

Mother's Own Birth & Women's Center 1715 W. Dean Rd. Suite C Temperance, MI 48182			Client Registration Form		
Name: <i>First</i> <i>Middle</i> <i>Last</i>			Phone: Home - Work / Cell -		
Address: <i>Street</i> <i>City</i> <i>Zip</i>					
Occupation:		Date of Birth:		Social Sec #:	
Partner/Spouse Name: <i>First</i> <i>Middle</i> <i>Last</i>			Phone: Home - Work / Cell -		
Occupation:		Date of Birth:		Social Sec #:	

Previous Pregnancies <i>Please complete this table regarding your own pregnancy history (from earliest to most recent).</i> <i>* Outcome refers to birth (cesarean or vaginal, forceps, vacuum), miscarriage, or termination of pregnancy</i>						
Month/Year	# weeks	Outcome	Name/ Sex	Labor Length	How did labor begin?	Breastfed? How long?

How would you describe your previous birth experiences?

Is there anything about your past pregnancies / births that you WOULD like repeated?

- that you would NOT like repeated?

Please describe your feelings about this pregnancy and upcoming birth:

How does your partner feel about this pregnancy and birth?

Medical History

- | | | | |
|---------------------|--------------------------|------------------------------|----------------------------|
| 1. Severe headaches | 11. Stomach problems | 21. Blood clotting problems | 31. Seizures |
| 2. Vision problems | 12. Ulcers | 22. Bowel problems / colitis | 32. Cancer * |
| 3. Hearing problems | 13. Chicken pox | 23. High blood pressure * | 33. Hospitalizations |
| 4. Dental problems | 14. Hepatitis | 24. Hemorrhoids | 34. Surgeries |
| 5. Anemia | 15. Liver problems | 25. Blood in stool | 35. Multiple pregnancies * |
| 6. Hemorrhage | 16. Diabetes * | 26. Gall bladder problems | 36. Birth defects * |
| 7. Varicose veins * | 17. Bladder infection(s) | 27. Kidney infection(s) | 37. Severe depression * |
| 8. Tuberculosis | 18. Hypoglycemia | 28. Urinary surgery | 38. Other |
| 9. Asthma | 19. Thyroid problems | 29. Aching joints | |
| 10. Skin disorders | 20. Rheumatic Fever | 30. Pelvis / back injuries | |

Please indicate, using the above numbers, if you have ever had any of these and when:

Please indicate if anyone in your immediate family has ever had any of the starred (*) conditions above and when:

Father of Baby - *Please indicate if the baby's father has or has ever had any of the following and when:*

- | | | |
|-------------------------------------|------------------------------|-------------------------|
| 1. Sexually transmitted disease(s) | 2. Severe emotional problems | 3. Alcohol / drug abuse |
| 4. Tobacco use | 5. Hepatitis | 6. Tuberculosis |
| 7. Birth defects (immediate family) | | |

Gynecological History

- | | | | |
|---------------------------|------------------------------------|---------------------------|-------------------------------------|
| Age at first period: | Cycle length (days): | Regular? Yes No Sometimes | Duration of bleeding: |
| Last Pap smear: | Have you ever had an abnormal Pap? | | Dates of Abnl Pap: |
| 1. Yeast infection | 2. Trichomonas | 3. Group B Strep | 4. Chlamydia / Gonorrhea / Syphilis |
| 5. Bacterial Vaginosis | 6. Cervicitis | 7. Cervical Surgery | 8. Cervical polyp |
| 9. Ovarian cyst | 10. Fibroids | 11. Endometriosis | 12. Genital sores |
| 13. Herpes (oral/genital) | 14. Genital warts | 15. Abnormal bleeding | 16. Uterine surgery |
| 17. Breast lump(s) | 18. Breast surgery | 19. Infertility | |

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

Current Pregnancy Information

- | | | | |
|---|-----------------------------|--------------------|-----------------|
| First day of last menstrual period: | Was period normal? | Yes No | If no, explain: |
| Suspected date of conception: | Date of positive preg test: | Planned pregnancy? | Yes No |
| If you are Rh-, have you received Rhogam with this pregnancy? | Yes No | If yes, when: | |

Please circle any of the following conditions you have experienced during this pregnancy (additional pregnancy related questions on page 6):

Nausea	Vomiting	Fever	Headache	Vaginal Infection	Leg Cramps	Backache
Constipation	Swelling	Diarrhea	Rash	Bleeding Gums	Depression	Anxiety
Varicose Veins	Hemorrhoids	Bleeding	Work problems	Family problems		Abdominal Pain

Please indicate if you have been exposed to any of the following during this pregnancy:

Tobacco	Alcohol	Caffeine	Fumes / sprays	Marijuana	Cocaine	Street Drugs
X-Rays	Ultrasound	Travel	Measles / Virus	Vaccinations	Cats	Medications

Some of the following questions are of a deep and personal nature and it may be difficult to share your response to them. They are optional. We feel your responses will enable us to better meet your physical and emotional needs during your pregnancy, birth and postpartum. Please feel free to voice any concerns you may have about these questions, or any feelings they make invoke. In addition, if there are any responses that you would NOT want discussed in front of your current partner, please let us know. Thank you!

Describe your current diet (vegan, vegetarian, ovo-lacto, omnivorous):

In your opinion, is your diet good, mediocre, or poor? Why?

Do you have an opportunity to rest or nap each day?

Do you sleep well at night?

Are you doing any special exercise, meditation, or yoga?

How do you feel about your sexual relationship since becoming pregnant?

Do you have any concerns about your relationship with your partner?

How do you feel about weight gain during pregnancy?

What childbirth related books have you read?

Describe your healthcare in the past five years. Do you use naturopathic physicians, chiropractors, acupuncturists, MDs, etc.?

Describe your occupation, how it affects your pregnancy, how long you plan to work, and if/when you plan to return to work postpartum:

How do you envision your ideal birth scenario? What sort of factors are important?

Do you trust your body to give birth?

Do you have any strong concerns about this pregnancy and birth?

Describe your personal strengths:

Your personal weaknesses:

What increases your strength / courage?

What diminishes your strength / courage?

What are your concerns about birth and mothering?

What are your hopes about birth and mothering?

Have you ever felt unsafe in your home for any reason? *Yes No*

Has a partner ever threatened to hit you? *Yes No*

Have you ever undergone any personal, emotional, physical, or sexual abuse in your life? *Yes No*

Have you ever been on medication for emotional / psychological disorders? *Yes No*

Have you ever been forced to have sex without your consent? *Yes No*

Has anyone ever told you, or do you think, that you have an eating disorder? *Yes No*

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

If your parents are living, what is your relationship with them now?

What are your family's thoughts on your pregnancy and birth plans?

Prenatal Screening Questionnaire

Father of the Pregnancy

Ethnic Origin / Religion
Occupation

Mother of the Pregnancy

Ethnic Origin / Religion
Occupation

Family and Patient History

Does your family or the father of the baby's family have the following ethnic background:

Yes No Southeast Asia, Taiwan, China, or the Phillippines

Yes No Italy, Greece, or the Middle East

If yes to the previous two questions, have you or your partner been tested for thalassemia? Yes No

Yes No Eastern European (Ashkenazi) Jewish

Yes No French Canadian

If yes to the previous two questions, have you or your partner been tested for Tay Sachs? Yes No

Yes No African American, African, or Black

If yes to the previous question, have you or your partner been tested for sickle cell anemia? Yes No

Have you, the baby's father, or anyone in either of your families ever had any of the following?

If "yes", please explain at the bottom in the space provided:

Yes No Down Syndrome

Yes No Other Chromosome Abnormalities

Yes No Neural Tube Defect (e.g. spina bifida, anencephaly)

Yes No Hemophilia or Other Bleeding Disorders

Yes No Cystic Fibrosis

Yes No Muscular Dystrophy

Yes No Neurofibromatosis

Yes No Huntington's Disease

Yes No Other Nerve, Muscle or Seizure Disorder (e.g. epilepsy)

Yes No Phenylketonuria (PKU)

Yes No Kidney Disease

Yes No Heart Defect (from birth)

Yes No Cleft Lip and/or Cleft Palate

Yes No Limb Defects (extra or missing digits, malformed arms, legs, hands or feet)

Yes No Deafness / Early Onset Hearing Loss

Yes No Blindness / Early Onset Vision Loss

Yes No Diabetes

Yes No Cancer before age 50

Yes No Heart Attack before age 40

Yes No Do you or the baby's father have any relatives with mental retardation or developmental delay?

Yes No Does anyone in either of your families have a genetic defect, or chromosome abnormality not listed above?

Yes No Have you or the baby's father had a baby that died shortly after birth or in the first year?

Yes No Have you or the baby's father had a stillborn child, or three or more first trimester miscarriages?

Yes No Are you and the baby's father blood-related in any way (i.e., cousins, uncle-niece, etc.)?

Yes No Is there any other family history that you have concerns about?

Pregnancy History

During this pregnancy, have you had any of the following?

If "yes", please describe, including dates, if known, in the space provided at the bottom:

Yes	No	Uterine cramping, vaginal bleeding (spotting) or vaginal leakage of fluid
Yes	No	Infections, rashes, or other illness, fever over 101 degrees
Yes	No	X-rays, hospitalizations, or surgery
Yes	No	Cigarettes, alcoholic beverages, or "street" drugs
Yes	No	Ultrasound ("sonogram")
Yes	No	Occupational, chemical, or other exposures
Yes	No	Prescription or non-prescription medications
Yes	No	Prenatal vitamins

Your Mother's Pregnancy History

Number of pregnancies she had

On average, how close was she to her due date (early, late, on time) ?

Her largest baby by weight

Your weight at birth

How much did the baby's father weigh at birth?

Comments and notes on the above questions:

Thank you for taking the time to answer these question!