11409 Hornsby Street
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CLIENT REGISTRATION

Sunflower Midwifery

Your community midwife

Name: First	Middle	Last	Today's date	Phone (h) (c) (w)

Race/ ethnic origin	Yrs education	Marital status	Occupation/ type of business	Date of birth

Address: Street	City	State	Zip

Spouse/Partner: First	Middle	Last	Race/ethnic origin	Yrs education	Date of birth

Address (if different from above)	Phone (c) (w)	Occupation/ type of business

Father of baby (if different from Partner):	Another person to contact in an emergency: Name:	Phone: Relationship:

How did you hear about us?

The following questions will help determine if there are potential issues that may affect your pregnancy and should be discussed further. This information is completely confidential.

FAMILY HISTORY – *Indicate if anyone in your immediate family has ever had any of these, who, and when.*

- ☐Diabetes _____
- ☐High blood pressure _____
- ☐Kidney disease____ _____
- ☐Cancer _____
- ☐Twins _____
- ☐Heart disease_____ _____
- ☐Lung disease _____
- ☐Seizures _____
- ☐Autoimmune disorder _____
- ☐Other _____

FATHER OF BABY – *Indicate if the baby's father has ever had any of these, and when.*

- ☐Sexually transmitted diseases _____
- ☐Herpes: ☐Genital ☐Oral
- ☐Severe emotional problems _____
- ☐Alcohol/ drug abuse _____
- ☐Tobacco use _____
- ☐Other _____

YOUR MOTHER'S HISTORY – *Please answer the following regarding your mother:*

- ☐No. of pregnancies _____
- ☐No. of births _____
- ☐Miscarriages _____
- ☐Any complications _____
- ☐Your weight at birth _____
- ☐Did she take DES with you?
  ☐ Yes ☐ No

PREVIOUS PREGNANCY OUTCOMES *Please complete this table regarding your own pregnancies (from earliest to most recent)*

Date	# Weeks	Birth/ Miscarriage/ Termination	Comments/ Problems – *include any of the following: preeclampsia, gestational diabetes, Group B Strep, induction of labor, posterior baby in labor, shoulder dystocia, water broken >12hrs, episiotomy, 3rd or 4th degree tear, postpartum hemorrhage, retained placenta*

Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?
Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?
Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
Yes No Are you and the FOB related by blood (e.g., cousins)?
Yes No Are you or the FOB from any of these ethnic/ racial groups? (circle)
Jewish/ Cajun/ Fr. Canadian Black/ African Asian Italian/Greek/Mediterranean
Yes No Have you or the FOB 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, had a blood transfusion, or had bisexual relations?
Yes No Do you think you are at increased risk for AIDS/HIV?
Yes No Have you ever experienced dramatic fluctuations in your weight?
Yes No Have you ever had anorexia, bulimia or other eating problems?
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 any medication for depression, anxiety or other mood disorders?
Yes No Has anyone ever told you, or do you think, that you have ever used alcohol or drugs excessively?

NAME _____

MEDICAL HISTORY ***Please indicate whether you have ever had any of these and when:***

- ☐ Severe headaches _____
- ☐ Eye/ vision problems _____
- ☐ Ear/ hearing problems _____
- ☐ Dental problems _____
- ☐ Hypo/hyper thyroid _____
- ☐ Asthma _____
- ☐ Bloodclotting disorder _____
- ☐ Hemoglobinopathy _____
- ☐ Anemia _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Varicose veins _____
- ☐ Hemorrhoids _____
- ☐ Skin disorders _____
- ☐ Stomach problems _____
- ☐ Ulcers _____
- ☐ Liver disease _____
- ☐ Bowel problems/ colitis _____
- ☐ Blood in stool _____
- ☐ Gall bladder problems _____
- ☐ Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Bladder infection _____
- ☐ Kidney infection _____
- ☐ Kidney stones _____
- ☐ Urinary surgery _____
- ☐ Aching joints _____
- ☐ Pelvic/ back injuries _____
- ☐ Seizures _____
- ☐ Rheumatic fever _____
- ☐ Cancer _____
- ☐ Hospitalizations _____
- ☐ Surgeries _____
- ☐ Other _____

Do you have any allergies? ☐ Yes ☐ No

Please list: _____

_____

INFECTION HISTORY ***Please indicate whether you have ever had any of these and when:***

- ☐ Hepatitis A _____
- ☐ Hepatitis B _____
- ☐ Hepatitis C _____
- ☐ HIV/AIDS _____
- ☐ Tuberculosis _____
- ☐ + skin test for TB _____
- ☐ Received BCG vaccine _____
- ☐ Lived w/ someone w/ TB _____
- ☐ Had chicken pox _____
- ☐ Received ch. pox vaccine _____
- ☐ Gonorrhea _____
- ☐ Chlamydia _____
- ☐ Syphilis _____
- ☐ HPV/genital warts _____
- ☐ Trichomoniasis _____
- ☐ PID/pelvic infection _____
- ☐ Herpes: ☐ Genital _____ ☐ Oral _____
- ☐ Other STD _____
- ☐ Other infection _____

GYNECOLOGIC HISTORY:

Age at first period: _____

Cycle length (days): _____

Regular? ☐ Yes ☐ No

Duration: _____

When was your last Pap?

_____

Have you ever had an abnormal Pap? (dates) _____

Diagnosis: _____

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

- ☐ Yeast _____
- ☐ Bacterial vaginosis _____
- ☐ Genital sores _____
- ☐ Cervicitis _____
- ☐ Cervical surgery _____
- ☐ Cervical polyp _____
- ☐ Ovarian cyst _____
- ☐ Fibroids _____
- ☐ Endometriosis _____
- ☐ PCOS _____
- ☐ Abnormal bleeding _____
- ☐ Uterine surgery _____
- ☐ Breast lump(s) _____
- ☐ Breast surgery _____
- ☐ Infertility _____
- ☐ Other _____

Are there any particular ethnic, cultural, or religious preferences during pregnancy, birth and/or the postpartum period that you'd like us to be aware of or participate in?

_____

_____

_____

_____

CURRENT PREGNANCY

Last menstrual period (1st day) _____ Normal? ☐ Yes ☐ No

Suspected date of conception _____

Pregnancy test (date) _____

Planned pregnancy? ☐ Yes ☐ No

Feelings about pregnancy _____

Father's/ Partner's feelings _____

Most recent birth control used _____

Contraception used in past; what, when, any problems?

_____

_____

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

- ☐ Nausea _____
- ☐ Vomiting _____
- ☐ Fever _____
- ☐ Infections _____
- ☐ Headache _____
- ☐ Dizziness _____
- ☐ Indigestion _____
- ☐ Leg cramps _____
- ☐ Rash/viral illness _____
- ☐ Backache _____
- ☐ Breast tenderness _____
- ☐ Swelling _____
- ☐ Constipation _____
- ☐ Diarrhea _____
- ☐ Urinary complaints _____
- ☐ Abdominal/pelvic pain _____
- ☐ Vaginal bleeding/spotting __
- ☐ Vaginal discharge _____
- ☐ Bleeding gums _____
- ☐ Varicose veins _____
- ☐ Hemorrhoids _____
- ☐ Depression _____
- ☐ Loneliness _____
- ☐ Family/relationship issues
- ☐ Work problems _____
- ☐ Other _____

Please indicate whether you have used, experienced, or been exposed to any of these before or during this pregnancy:

	3 mos before pregnancy	Since conception
☐ Cigarettes (#cigs/day)	_____	_____
☐ Alcohol (#drinks/wk)	_____	_____
☐ Caffeine	_____	_____
☐ Marijuana	_____	_____
☐ Cocaine	_____	_____
☐ Other street drugs	_____	_____
☐ Prescription meds	_____	_____
☐ Non-prescr (OTC) meds	_____	_____
☐ Vitamins/supplements	_____	_____
☐ Herbs	_____	_____
☐ Fumes/pesticides	_____	_____
☐ X-rays	_____	_____
☐ Measles/viruses	_____	_____
☐ Vaccinations	_____	_____

- ☐ Travel outside U.S. _____
- ☐ Cats _____
- ☐ Other _____

Please use this space to add any other information regarding any of the above:

_____

_____

_____

_____