# Tree of Life Midwifery Care
## Lisa Black, LM, CPM – 214-394-5687

| Name First Middle Last Maiden | | | | Date | Phone (home)<br>(work) |
|---|---|---|---|---|---|
| Race | Religion | Yrs. Educ. | Marital Status | Occupation/Type of Business | Date of Birth | State of Birth |
| Address: Street City Zip | | | | Inside City Limits<br>Yes No | How long a t this address? |
| Father of Baby: | | Race | Yrs. Educ. | Date of Birth | State of Birth |
| Address (if different from above- if the same write "Same") | | | | Phone (work)<br>(home) | Occupation/Type of business |
| Partner/Husband (if different from Father) | Another person to contact in emergency<br>Name: | | | Phone:<br>Relationship: | |
| Method of Payment: Cash<br>Medicaid Other: | Insurance Information: Copay ___________<br>Policy #: | | | Name of Policy Holder: ________________________________<br>Group #: | |
| Social Security #: | Father's Social Security #: | | Social Security Number requested for baby? | | Referred by: |

**Please complete this form in preparation for your initial visit. The above information is required for completion of your baby's birth certificate. Your responses will be kept completely confidential. In the event your records are copied for another care provider, this page will not be copied. If you need more spaces, please use the area provided on the back.**

FAMILY HISTORY – Indicate if anyone in your immediate family had any of these, who; when.

High Blood Pressure __________________
Cancer ______________________________
Diabetes______________________________
Twins ______________________________
Severe emotional problems ____________
Alcohol abuse ________________________
Drug abuse __________________________
Other _______________________________

FATHER OF BABY – Indicate if the baby's father has ever had one of these; when.

Sexually transmitted diseases _____________
Herpes: Genital Oral
Severe emotional problems _______________
Alcohol abuse __________________________
Drug/Tobacco abuse ______________________
Other __________________________________
________________________________________
________________________________________

YOUR MOTHER'S HISTORY – Please answer the following reguarding your mother.

No. of pregnancies ______________
No. of births ____________________
Miscarriages _____________________
Any complications? ______________
Your weight at birth _____________
Did she take DES with you?
Yes No

| # | Month/ Year | Weeks Gestation | Length of Labor 1st stage | 2nd stage | Type of Delivery | Medication /Anesthesia | Induction? | Birth Site | Birth Weight | Sex | Breast Fed? | Name |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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## QUESTIONARRE

**Please answer the following questions which will help determine if there are potential problems which should be discussed further. Again, this information is completely confidential.**

Yes No Have you or the father of the baby (FOB) ever had a baby with 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 ethnic/racial groups? (circle)
Jewish Black/African Asian Mediterranean
Yes No Have your or the FOB ever had hepatitis or jaundice?
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 an increased risk for having a baby with a birth defect or genetic problem?
Yes No Do you think you are at an 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 you 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 ___________________________________________**

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 | 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

Duration __________

Have you ever had an abnormal Pap? (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 | Abdominal Bleeding |
| PID/Pelvic infection | Uterine Surgery |
| Genital sores | Breast lump(s) |
| Herpes: Genital<br>Oral | Breast surgery<br>Infertility |
| Condyloma (warts) | Other |

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 complications |
|---|---|
| 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 | Vaccinations |
| Other meds | Travel |
| Non-Pres. Drugs | Cats |
| Vitamins | Other |

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