

Registration

Everyday Miracles



Today's Date:

Name		Maiden?	Phone (hm) (wk) (cell)	
		E-mail		
Race:	Religion:	Years of Education:		
Marital Status	Occupation	Date of Birth	Place of Birth	Age
How tall are you?		Pre-pregnancy weight		
Address:		How long at this address?		
Father of Baby:		Phone (hm) (wk) (cell)	Date of Birth	Place of Birth
		Age		
Race:	Religion:	Years of Education:		
Address (if different from above)		Occupation		
Partner/Husband (if different from Father)		Phone (hm) (wk) (cell)	Date of Birth	Place of Birth
		Age		
Race:	Religion:	Years of Education:		
Address (if different from above)		Occupation		
Insurance:		Policy Holder:	Number:	
Mother's Social Security Number		Father's SSN	SSN Requested for baby YES NO	
Other emergency contact:		Phone:	Relationship:	
Method of payment: Insurance	Medicaid	Cash	Payment Plan	
Pediatrician:	Phone:	Primary Care Provider:	Phone:	
Referred by:				

Please complete this form. The information is necessary to complete your baby's birth certificate and to provide you with optimum care. If you need more space, please use the back of the form. All information is kept completely confidential. Thank you!

YOUR FAMILY HISTORY:

Has anyone in your immediate family ever had one or more of these? Who and when?

- High Blood Pressure _____
- Cancer _____
- Diabetes _____
- Twins or Higher _____
- Genetic Problems _____
- Hepatitis/Jaundice: _____
- Severe emotional problems _____
- Alcohol/drug abuse _____
- Other _____
- Family ethnicity
Jewish/Black/African/Asian/Mediterranean (circle)

FATHER OF BABY:

Has the baby's father ever had any of these? When?

- Tobacco use _____
- Alcohol/drug abuse _____
- Sexually transmitted diseases _____
- Genetic Problems _____
- Hepatitis/Jaundice: _____
- Herpes: Genital Oral
- HIV Risk: _____
- Related to mother? _____
- Severe emotional problems _____
- Other _____
- Family ethnicity
Jewish/Black/African/Asian/Mediterranean (circle)

YOUR MOTHER'S HISTORY:

Number of Pregnancies _____
 Number of Live Births _____
 Miscarriages? _____
 Pre-term Labor? _____
 Complications? _____
 Your Birth weight _____
 Were you full term? _____
 Were you Breastfed? _____ How long? _____
 Did she take DES while pregnant with you? Yes No

SOCIAL HISTORY:

List Household Members: _____
 Describe your living environment: _____
 Sexual Partners: _____
 Any Abuse history _____
 Pets: _____
 Dietary Practices: _____
 Activity Levels: _____

NOTES: _____

YOUR PREGNANCY HISTORY: from earliest to most recent, including miscarriages and abortions

Total #:	Term:	Premature:	Abortions	Miscarriage	Stillbirths:	Ectopic:	Multiples:	Living Children:

Date	#Weeks	Where Delivered	Vaginal/ Cesarean	Meds	Length Of labor	Episiotomy /Laceration	Comments /Problems	M /F	Birth Wt	Name	Breast fed?

YOUR MEDICAL HISTORY:

Please indicate if you have ever had any of these, and when?

- Severe headaches _____
- Severe depression: _____
- Emotional problems: _____
- Eye/vision problems _____
- Ear/hearing problems _____
- Dental problems _____
- Thyroid problems _____
- Asthma _____
- Rheumatic fever _____
- High blood pressure _____
- Blood clotting problems _____
- Hemorrhage _____
- Anemia _____
- Dramatic weight fluctuations: _____
- Eating disorders: _____
- Stomach problems _____
- Ulcers _____
- Hypoglycemia _____
- Diabetes _____
- Hepatitis _____
- Gall bladder problems _____
- Liver problems _____

- Bladder infections _____
- Kidney infections _____
- Urinary surgery _____
- Urethral dilation _____
- Bowel problems/colitis _____
- Blood in stool _____
- Varicose veins _____
- Hemorrhoids _____
- Aching joints _____
- Tuberculosis _____
- Pelvic/back injuries _____
- Seizures _____
- Skin disorders _____
- Cancer _____
- Chicken Pox _____
- Injuries _____
- Chronic illness _____
- Surgeries _____
- Hospitalizations _____

ALLERGIES: list any and what happens None

YOUR BLOOD TYPE: _____

Baby's Father's Blood Type: _____
Have you ever had RHOGAM? _____

MEDICATIONS/HERBS: list any taken NONE

GYNECOLOGIC HISTORY:

Age at first period _____ Cycle length _____
Regular? Yes No Duration _____
Last Menstrual Period: _____ Normal? _____
Last Pap smear _____ Any Abnormal? _____
Any Problems _____
What Birth Control have you ever used and when? _____

Do you have a history of any of these?

- Yeast _____
- Trichomonas _____
- Group B Strep _____
- Bacterial vaginosis _____
- Chlamydia _____
- Syphilis _____
- Genital Sores _____
- Herpes: Genital _____
 Oral _____
- Condyloma _____
- Cervicitis _____
- Cervical surgery _____
- Cervical polyp _____
- Ovarian cyst _____
- Fibroids _____
- Gonorrhea _____
- Endometriosis _____
- Abnormal bleeding _____
- PID _____
- Uterine surgery _____
- Breast lump(s) _____
- Breast surgery _____
- Infertility _____
- Other _____

Notes: _____

PRESENT PREGNANCY

Suspected date of conception _____
Pregnancy tests (dates) _____
Planned pregnancy? Yes No
Feelings about pregnancy _____

Fathers/Partner's feelings _____

Have you had any of the following since pregnant?

- Nausea Urinary frequency
- Vomiting Abdominal/pelvic pain
- Fever Vaginal bleeding/spotting
- Infections Vaginal discharge
- Headache Bleeding gums
- Dizziness Varicose veins
- Indigestion Hemorrhoids
- Leg cramps Swelling
- Rash Backache
- Constipation Diarrhea
- Depression Loneliness
- Family/relationship problems _____

Work problems _____

Other _____

TOXINS:

Have you been exposed to any of these while pregnant?

- Tobacco Herbs
- Alcohol Fumes/sprays
- Caffeine X-rays
- Marijuana Ultrasound
- Cocaine Measles/Viruses
- Street drugs Travel/Long Commute
- Other meds Vaccinations
- OTC drugs Cats
- Vitamins Other

BIRTH PLANNING:

Planned place of birth:

- Home Birth Center Hospital
- If home: House Apartment Other _____
- Water Electricity Telephone Safe Neighborhood
- VBAC Waterbirth Doula
- Childbirth classes: _____
- Support systems: _____

Infant Feeding Plan: Breast ABM
 Both Undecided

Circumcision: No Yes Undecided

Are there any ethnic, cultural or religious preferences for during your pregnancy or birth?