Midwife York, LM, CPM

Registration Form

Date: _____ Care Site: _____

Name: _____ Age:_____ DOB:_____

Occupation _____ Marital Status _____ Husband's Full Name_____

Full Address:_____

Emails _____

Telephones/cell # 1)_____ #2)_____

Referred from/by: _____

Are you receiving care from another healthcare provider? (OB, Naturopath, Chiropractor…) Y / N

Have you had any ultrasounds or laboratory tests? _____ Typically labs are requested by 28 weeks (Blood type & Rh, Antibody screen if Rh negative, CBC, Hepatitis B, Rubella, HIV/AIDS. If these are completed, please send copies of all results. (rcv'd _____)

Family Information

Your Mother: _____ pregnancies, _____ births, _____ miscarriages or abortions,
_____ C/Section, _____ twins/multiples, _____ premature births
You or any family member: diabetes Y / N diabetes in pregnancy Y / N kidney disease Y / N heart disease Y / N
High blood pressure in pregnancy Y / N pre-eclampsia/toxemia Y / N
Are you aware of any birth defects, deformities, inheritable conditions? Y / N _____
Give additional info if you responded Yes to any question: _____

_____

Your birth wt _____ Husband's birth wt _____ his blood type _____ Are you related? Y / N

Your Pregnancies

_____ Pregnancies, _____ births, _____ miscarriages/abortions, _____ C/Section, _____ multiples

#	DoB / gender	Wks gest.	L&D - induct, epis, C/S	Where	Wt / Health	Complications

NAME: DOB: EDD:

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Any known Allergies/sensitivities? Y / N _____ Medications? Y / N _____

Did you plan this pregnancy? Y / N How do you feel about this pregnancy? _____
First day of last normal menstrual period? _____ Sure / Unsure Suspected conception date _____
Periods regular? Y / N Length of cycles: every _____ days x _____ days. Did you have a pregnancy test? Y / N
Date of positive pregnancy test _____ . Date you felt baby movements/kicks _____
Any ultrasounds done yet? Y / N Date of ultrasounds _____ . Please send a the results (Rcv'd _____)
What is your Height: _____ Pre-pregnancy weight: _____ Do you do breast sellf-exams Y / N
Do you bruise easily? Y / N Do you have varicose veins? Y / N If so, Where? _____
Have you been feeling unwell during this pregnancy? Y / N Any of the following: Dizziness Y / N Headache Y / N Visual disturbances Y / N Epigastric pain Y / N Swelling of Face Y / N Swelling of Hands Y / N Any Swelling that does not subside with rest Y / N (Explain any YES answers) _____

_____

_____

Do you feel you have the emotional and physical support you need during pregnancy? Y / N For labor and birth? Y / N
For an Out-of-Facility/Home Birth experience? Y / N (Explain)_____

_____

Have you ever been abused physically, sexually, mentally? Y / N Are you receiving counseling for any past sexual or birth Experiences? Y / N (Explain) _____

_____

If you are receiving concurrent prenatal care, will the same professional be providing care to you after the birth (postpartum)? Y / N (Explain plan of care you desire) _____

_____

Do you have a professional who will provide newborn care and evaluations? (Explain plan of pediatric care) _____

_____

Are you taking prenatal or childbirth education classes? Y / N (Any topics to discuss at this time?) _____

_____

Have you written a "Birth Plan"? Y / N If so, please share your desires with me. If not, it would be good to write one by your 30 week visit. (Any topics to discuss at this time?) _____

_____

Are you considering having a professional labor companion/doula attend this birth? Y / N
Please note anything else you wish to tell me: _____

_____

_____

_____

NAME: DOB: EDD: