Client Registration

Spokane Midwives

127 E Euclid Ave. Spokane, WA

Date:

Name: First	Middle	Last	Maiden?		
Address: Street	City	Zip	County	Inside City Limits? ☐ Yes ☐ No	
How long at this Address?	Mailing Address if Different				
Race	Tribe/Hispanic Origin/Islander origin (if app.)	Religion	Yrs Educ/Degree	Marital Status	Occupation/Type of Business
State of Birth	Date of Birth **Age**	Height:	Pre-preg wt:	Cell Phone- Home -	
Father of Baby: First	Middle	Last	State of Birth	Date of Birth **Age**	
Race	Tribe/Hispanic Origin/Islander origin (if app.)	Yrs Educ/Degree	Cell Phone - Home-	Occupation/Type of Business	
Mother's Social Security Number	Father's SSN	Requesting SSN for baby? ☐ Yes ☐ No			
Another person to contact in an emergency Name:	Phone: Relationship:	Your Email-			

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

Family History – Indicate if anyone in your immediate family has ever had any of these, who; when.

- ☐ High Blood Pressure_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Twins_____
- ☐ Severe emotional problems_____
- ☐ Alcohol/drug abuse_____
- ☐ Other_____

Father of Baby – Indicate if the baby's father has ever had any of these; when.

- ☐ Sexually transmitted diseases_____
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Severe emotional problems_____
- ☐ Alcohol/drug abuse_____
- ☐ Tobacco use_____
- ☐ Other_____

Your Mother's History – Please answer the following regarding your mother:

- ☐ No. of pregnancies_____
- ☐ No. of births_____
- ☐ Miscarriages_____
- ☐ Any Complications_____
- ☐ Your weight at birth_____

Previous pregnancy outcomes **Please complete this table regarding your own pregnancies (from earliest to most recent)**

Date	#Weeks	Birth/Miscarriage/Termination	Comments/Problems

Yes	No	Have you or the father of the baby (FOB) ever had a baby with a 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 ethic/racial groups? (circle) Jewish Black/African Asian Mediterranean
Yes	No	Have you or the FOB ever had hepatitis or jaundice?
Yes	No	Have you ever used any drug intravenously (IV) or had a blood transfusion?
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 increased risk for having a baby with a birth defect or genetic problem?
Yes	No	Do you think you are at 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 your 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_____ **DATE:** _____

MEDICAL HISTORY Please indicate if you have ever had any of these; when:

☐ Severe headaches_____
☐ Eye/vision problems_____
☐ Ear/hearing problems_____
☐ Dental Problems_____
☐ Thyroid problems_____
☐ Rheumatic fever_____
☐ Blood clotting problems_____
☐ Anemia_____
☐ Hemorrhage_____
☐ High Blood pressure_____
☐ Varicose veins_____
☐ Hemorrhoids_____
☐ Tuberculosis_____
☐ Asthma_____
☐ Skin disorders_____
☐ Stomach problems_____
☐ Ulcers_____
☐ Chicken Pox_____
☐ Bowel problems/colitis_____
☐ Blood in stool_____
☐ Gall bladder problems_____
☐ Liver problems_____
☐ Hepatitis_____
☐ Diabetes_____
☐ Hypoglycemia_____
☐ Bladder infection_____
☐ Kidney infection_____
☐ Urinary surgery_____
☐ Urethral dilation_____
☐ Aching joints_____
☐ Pelvic/back injuries_____
☐ Seizures_____
☐ Cancer_____
☐ Hospitalizations_____
☐ Surgeries_____
☐ Other_____

Do you have any allergies? ☐ Yes ☐ No
Please List:_____

_____

GYNECOLOGIC HISTORY

Age at first period_____
Cycle length (days)_____
Regular? ☐ Yes ☐ No
Duration_____

When was your last Pap smear?
_____
Have you ever had an abnormal pap?
(dates)_____
Please describe_____

Please indicate if you have ever had any of the following; when:

☐ Yeast_____
☐ Trichomonas_____
☐ Group B Strep_____
☐ Bacterial vaginosis_____
☐ Chlamydia_____
☐ Gonorrhea_____
☐ Syphilis_____
☐PID/Pelvic infection_____
☐Genital Sores_____
☐ Herpes: ☐ Genital ☐ Oral
☐ Condyloma (warts)_____
☐ Cervicitis_____
☐ Cervical surgery_____
☐ Cervical polyp_____
☐ Ovarian cyst_____
☐ Fibroids_____
☐ Endometriosis_____
☐ Abnormal bleeding_____
☐ Uterine surgery_____
☐ Breast lump(s)_____
☐ Breast surgery_____
☐ Infertility_____
☐ Other_____

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

_____

_____

_____

_____

_____

_____

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_____
☐ Vomiting_____
☐ Fever _____
☐ Infections_____
☐ Headache_____
☐ Dizziness_____
☐ Indigestion_____
☐ Leg cramps_____
☐ Rash_____
☐ Backache_____
☐ Swelling_____
☐ Constipation_____
☐ Diarrhea_____
☐ Urinary complaints_____
☐ Abdominal/Pelvic pain_____
☐ Vaginal bleeding/spotting_____
☐ Vaginal discharge_____
☐ Bleeding gums_____
☐ Varicose veins_____
☐ Hemorrhoids_____
☐ Depression_____
☐ Loneliness_____
☐ Family/relationship problems_____
☐ Work problems_____
☐ Other_____
_____

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

☐ Tobacco_____
☐ Alcohol_____
☐ Caffeine_____
☐ Marijuana_____
☐ Cocaine_____
☐ Street drugs_____
☐ Other meds_____
☐ Non-pres. Drugs_____
☐ Vitamins_____
☐ Herbs_____
☐ Fumes/sprays_____
☐ X-rays_____
☐ Ultrasound_____
☐ Measles/Viruses_____
☐ Travel_____
☐ Vaccinations_____
☐ Cats_____
☐ Other_____

Planned place of birth:

☐ Home ☐ Birth Center ☐ Hospital

If home, please indicate if you have:

☐ Water ☐ Electricity ☐ Telephone

Top two reasons for choosing home/clinic birth:

☐ Family Unity
☐ Control
☐ Dislike hospitals
☐ Atmosphere
☐ Safety
☐ Effect on baby
☐ Spiritual
☐ Desire for natural birth
☐ "High Risk"
☐ Social Pressure
☐ Partner preference
☐ Other_____