Health History

Welcome to Nest Midwifery! We are honored to serve you during this exceptional time in your life. Please complete this confidential health history form & bring it with you to your next appointment.

Mother

Full legal name	date of birth
Maiden name	SSN
street address	
Mailing address if different	State of Birth
education (highest grade completed)	occupation
Your height	Pre-pregnant weight

Partner

Full legal name	date of birth
education (highest grade completed)	SSN
Alternate address	Occupation
State of Birth	Married ? Yes No

Children

names & ages

Pets

names & species

Contact information

h = home / w = work / c = cell

Mother's email:	
phone #: h w c	phone #: h w c
Partner's email:	
phone #: h w c	phone #: h w c

Medical History

Family History – Has anyone in your immediate family had any of these issues/conditions?

☐ heart disease	☐ cancer	☐ seizures
☐ lung disease	☐ diabetes	☐ alcohol/drug abuse
☐ kidney disease	☐ high blood pressure	☐ severe emotional problems

If so, who & when? Any other issues?

Father of the baby – Has the father of the baby ever had any of these issues/conditions?

☐ sexually transmitted infection	☐ urethritis	☐ severe emotional problems
☐ oral herpes / chancre sores	☐ tobacco use	☐ other
☐ genital herpes	☐ alcohol/drug abuse	

If so, when? Details:

Your Medical History – Have you ever had any of these issues/conditions and when?

☐ allergies / sensitivities	☐ liver problems	☐ excessive fatigue
☐ stomach problems	☐ hepatitis	☐ severe headaches
☐ gall bladder problems	☐ hypoglycemia	☐ eye / vision problems
☐ ulcers	☐ diabetes	☐ ear / hearing problems
☐ bowel problems	☐ high blood pressure	☐ dental problems
☐ colitis	☐ anemia	☐ thyroid issues
☐ blood in stool	☐ bruising easily / bleeding easily	☐ skin problems / acne / eczema
☐ chronic diarrhea	☐ hemorrhage	☐ pelvic or back – pain / injury
☐ chronic constipation	☐ blood clotting problems	☐ aching joints / arthritis
☐ hemorrhoids	☐ varicose veins	☐ psychological eval / treatment
☐ bladder infection	☐ rheumatic fever	☐ seizures / epilepsy
☐ incontinence	☐ chest pains	☐ sleep problems
☐ urinary surgery / dilation	☐ asthma	☐ hospitalizations
☐ kidney infection	☐ tuberculosis	☐ surgeries

If so, when? Details:

Screening Questions

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

Yes No Do you or the baby's father have any family members with birth defects or conditions diagnosed as genetic or inherited?

Yes No Are you and the baby's father related by blood (for example, are you cousins)?

Yes No Are you or the baby's father from any of these ethnic/racial groups? (circle all that apply)

Jewish African Asian Mediterranean Greek Italian Cajun/Fr. Canadian

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

Yes No Are there any twins, triplets, etc. in your family or the family of the baby's father?

Yes No Have you or the father of the baby 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 drug IV or had a blood transfusion?

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

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

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

Yes No Is there anything about the development of your sexuality that you'd like to discuss?

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

Yes No Have you ever had severe emotional problems?

Yes No Have you ever been on medication for depression or other psychological conditions?

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

Your Gynecological History

Age menstruation began:	Age at first intercourse:
Are your periods regular?	Do you currently have pain with intercourse?
How many days do you usually flow?	Amount of flow: Heavy Medium Light
How many days apart are your periods (from beginning of bleeding to beginning again?)	
Do you have cramps, backache, or other pain with your period?	Do you have premenstrual symptoms / PMS? Describe:

Please indicate which methods of birth control you have used and when: *(check all that apply)*

☐ cervical cap	☐ diaphragm	☐ condoms	☐ spermicides (gels, foam, sponges)
☐ IUD	☐ natural family planning	☐ rhythm method	☐ withdrawal
☐ birth control pills	☐ depo-provera injection	☐ Norplant	☐ other

Dates & details:

What method of birth control, if any, were you using when you became pregnant this time?	Are you currently breastfeeding? Yes No child's age:

Please indicate if you have ever had any of the following, and when:

☐ vaginal yeast infection	☐ gonorrhea	☐ cervical polyp	☐ breast lumps
☐ nonspecific vaginitis (NSV)	☐ syphilis	☐ ovarian cyst	☐ breast biopsy / surgery
☐ trichomonas	☐ genital sores	☐ fibroids	☐ abnormal vaginal bleeding
☐ bacterial vaginosis (BV)	☐ genital herpes	☐ endometriosis	☐ pelvic inflammatory disease (PID)
☐ gardnerella	☐ cervicitis	☐ infertility	☐ oral herpes / chancre sores
☐ chlamydia	☐ cervical surgery	☐ uterine surgery	☐ condyloma (genital warts)

Dates & details:

When was your last Pap smear?

Have you ever had an abnormal Pap, when?

Did you have any treatment (cryosurgery, LEEP, etc.) ?

Your Mother's Obstetric History

How were you born (vaginally, C-section)?	Your birth weight
How many times was your mother pregnant?	How many live births?
What were your mother's labors like? Any complications?	
Did your mother breastfeed her children? How long?	

Your Obstetric History

How many times have you ever been pregnant, including now?
Have you ever had a miscarriage, and if so, when? (month, year, how far along)
Did you receive medical care for the miscarriage? Have a D&C? Take medication?
Please include dates of any abortions, how far along in pregnancy, and method used:
Have you ever suffered a stillbirth? When? If known, what was the cause of the loss?
Do you have any unresolved feelings, concerns, or questions about any of your pregnancy losses, including miscarriage, abortion, and stillbirth?

Please let us know if you would like to talk about your past pregnancy losses, as unresolved feelings
from past pregnancy losses can affect your current pregnancy, labor, and birth.

To the best of your knowledge, please complete for each of your childbirths:
(use additional sheets, as necessary)

child's name				
birth date				
length of pregnancy				
baby's weight				
baby's length				
your weight gain				
born where (home / hosp)				
pregnancy problems				
first labor sign				
length 1st stage (dilating)				
length 2nd stage (pushing)				
length 3rd stage (placenta)				
when water broke				
IV				
fetal monitor				
induced? how?				
used Pitocin				
medication type(s)				
forceps / vacuum				
episiotomy / tear				
presentation (head, butt, etc)				
complications				
cesarean section				
hemorrhage				
breastfed				
jaundice				
other				

Was there anything done to you or your baby that you particularly liked or disliked?

Your Current Pregnancy

Did you have trouble conceiving?	Is this a planned pregnancy?

List the dates of your last two periods. Indicate if the dates are estimates.	
last period:	previous period:
Do you know when you conceived?	
Did you have a pregnancy test? When and what type?	
Have you felt your baby move? When?	
Have you had an ultrasound? When?	

Please indicate if you've had any of the following during this pregnancy:

☐ gas / heartburn	☐ unusual vaginal discharge	☐ swelling
☐ abdominal pain	☐ bleeding / spotting	☐ unusual weight gain
☐ constipation	☐ dizziness / fainting	☐ nausea
☐ diarrhea	☐ fatigue	☐ vomiting
☐ back pain	☐ sleeping problems	☐ leg cramps
☐ hemorrhoids	☐ vision problems / seeing stars	☐ frequent urination
☐ varicose veins	☐ bleeding gums	☐ urinary problems
☐ breast tenderness	☐ difficulty breathing	☐ pelvic pain

Details:

Indicate if you have used or been exposed to (at work, home) the following during this pregnancy:

☐ tobacco or tobacco smoke	☐ aspirin	☐ measles (incl. Rubella)
☐ alcohol (beer, wine, liquor)	☐ anti-histamines, decongestants	☐ viruses (incl. the flue, colds, etc)
☐ caffeine (coffee, tea, chocolate)	☐ other non-prescription drugs	☐ vaccinations
☐ marijuana	☐ vitamin supplements	☐ pesticides
☐ cocaine	☐ herbs	☐ paints
☐ other street drugs	☐ x-rays	☐ microwaves
☐ prescription drugs	☐ ultrasound	

Details:

Do you rest / nap daily?	Sleep well at night? # hours
Have you felt moody, lonely, depressed, or emotionally unstable during this pregnancy?	

Any relationship problems or severe family conflicts?
Any work / school related problems?
Any major financial difficulties?
If you are employed or attending school, what are your plans for continuing after the baby is born?
How has your sexual relationship changed with pregnancy?
Are you taking a prenatal vitamin? What brand?
Are you a vegetarian? What type?
Do you have a special diet due to food sensitivities, religious practice, etc?
Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy, birth, and postpartum that you would like to discuss?
Have you faced any opposition to your plans for an out-of-hospital birth?
How do you feel about going to the hospital if complications arise?
How would you feel if you had a Down Syndrome or differently-abled child?
What else should we know about you in order to serve you better?

You're done!