City of Oaks
MIDWIFERY

NAME: _____ TODAY'S DATE: ____/____/____ BIRTHDATE: ____/____/____

PRIMARY CARE PROVIDER: _____

REASON FOR VISIT: _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

	YES	NO		YES	NO
Acne			Hepatitis		
Anemia			High Blood Pressure		
Anxiety			High Cholesterol		
Arthritis			Incontinence		
Asthma			Irritable Bowel Syndrome		
Blood transfusions			Kidney Infections		
Cancer			Kidney Stones		
Chronic Lung Disease			Lupus		
Crohn's Disease			Osteoporosis		
Depression			Polycystic Ovarian Syndrome		
Diabetes			Seizures		
Eczema			Sexually Transmitted Diseases		
Gastroesophageal Reflux Disease			Stroke		
Glaucoma			Tuberculosis - TB		
Headaches			Thyroid Disease		
Heart Murmur			Ulcerative Colitis		
Heart Problems			Other:		

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	Date		Date
Bone Density		Flu shot	
Colonoscopy		Gardasil vaccine	
Mammogram		TDAP vaccine	
Pap Smear		Other:	

LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

Surgery/Complications	Date	Surgery/Complications	Date

LIST MEDICATIONS, VITAMINS AND SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

Drug Name	Dose & Frequency	Drug Name	Dose & Frequency

LIST ALLERGIES TO MEDICATION, FOOD, ENVIRONMENT (including Latex)

Allergy	Reaction	Allergy	Reaction

YOUR GYNECOLOGY HISTORY

Have you ever had an abnormal pap smear? [ ] Yes [ ] No
If yes, were you treated? [ ] Yes [ ] No [ ] Colposcopy [ ] LEEP

Do you use birth control? [ ] Yes [ ] No [ ] Not sexually active
If yes, what method of birth control: _____

What age did you have your fist period: _____ Are your periods [ ] regular [ ] irregular
How many days are there from start of period to start of next period: _____
How long does your period last: _____ days Flow: [ ] Light [ ] Medium [ ] Heavy
What is the date of your last period: _____
Do you pass blood clots? [ ] Yes [ ] No Do you have bleeding between menses? [ ] Yes [ ] No
Do you have painful menstrual cramps? [ ] Yes [ ] No Do you have pelvic pain? [ ] Yes [ ] No

Have you gone through menopause? [ ] Yes [ ] No If yes, at what age: _____
Are you on hormone replacement therapy? [ ] Yes [ ] No

YOUR OBSTETRIC HISTORY

	Number		Number
Full Term births		Abortions	
Pre Term births		Ectopic Pregnancies	
Living Children		Miscarriages	

	Birth Date	Weeks Gestation	Hours in Active Labor	Baby's Weight and Sex	Type of Delivery	Anesthesia	Preterm contractions Yes or No	Complications	Location / Delivered by
1									
2									
3									
4									
5									

CHECK IF YOUR BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

	YES	NO	What Blood Relative	Age at Diagnosis
Blood Clots				
Crohn's Disease				
Breast Cancer				
Ovarian Cancer				
Uterine Cancer				
Other Cancers				
Depression/Anxiety/Mood disorders				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Osteoporosis				
Stroke				
Thyroid Disease				
Ulcerative Colitis				
Other:				

YOUR SOCIAL HISTORY

Are you sexually active? [ ] Yes [ ] No
Are you [ ] married [ ] single [ ] divorced [ ] widowed
What is your occupation? _____
Smoke [ ] Yes [ ] No Packs per day: _____ Number of Years: _____
Alcohol [ ] Yes [ ] No Drinks per day: _____ Drinks per week: _____
Drug Use [ ] Yes [ ] Quit [ ] Never Kind: _____ Frequency: _____
History of abuse [ ] Yes [ ] No Do you feel safe now? [ ] Yes [ ] No [ ] Physical [ ] Emotional [ ] Sexual