No
8. Have you had genetic counseling in the past? ☐ Yes ☐ No
9. Have either of you had a chromosomal study? If YES, indicate who and the results: ☐ Yes ☐ No

   ____

10. Does anyone in the immediate family now have (or ever had) any of the following conditions?
    (Yourself, Father, Mother, Sisters, Brothers, Father of the baby, his children, your children)

	No One	You	Baby's Father	Your Children	Other Family Who?	Explain
Down Syndrome (mongolism)						
Other chromosome problem						
Spina Bifida (open spine)						
Anencephaly (no brain)						
Hemophilia (bleeding disorders)						
Cystic Fibrosis						
Muscular Dystrophy (muscle disease)						
Cleft Lip or palate (Harelip)						
Skeleton Disorders ("little person")						
Mental Retardation						
Childhood Heart Defect (or at birth)						
Congenital Dislocation of Hip						
Other inherited genetic disease such as: Deafness, Huntington's Chorea, Neurofibromatosis, FragileX Syndrome, Polycystic Kidney Disease, Congenital Adrenal Hyperplasia						
Other Birth Defects						

Reviewed with patient: Date: _____________ LM, CPM signature: ______________________________________

Client's Notes

Please note any questions that you would like to ask us.

Please indicate the two most compelling reasons you would like to have a homebirth.

Primary reason for choosing intended place of birth (as stated by mother)]

- (•) -
- ( ) desire for natural birth
- ( ) safety
- ( ) high risk
- ( ) effect on baby
- ( ) family unity
- ( ) partner preference
- ( ) control
- ( ) atmosphere
- ( ) dislikes hospitals
- ( ) social pressure
- ( ) other...
- ( ) spiritual
- ( ) cost

Other reason: ______

Secondary reasons for choosing intended place of birth (as stated by mother)

- [ ] high risk
- [ ] desire for natural birth
- [ ] cost
- [ ] other...
- [ ] partner preference
- [ ] effect on baby
- [ ] safety
- [ ] dislikes hospitals
- [ ] control
- [ ] family unity
- [ ] spiritual
- [ ] social pressure
- [ ] atmosphere