MEDICAL AND PERSONAL HISTORY

PARENTS:

Mother _____ DOB _____ Occupation _____

Partner _____ DOB _____ Occupation _____

Address _____

Phone _____(Mom's Cell) _____(Partner's Cell) Email _____

Email Address _____

PHYSICIAN/MIDWIFE & HOSPITAL:

Name _____ Practice/Group _____ Phone _____

Hospital/Birth Center you plan to use _____ Phone _____

Pediatrician/Family Practice Physician _____ Phone_____

BABY BASICS:

Due Date _____ Sex of baby Boy Girl ??? Name of Baby _____(if known)

Have you taken Childbirth Education Classes? Y N If yes, location & instructor _____

Have you taken a Breastfeeding Class? Y N If yes, location & instructor _____

Other classes taken in preparation _____

Who have you invited to your birth? _____

Do you have good help after the birth (who and how long)? _____

Do you plan to breastfeed? Yes Undecided No Do you sleep well? Yes Sometimes No

In general, how have you felt with this pregnancy? _____

_____

PREGNANCY HISTORY:

of pregnancies(gravida) _____ # of Births(para) _____ # of Abortions _____ # of Miscarriages _____@_____wk

Child's Name Birth Date Birth Weight Born Early/Late Spontaneous/Induced Length of Labor Length of Pushing

_____

_____

_____

Did you have any complications during pregnancy, labor, delivery or postpartum _____

_____

MEDICAL AND PERSONAL HISTORY, Continued

HEALTH HISTORY:

Are you taking any medications, supplements, herbs? If yes, what? _____

To what extent do you drink alcohol? _____

Do you smoke cigarettes? Yes No If yes, where and how much? _____

Does your partner? Yes No If yes, where and how much? _____

MEDICAL HISTORY (Mother (M) and Partner (P)):

_____Asthma _____Allergies _____Anemia _____Diabetes _____HIV ____PIH ____Muscular/Skeletal Issues

_____Rh Factor _____Herpes _____Cancer _____Group B Strep _____Eating Disorder _____Drug Use _____ Infertility

_____Hyper/Hypotension _____Bladder/Kidney Infections _____Surgeries _____PCOS _____Other (Comment)

Comments/Additional Medical History _____

_____

PSYCHOLOGICAL HISTORY (Mom or Partner):

_____Anxiety _____Chronic Pain _____Panic Attacks _____Medical Trauma

_____Bipolar _____Depression _____Obsessive/Compulsive _____Other

Comments _____

_____

What else would you like me to know about your history, hopes, dreams, fears, strengths or limitations?
What is your vision for bringing your baby into this world?

☐ I/We consent to sharing medical and health history with designated back up doula if the need arises for continuity of care. Information may be shared verbally, electronically or physically as needed. All information will remain confidential between all parties.