

HISTORY OF PREVIOUS PREGNANCIES

Name: _____ Phone(s): _____

Blood Type: _____ Last menses: _____ EDD: _____

Allergies: _____

PREVIOUS PREGNANCIES and/or BIRTHS:

(Please include any miscarriages, abortions and/or ectopic pregnancies. Feel free to use the back of this page to go into more detail if you need to.)

DATE	DUE DATE	WEIGHT/ GENDER	OUTCOME AND ANY COMPLICATIONS

How long were you in labor with each child? _____

Did you have an episiotomy or tear? If yes, did you receive stitches? _____

Did you have any problem with hemorrhaging (bleeding too much after the baby's born)? _____

PRENATAL CARE FORM

Name: _____ Age: _____ DOB: _____

Address: _____

_____ County _____ Zip Code: _____

Phone(s): _____ Occupation: _____

Family member's names: _____

Name and number of person to contact in case of emergency:

Directions to your home (please draw a map on back if necessary):

What was the first day of your last period? _____

Conception date, if known: _____

Was there anything unusual about your last period? _____

Is your menstrual cycle usually 28 days? Longer? Shorter? _____

Have you taken a pregnancy test? _____ Date: _____

What symptoms of pregnancy have you had? _____

Were you using birth control? Which method? _____

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Please have both parents discuss and answer the following questions.

What are your reasons for considering a home birth?

What kind of birth experience would you like to have?

What are your expectations of a midwife?

What other health care professionals are you seeing for care during this pregnancy?
(please include chiropractors, naturopaths, massage therapists, etc.)

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

Are there any other health or personal considerations that we should be aware of?

