**Spokane Midwives**

**127 E Euclid Ave. Spokane, WA 99207**

**Client Registration**

**Date:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: First | Middle | Last | Maiden? |
| Address: Street | City | Zip | County | Inside City Limits?□ Yes □ No |
| How long at this Address? | Mailing Address if Different |
| Race | Tribe/Hispanic Origin/Islander origin (if app.) | Religion | Yrs Educ/Degree | Marital Status | Occupation/Type of Business |
| State of Birth | Date of Birth **Age** | Height: | Pre-preg wt: | Cell Phone- Home -  |
| Father of Baby: First | Middle | Last | State of Birth | Date of Birth **Age** |
| Race  | Tribe/Hispanic Origin/Islander origin (if app.) | Yrs Educ/Degree | Cell Phone - Home- | Occupation/Type of Business |
| Mother’s Social Security Number | Father’s SSN | Requesting SSN for baby?□ Yes □ No |
| Another person to contact in an emergencyName: | Phone:Relationship: | Your Email-  |

**Please answer the following questions which will help determine if there are potential problems which 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; when.

□ High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Twins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Severe emotional problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Alcohol/drug abuse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father of Baby –** Indicate if the baby’s father has ever had any of these; 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Previous pregnancy outcomes Please complete this table regarding your own pregnancies (from earliest to most recent)** |
| Date | #Weeks | Birth/Miscarriage/Termination | Comments/Problems |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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 Are you and the FOB related by blood? (e.g., cousins)

Yes No Are you or the FOB from any of these ethic/racial groups? (circle)

 Jewish Black/African Asian 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 having a baby with a birth defect or genetic problem?

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 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 any medication for psychological problems?

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

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY Please indicate if you have ever had any of these; when:**

**□** Severe headaches\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Bowel problems/colitis\_\_\_\_\_\_\_\_\_\_

**□** Eye/vision problems\_\_\_\_\_\_\_\_\_\_\_ **□** Blood in stool\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Ear/hearing problems\_\_\_\_\_\_\_\_\_\_ **□** Gall bladder problems\_\_\_\_\_\_\_\_\_\_\_

**□** Dental Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Liver problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Thyroid problems\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Hepatitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Rheumatic fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Blood clotting problems\_\_\_\_\_\_\_\_ □ Hypoglycemia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Anemia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Bladder infection\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hemorrhage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Kidney infection\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ High Blood pressure\_\_\_\_\_\_\_\_\_\_\_ □ Urinary surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Varicose veins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Urethral dilation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hemorrhoids\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Aching joints\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Tuberculosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Pelvic/back injuries\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Seizures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Skin disorders\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Stomach problems\_\_\_\_\_\_\_\_\_\_\_\_ □ Hospitalizations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Ulcers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Chicken Pox\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies? □** Yes **□** No

Please List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GYNECOLOGIC HISTORY**

Age at first period\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was your last Pap smear?

Cycle length (days)\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regular? □ Yes □ No Have you ever had an abnormal pap?

Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dates)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if you have ever had any of the following; when:**

□ Yeast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cervicitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Trichomonas\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cervical surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Group B Strep\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cervical polyp\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Bacterial vaginosis\_\_\_\_\_\_\_\_\_\_\_\_ □ Ovarian cyst\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Chlamydia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Fibroids\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Gonorrhea\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Endometriosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Syphilis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Abnormal bleeding\_\_\_\_\_\_\_\_\_\_\_\_\_

□PID/Pelvic infection\_\_\_\_\_\_\_\_\_\_\_\_ □ Uterine surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Genital Sores\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Breast lump(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Herpes: □ Genital □ Breast surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Oral □ Infertility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Condyloma (warts)\_\_\_\_\_\_\_\_\_\_\_\_ □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are there any particular ethnic, cultural or religious preferences for your care during pregnancy and birth that you’d like to discuss?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENT 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 if you’ve had any of the following problems during this pregnancy:**

□ Nausea\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Urinary complaints\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Vomiting\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Abdominal/Pelvic pain\_\_\_\_\_\_\_\_\_\_\_

□ Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Vaginal bleeding/spotting\_\_\_\_\_\_\_\_

□ Infections\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Vaginal discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Headache\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Bleeding gums\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Dizziness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Varicose veins\_\_\_\_\_\_\_\_\_\_\_\_

□ Indigestion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Hemorrhoids\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Leg cramps\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Depression\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Rash\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Loneliness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Backache\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Family/relationship problems\_\_\_\_\_

□ Swelling\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Work problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Constipation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Diarrhea\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:**

□ Tobacco\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Herbs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Fumes/sprays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Caffeine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ X-rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Marijuana\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Ultrasound\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Cocaine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Measles/Viruses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Street drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Travel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other meds\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Vaccinations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Non-pres. Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cats\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Vitamins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Planned place of birth:**

□ Home □ Birth Center □ Hospital

**If home, please indicate if you have:**

 □ Water □ Electricity □ Telephone

**Top two reasons for choosing home/clinic birth:**

□ Family Unity □ Spiritual

□ Control □ Desire for natural birth

□ Dislike hospitals □ “High Risk”

□ Atmosphere □ Social Pressure

□ Safety □ Partner preference

□ Effect on baby □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_