North Jersey Midwifery Care, L.L.C., Donna Tabas, C.N.M.

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PATIENT HEALTH HISTORY

Date____/____/_____ Name_____

SS # _____Date of Birth_____ Age_____

Home telephone_____ Cell #_____work#_____

Address_____

Email:_____

Occupation_____Education_____

Religion_____Race/Ethnicity_____Birthplace_____

Marital Status: Married_____ Single_____ Divorced_____ Separated____ Widowed____ Domestic Partner_____

Husband/Co-Parent/Father of Baby: Name_____ Tel #_____

Emergency Contact (Name, Relationship, #)_____

Insurance & plan name_____Account #_____Group #_____

Insurance telephone # for providers_____Subscriber's Name_____M/F_____

Subscriber's Birthdate_____ Subscriber's SS#_____

Please list all the **MEDICATIONS**, both prescription, over-the-counter, and/or herbal/nutritional supplements you are taking regularly:

_____

_____

_____

WEIGHT (if pregnant, just before pregnancy)_____ **Height**_____

ALLERGIES:

Medications (list):	Yes	If Yes, Reaction	No
Latex:	Yes	If Yes, Reaction	No
Food (list):	Yes	If Yes, Reaction	No
Other (list):	Yes	If Yes, Reaction	No

MENSTRUAL / BIRTH CONTROL HISTORY

What was the **first day of your last menstrual period?** _____

Was the period: ☐ NORMAL or ☐ ABNORMAL?

Are you: ☐ CERTAIN or ☐ UNCERTAIN of this date?

Have you had any spotting between your periods_____

Are your periods normally: ☐ REGULAR or ☐ IRREGULAR?
How old were you when you had your first period? _____

How often do you usually get your period? Every _____ days.

For how long do you usually flow? For _____ days.

Are your periods light_____ moderate_____ or heavy_____

Pain or cramps with your period? ☐ YES ☐ NO ☐ SOMETIMES.

Date of your last Pap Smear_____

What forms of birth control, if any, have you used in the past?_____
_____

_____
If pregnant, describe the last form of birth control you used before this pregnancy, and when you stopped it._____

If pregnant, was this a planned pregnancy_____

If pregnant, did you take a home pregnancy test_____

Date positive_____

GYNECOLOGICAL HISTORY

Have you ever had?

____ A previous pelvic exam
____ A bad experience with a pelvic exam
____ Any abnormal pap smears (dysplasia or CIN)
____ Colposcopy (microscopic examination of the cervix)
____ Cryosurgery (freezing of the cervix)
____ LEEP procedure (removal of abnormal cervical tissue)
____ Cone biopsy (removal of abnormal cervical tissue)
____ Infertility work-up
____ Uterine fibroids (non-cancerous tumor)
____ Uterine surgery (including Cesarean Section)
____ Uterine anomalies
____ Ovarian cysts
____ Cervical, uterine, or ovarian cancer
____ Endometriosis
____ PCOS (polycystic ovarian syndrome)
____ Painful intercourse
____ Sexual difficulties; difficulty achieving orgasm
____ Abnormal or unusual vaginal bleeding
____ Frequent (> 3 per year) vaginal infections (yeast, BV)
____ Unusual vaginal discharge (heavier than usual, foul-smelling, or itchy?)
____ Dysmenorrhea (severely painful periods)
____ Ectopic pregnancies
____ Miscarriage
____ Voluntary abortion
____ Genital warts
____ Sexually transmitted diseases; (Syphilis, Gonorrhea, Chlamydia, Trichomonas, Herpes, HPV, Hepatitis B, Hepatitis C, HIV)
____ Pelvic inflammatory disease (PID)
____ Toxic Shock Syndrome
____ Breast cancer
____ Breast lumps, cysts, discharge, or other breast disease
____ Other_____

SEXUAL HISTORY

Do you currently have a sexual partner_____
Is your sexual partner male, female, or both_____
How many sexual partners have you had in the last 6 months?_____
Do any of your sexual partners have any sexually transmittable infections? (Syphilis, Gonorrhea, Chlamydia, Trichomonas, Herpes, HPV, Hepatitis B, Hepatitis C, HIV)_____
Do you have pain or bleeding during or after sexual relations?_____
Do you have any sexual problems or issues you would like to discuss with your care provider?_____
Are you planning to have a tubal ligation after this pregnancy is delivered?_____

MEDICAL HISTORY

Do you have a personal history of any of the following?

1. ____ High Blood Pressure
2. ____ Heart Disease
3. ____ Heart murmur, Mitral Valve Prolapse
   If yes, have you been told you need antibiotic prophylaxis for dental work?_____
4. ____ Stroke
5. ____ Blood clots in veins (Phlebitis)
6. ____ Pulmonary embolism
7. ____ Diabetes
8. ____ Cancer (specify type)_____
9. ____ Asthma
10. ____ Lung disease, Tuberculosis, or positive PPD (circle)
11. ____ Seasonal allergies
12, ____ Frequent sinus infections
13. ____ Thyroid disorder_____
14. ____ Liver disease (including hepatitis)
15. ____ Gallbladder disease or stones
16. ____ Hemorrhoids or rectal problems
17. ____ Gastrointestinal problems (irritable bowel disease, colitis, ulcers, constipation, diarrhea)
18. ____ Anemia (low iron)
19. ____ Sickle Cell Anemia or Trait
20. ____ Bleeding tendencies, blood or clotting disorders
21. ____ Hemorrhage (excessive blood loss)
22. ____ Blood transfusions
23. ____ Positive antibody screen
24. ____ Hyperlipidemia (high cholesterol)
25.____ Varicose veins
26. ____ Seizures or epilepsy
27. ____ Migraine headaches (with / without aura)
28. ____ Frequent headaches
29. ____ Frequent urinary tract infections (>3/year)
30. ____ Kidney disease, kidney stones
31. ____ Involuntary loss of urine or stool
32. ____ Muscle, bone, or joint problems (scoliosis, arthritis)
33. ____ Bone fractures
34. ____ Osteoporosis
35. ____ Autoimmune disorders, Lupus, Multiple Sclerosis
36. ____ Skin disorders
37. ____ Eye or vision problems, glaucoma
38. ____ Corrective lenses or contacts
39. ____ Hearing loss
40. ____ Dental problems, gum disease
41. ____ Rheumatic Fever
42. ____ Scarlet Fever
43. ____ Chicken Pox (varicella) disease (or was vaccinated)
44. ____ German Measles (rubella) disease (or was vaccinated)
45. ____ Measles (rubeola) disease (or was vaccinated)
46. ____ Mumps disease (or was vaccinated)
47. ____ HIV positive or AIDS
48. ____ Obesity, underweight, or recent changes in weight
49. ____ Eating disorders; anorexia, bulimia
50. ____ Drug addiction, alcoholism, substance abuse
51. ____ Psychiatric or psychological problems (anxiety, depression, postpartum depression)
52. ____ Psychiatric hospitalization
53. ____ Date of last Tetanus shot_____
53. ____ Other_____
    _____

SURGICAL /INJURY / HOSPITALIZATION HISTORY:

Please list any **surgeries** OR **significant injuries from accidents** OR **hospitalizations** (excluding normal childbirth) you may have had, including Cesarean births, D&C's, voluntary pregnancy terminations, tonsil, gallbladder, or appendix removals, oral surgeries, breast surgeries/biopsies, fractures etc.:

DATE	SURGERIES / INJURIES FROM ACCIDENTS / HOSPITALIZATIONS

PREGNANCY HISTORY

_____How many times total have you been pregnant?

_____How many live births?

_____How many live births were full term (>37 wks)?

_____How many live births were preterm (<37 wks)?

_____How many miscarriages or abortions?

_____If you had any live births, how many children are still alive?

Please list all past pregnancies, including miscarriages or terminations.

PREGNANCY NUMBER	DATE	WEEKS PREGNANT	VAGINAL OR C-SECTION	LENGTH OF LABOR	ANESTHESIA	HOSPITAL	SEX OF BABY	WEIGHT OF BABY	COMPLICATIONS
1									
2									
3									
4									
5									
6									
7									
8									

During PREVIOUS pregnancies or births, have you ever had any complications such as?:

_____Ectopic pregnancy _____Molar pregnancy _____Cesarean Section, or any surgery on your uterus other than in pregnancy _____Preterm Labor or birth (<37 wks) _____Multiple gestation (twins, etc.) _____Hospitalization before labor _____Excessive nausea/vomiting requiring medication/hospitalization _____Gestational Diabetes _____Preeclampsia, or Gestational Hypertension (high blood pressure) _____Intrauterine Growth Retardation (baby too small for dates) _____Placenta Previa	_____Oligohydramnios or Polyhydramnios (too little or too much amniotic fluid) _____ICP (Intraheptaic Cholestasis of Pregnancy) _____Excessive bleeding after delivery (postpartum hemorrhage) _____RhoGam injections _____Blood clots in legs, or other thrombotic disease _____Baby born > 8lbs 14oz, or < 5lbs 9oz _____Baby in position other than head down at term (Breech, etc.?) _____A baby with a birth defect or abnormality _____A baby with a serious infection and/or GBS sepsis _____A baby admitted to the neonatal intensive care unit _____A baby with jaundice _____A stillborn baby _____Infant death following delivery _____Other:_____ _____

If you are pregnant now, during THIS pregnancy, have you experienced any of the following?

_____ Nausea or vomiting? _____ Vaginal bleeding? _____ Painful urination? _____ Abdominal pain? _____ Fever, Rash, Flu, Chicken Pox, Measles? _____ Exposure to Tuberculosis, other illness? _____ Taken any medications? (aspirin, antibiotics, other?) _____ Taken Prenatal vitamins? _____ Do you eat unusual non-food substances like clay, starch, paint? (known as Pica)	Exposed to: _____ X-rays? _____ Chemical solvents/paint fumes? _____ High temperatures or hot saunas? _____ Mercury, lead? _____ Radiation? _____ Taken Drugs such as marijuana, cocaine, ecstasy, heroin, speed, LSD, crack, acid, other mind altering drugs, etc.? _____ Drank alcohol since you found out you are pregnant? _____ Smoke? # Cigarettes per day_____

FAMILY HISTORY

Does any member of your immediate family have any of the following?

YES	NO	CONDITION	PLEASE NOTE WHICH FAMILY MEMBERS ARE AFFECTED.
☐	☐	HEART DISEASE OR HEART ATTACK	
☐	☐	HIGH BLOOD PRESSURE	
☐	☐	KIDNEY OR BLADDER DISEASE	
☐	☐	TUBERCULOSIS	
☐	☐	DIABETES	
☐	☐	EMOTIONAL OR PSYCHIATRIC DISORDER	
☐	☐	STROKE, BLOOD CLOTS OR PHLEBITIS	
☐	☐	BLOOD VARIATIONS (SICKLE CELL, THALASSEMIA, G6PD)	
☐	☐	BIRTH DEFECTS, DOWN SYNDROME, NEURAL TUBE DEFECTS	
☐	☐	HEMOPHILIA	
☐	☐	MUSCULAR DYSTROPHY OR CYSTIC FIBROSIS	
☐	☐	HUNTINGTON CHOREA	
☐	☐	TAY-SACHS DISEASE	
☐	☐	TWINS OR MULTIPLE BIRTHS	
☐	☐	CANCER	
☐	☐	CHRONIC ILLNESSES	
☐	☐	DRUG OR ALCOHOL ABUSE	
☐	☐	MAJOR OPERATIONS	
☐	☐	PREGNANCY COMPLICATIONS	
☐	☐	DID YOUR MOTHER TAKE ANY HORMONES (DES) WHILE CARRYING YOU?	

Please indicate whether the following members of your family are living or deceased, and if they have any health conditions:

Family member	Alive or Deceased If deceased, what age?	Health Problems
Mother		
Father		
Siblings		
Children		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

GENETIC SCREENING

Some genetic problems may occur more frequently in couples with certain racial or ancestral backgrounds. Please check if either **you** or the **baby's father** is one of these backgrounds:

ETHNICITY	YES	NO	IF YES, HAVE YOU HAD SCREENING?	RESULT DATE
Jewish (Ashkenazi) ancestry			(for Tay Sachs and related illnesses) YES NO	
African descent			(for Sickle Cell disease) YES NO	
Italian, Greek, Mediterranean descent			(for Beta-Thalassemia) YES NO	
Philippine or Southeast Asian descent			(for Alpha-Thalassemia) YES NO	

(Indicate whether you, the baby's father, or anyone in either family has any of these conditions, and who has it)

ITEM	YES	NO	ITEM	YES	NO
Will you be > 35 y.o. when baby is due to be born			Mental retardation / Autism?		
Thalassemia (common in Italian, Greek, Mediterranean, or Asian Background			If yes, was the person tested for Fragile X?		
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			Other inherited Genetic or Chromosomal Disorders		
Congenital Heart Defect			Maternal Metabolic Disorder (*i.e.* insulin-dependent diabetes, PKU)		
Down's Syndrome			Have either you or the baby's father had a child with birth defects not listed above? Describe:		
Tay-Sach's or other Ashkenazi related disorders (seen in those of Jewish, Cajun, French, Canadian descent)			Do either you or the baby's father have a birth defect? Describe:		
Sickle Cell Disease or Trait (seen in those of African, African-American descent)			Do you or baby's father have history of recurrent Pregnancy Losses (≥ 3) or a stillbirth?		
Hemophilia or other bleeding disorders?			Medications / Street Drugs / Excessive Alcohol since last menstrual period? If yes, list agents:		
Muscular Dystrophy			G6PD		
Cystic Fibrosis			Huntington's Chorea		

NUTRITIONAL HISTORY

Do you have any dietary restrictions? (vegetarian, vegan, gluten-free, lactose intolerant, PKU, food allergies, Kosher/Halal)_____

How many meals do you eat each day?_____

How many snacks do you eat each day?_____

Do you often miss meals?_____ If so, which meal?_____

Do you frequently eat meals away from home?_____

Have you had challenges in the past regarding maintaining a healthy weight, either being under or overweight, or fluctuating weight? _____

_____

On average, how many servings per day do you have of:

FOOD TYPE	NUMBER OF SERVINGS PER DAY
Dairy products (milk, cheese, yogurt, ice cream, pudding)	
Vegetables	
Fruits	
Breads, grains, cereals	
Protein foods (meat, poultry, pork, lamb, fish eggs, tofu, nuts, beans, peas)	
Foods with Vitamin C (orange/grapefruit fruit or juice, tomatoes, peppers, cantaloupe, cabbage)	
Foods with Vitamin A (yellow or orange colored fruits and vegetables)	
Eight ounce glasses of fluids (water, juice, soda, diet soda, seltzer, milk, soy milk, sports drinks, tea, coffee)	
Desserts, sweets, junk food, chips	

SOCIAL HISTORY

I understand that some of these questions are sensitive, but this information can help me to take care of you in a holistic way. I can discuss any of these issues privately with you if you would like.

Do you smoke? YES____ NO____ If yes, for how many years?_____
How many cigarettes per day **prior to pregnancy**_____
How many cigarettes per day **now**_____
Are you interested in stopping smoking_____

Do you drink alcoholic beverages? YES_____ NO_____
# of drinks **prior to pregnancy** per day____, week_____, month_____
# of drinks **now** per day____, week_____, month_____

Do you use drugs such as marijuana, cocaine, ecstasy, heroin, speed, LSD, crack, acid, other mind altering drugs, etc.? YES____ NO____ If yes, how frequently?_____ Last used_____

Are you currently employed_____ What is the nature of your work?_____

Are you experiencing high levels of stress in your personal life? (financial, employment, housing, family, other?) YES ___NO__
Briefly Explain:_____

Are you experiencing marital problems_____

Is there violence in any of your relationships_____

Have you ever been physically or emotionally abused, hurt, or threatened by an intimate partner, or anyone else_____

Are you afraid of a partner or any other person in your life_____

Have you been the victim of childhood sexual abuse_____

Have you ever been coerced or forced to have sex or sexual contact without your consent (incest, rape, molestation)?_____

Have you experienced a significant recent loss (death), trauma, been a victim of crime, or experienced a catastrophic event_____

Do you have a social support system (family, friends, religious group, etc) to which you can turn in times of stress/need?_____

Do you exercise regularly_____ How often_____ What forms of exercise?_____

How many hours of sleep do you get, on average, per night_____ Do you have sleeping difficulties?_____

Have you recently traveled out of the country?_____ If yes, where?_____

Do you have any pets?_____ If yes, please specify_____

What do you do for fun_____