



# 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

name	date of birth
	SSN
street address	
mailing address, if different	
education (highest grade completed)	occupation

## Partner

name	date of birth
education (highest grade completed)	occupation
alternate address	

## Children

names & ages
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## Pets

names & species
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## 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?*

<input type="checkbox"/> heart disease	<input type="checkbox"/> cancer	<input type="checkbox"/> seizures
<input type="checkbox"/> lung disease	<input type="checkbox"/> diabetes	<input type="checkbox"/> alcohol/drug abuse
<input type="checkbox"/> kidney disease	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> 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?*

<input type="checkbox"/> sexually transmitted infection	<input type="checkbox"/> urethritis	<input type="checkbox"/> severe emotional problems
<input type="checkbox"/> oral herpes / chancre sores	<input type="checkbox"/> tobacco use	<input type="checkbox"/> other
<input type="checkbox"/> genital herpes	<input type="checkbox"/> alcohol/drug abuse	

If so, when? Details:

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

<input type="checkbox"/> allergies / sensitivities	<input type="checkbox"/> liver problems	<input type="checkbox"/> excessive fatigue
<input type="checkbox"/> stomach problems	<input type="checkbox"/> hepatitis	<input type="checkbox"/> severe headaches
<input type="checkbox"/> gall bladder problems	<input type="checkbox"/> hypoglycemia	<input type="checkbox"/> eye / vision problems
<input type="checkbox"/> ulcers	<input type="checkbox"/> diabetes	<input type="checkbox"/> ear / hearing problems
<input type="checkbox"/> bowel problems	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> dental problems
<input type="checkbox"/> colitis	<input type="checkbox"/> anemia	<input type="checkbox"/> thyroid issues
<input type="checkbox"/> blood in stool	<input type="checkbox"/> bruising easily / bleeding easily	<input type="checkbox"/> skin problems / acne / eczema
<input type="checkbox"/> chronic diarrhea	<input type="checkbox"/> hemorrhage	<input type="checkbox"/> pelvic or back – pain / injury
<input type="checkbox"/> chronic constipation	<input type="checkbox"/> blood clotting problems	<input type="checkbox"/> aching joints / arthritis
<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> varicose veins	<input type="checkbox"/> psychological eval / treatment
<input type="checkbox"/> bladder infection	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> seizures / epilepsy
<input type="checkbox"/> incontinence	<input type="checkbox"/> chest pains	<input type="checkbox"/> sleep problems
<input type="checkbox"/> urinary surgery / dilation	<input type="checkbox"/> asthma	<input type="checkbox"/> hospitalizations
<input type="checkbox"/> kidney infection	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> 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:	
<i>Please indicate which methods of birth control you have used and when: (check all that apply)</i>			
<input type="checkbox"/> cervical cap	<input type="checkbox"/> diaphragm	<input type="checkbox"/> condoms	<input type="checkbox"/> spermicides (gels, foam, sponges)
<input type="checkbox"/> IUD	<input type="checkbox"/> natural family planning	<input type="checkbox"/> rhythm method	<input type="checkbox"/> withdrawal
<input type="checkbox"/> birth control pills	<input type="checkbox"/> depo-provera injection	<input type="checkbox"/> Norplant	<input type="checkbox"/> 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:	
<i>Please indicate if you have ever had any of the following, and when:</i>			
<input type="checkbox"/> vaginal yeast infection	<input type="checkbox"/> gonorrhea	<input type="checkbox"/> cervical polyp	<input type="checkbox"/> breast lumps
<input type="checkbox"/> nonspecific vaginitis (NSV)	<input type="checkbox"/> syphilis	<input type="checkbox"/> ovarian cyst	<input type="checkbox"/> breast biopsy / surgery
<input type="checkbox"/> trichomonas	<input type="checkbox"/> genital sores	<input type="checkbox"/> fibroids	<input type="checkbox"/> abnormal vaginal bleeding
<input type="checkbox"/> bacterial vaginosis (BV)	<input type="checkbox"/> genital herpes	<input type="checkbox"/> endometriosis	<input type="checkbox"/> pelvic inflammatory disease (PID)
<input type="checkbox"/> gardnerella	<input type="checkbox"/> cervicitis	<input type="checkbox"/> infertility	<input type="checkbox"/> oral herpes / chancre sores
<input type="checkbox"/> chlamydia	<input type="checkbox"/> cervical surgery	<input type="checkbox"/> uterine surgery	<input type="checkbox"/> 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 1 <sup>st</sup> stage (dilating)				
length 2 <sup>nd</sup> stage (pushing)				
length 3 <sup>rd</sup> 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?

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## 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:*

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

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

<input type="checkbox"/> tobacco or tobacco smoke	<input type="checkbox"/> aspirin	<input type="checkbox"/> measles (incl. Rubella)
<input type="checkbox"/> alcohol (beer, wine, liquor)	<input type="checkbox"/> anti-histamines, decongestants	<input type="checkbox"/> viruses (incl. the flue, colds, etc)
<input type="checkbox"/> caffeine (coffee, tea, chocolate)	<input type="checkbox"/> other non-prescription drugs	<input type="checkbox"/> vaccinations
<input type="checkbox"/> marijuana	<input type="checkbox"/> vitamin supplements	<input type="checkbox"/> pesticides
<input type="checkbox"/> cocaine	<input type="checkbox"/> herbs	<input type="checkbox"/> paints
<input type="checkbox"/> other street drugs	<input type="checkbox"/> x-rays	<input type="checkbox"/> microwaves
<input type="checkbox"/> prescription drugs	<input type="checkbox"/> 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!***